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: 0053686

Facility Name: SYMPHONY OF CHICAGO WEST

Address: 5130 W Jackson Blvd . (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			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 OF CHICAGO WEST # 0053686 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	234	Skilled (SNF)	234	85,410	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	234	TOTALS	234	85,410	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			13,868	13,868	8
9	SNF/PED					9
10	ICF	59,447	1,156	5,702	66,305	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,447	1,156	19,570	80,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.87%

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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 234 and days of care provided 5,313

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 OF CHICAGO WEST # 0053686 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	336,744	142,665	38,874	518,283		518,283		518,283			1
2	Food Purchase		401,674		401,674		401,674	(58)	401,616			2
3	Housekeeping			346,637	346,637		346,637		346,637			3
4	Laundry		204,378		204,378		204,378		204,378			4
5	Heat and Other Utilities			371,889	371,889		371,889	(37,763)	334,126			5
6	Maintenance	68,939		304,541	373,480		373,480	5,969	379,449			6
7	Other (specify):*							3,757	3,757			7
8	TOTAL General Services	405,683	748,717	1,061,941	2,216,341		2,216,341	(28,095)	2,188,246			8
	B. Health Care and Programs											
9	Medical Director			26,100	26,100		26,100		26,100			9
10	Nursing and Medical Records	4,303,374	369,342	141,349	4,814,065		4,814,065	156,038	4,970,103			10
10a	Therapy			243	243		243		243			10a
11	Activities	137,560		1,733	139,293		139,293		139,293			11
12	Social Services	254,458			254,458		254,458		254,458			12
13	CNA Training											13
14	Program Transportation			36,143	36,143		36,143	(3,231)	32,912			14
15	Other (specify):*							24,557	24,557			15
16	TOTAL Health Care and Programs	4,695,392	369,342	205,568	5,270,302		5,270,302	177,364	5,447,666			16
	C. General Administration											
17	Administrative	152,104		720,624	872,728		872,728	(645,378)	227,350			17
18	Directors Fees											18
19	Professional Services			419,732	419,732		419,732	(9,456)	410,276			19
20	Dues, Fees, Subscriptions & Promotions			51,854	51,854		51,854	(10,029)	41,825			20
21	Clerical & General Office Expenses	267,794	1,246	724,451	993,491		993,491	(356,857)	636,634			21
22	Employee Benefits & Payroll Taxes			921,837	921,837		921,837		921,837			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,464	3,464		3,464	1,512	4,976			24
25	Other Admin. Staff Transportation			4,677	4,677		4,677	8,988	13,665			25
26	Insurance-Prop.Liab.Malpractice			454,902	454,902		454,902	3,406	458,308			26
27	Other (specify):*							56,199	56,199			27
28	TOTAL General Administration	419,898	1,246	3,301,541	3,722,685		3,722,685	(951,614)	2,771,071			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,520,973	1,119,305	4,569,050	11,209,328		11,209,328	(802,345)	10,406,983			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 OF CHICAGO WEST #0053686 **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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,917	17,917		17,917	263,003	280,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			167,135	167,135		167,135	(13,877)	153,258			32
33	Real Estate Taxes			580,952	580,952		580,952	(43,737)	537,215			33
34	Rent-Facility & Grounds			2,773,245	2,773,245		2,773,245	(2,766,703)	6,542			34
35	Rent-Equipment & Vehicles			42,859	42,859		42,859	4,691	47,550			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,582,108	3,582,108		3,582,108	(2,556,622)	1,025,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		355,677	1,603,668	1,959,345		1,959,345	(19,244)	1,940,101			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			582,512	582,512		582,512		582,512			42
43	Other (specify):*			101,249	101,249		101,249	(101,249)	0			43
44	**TOTAL Special Cost Centers**		355,677	2,287,429	2,643,106		2,643,106	(120,493)	2,522,613			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,520,973	1,474,982	10,438,587	17,434,542		17,434,542	(3,479,460)	13,955,082			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 OF CHICAGO WEST # 0053686 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	(13,196)	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	259,414	30		9
10	Interest and Other Investment Income	(29,348)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58)	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	(1,642)	21		18
19	Entertainment				19
20	Contributions	(3,350)	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	(444,819)	21		24
25	Fund Raising, Advertising and Promotional	(1,704)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,197,648)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,432,351)		$	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)	(47,109)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (47,109)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,479,460)		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 OF CHICAGO WEST

ID# 0053686

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (2,146)	21	1
2	Medical Supplies-Veteran	(121)	10	2
3	Pharmacy Costs-Veteran	(838)	10	3
4	Lab Costs-Veteran	(290)	10	4
5	Medical Equipment Rental-Veteran	(196)	10	5
6	Director of Customer Experience	(43,535)	21	6
7	Sequestration	(144,798)	21	7
8	Damage Loss	(1,401)	21	8
9	Patient Need	(683)	10	9
10	Sales Tax-Administrative	(1,706)	21	10
11	Marketing Expense	(101,249)	43	11
12	Bank Charges	(358)	21	12
13	Additional R&M	9,158	06	13
14	Rent for Sale/Leaseback Agreement	(2,773,245)	34	14
15	PAC Dues	(12,211)	20	15
16	Non Allowable Legal	(17,329)	19	16
17	RE Tax Late Fees	(11,099)	33	17
18	Capitalized R&M	(15,938)	06	18
19	Rental Income	(13,150)	06	19
20	Clinical Allocation - Utilities	(26,903)	05	20
21	Clinical Allocation - Real Estate	(36,761)	33	21
22	Non-Care Depreciation	(2,849)	30	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**	(3,197,648)		49

SYMPHONY OF CHICAGO WEST

ID# 0053686

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 OF CHICAGO WEST # 0053686 **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	(58)											(58)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(40,099)		2,336									(37,763)	5
6	Maintenance	(19,930)		25,899									5,969	6
7	Other (specify):*			3,757									3,757	7
8	**TOTAL General Services**	(60,087)		31,992									(28,095)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,128)		158,166									156,038	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(3,231)							(3,231)	14
15	Other (specify):*			24,557									24,557	15
16	**TOTAL Health Care and Programs**	(2,128)		182,723		(3,231)							177,364	16
	C. General Administration													
17	Administrative			(645,378)									(645,378)	17
18	Directors Fees													18
19	Professional Services	(17,329)		7,872									(9,456)	19
20	Fees, Subscriptions & Promotions	(17,265)		7,236									(10,029)	20
21	Clerical & General Office Expenses	(640,405)		283,548									(356,857)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,512									1,512	24
25	Other Admin. Staff Transportation			8,988									8,988	25
26	Insurance-Prop.Liab.Malpractice			3,406									3,406	26
27	Other (specify):*			56,199									56,199	27
28	**TOTAL General Administration**	(674,999)		(276,615)									(951,614)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(737,214)		(61,900)		(3,231)							(802,345)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 **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	256,565		6,438									263,003	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(29,348)		15,471									(13,877)	32
33	Real Estate Taxes	(47,860)		4,123									(43,737)	33
34	Rent-Facility & Grounds	(2,773,245)		6,542									(2,766,703)	34
35	Rent-Equipment & Vehicles			4,691									4,691	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(2,593,888)		37,266									(2,556,622)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(19,244)								(19,244)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(101,249)											(101,249)	43
44	**TOTAL Special Cost Centers**	(101,249)			(19,244)								(120,493)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,432,351)		(24,634)	(19,244)	(3,231)							(3,479,460)	45

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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%	$ 2,336	$ 2,336	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	20,719	20,719	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	5,180	5,180	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,757	3,757	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	134,585	134,585	19
20	V	10	CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100.00%	23,581	23,581	20
21	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	24,557	24,557	21
22	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	75,246	75,246	22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	7,872	7,872	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	7,236	7,236	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	242,540	242,540	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	41,008	41,008	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,512	1,512	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	8,988	8,988	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,406	3,406	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	56,199	56,199	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	6,438	6,438	31
32	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	15,471	15,471	32
33	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	4,123	4,123	33
34	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	6,542	6,542	34
35	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	1,089	1,089	35
36	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	3,602	3,602	36
37	V								37
38	V	17	MANAGEMENT FEE	720,624	MAESTRO CONSULTING SERVICES LLC	100.00%		(720,624)	38
39	Total			$ 720,624			$ 695,990	$ * (24,634)	39

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	$ 90,474	Integra Healthcare Equipment LLC		$ 71,230	$ (19,244)	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			$ 90,474			$ 71,230	$ * (19,244)	39

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	$ 29,215	Lifeline Ambulance LLC		$ 25,984	$ (3,231)	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			$ 29,215			$ 25,984	$ * (3,231)	39

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	$ 151,582	Maple Leaf Insurance	100.00%	$ 151,582	$	15
16	V	26	Liability Insurance	492,217	Maple Leaf Insurance	100.00%	492,217		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			$ 643,799			$ 643,799	$ *	39

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 CRESTWOOD	CRESTWOOD				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY OF DECATUR	DECATUR				16
17			SYMPHONY OF DYER	DYER, IN				17
18			SYMPHONY OF EVANSTON	EVANSTON				18
19			SYMPHONY OF GLENDALE	GLENDALE, WI				19
20			SYMPHONY OF HANOVER PARK	HANOVER PARK				20
21			SYMPHONY OF JOLIET	JOLIET				21
22			SYMPHONY OF LINCOLN	LINCOLN				22
23			SYMPHONY OF LINCOLN PARK	CHICAGO				23
24			SYMPHONY OF MORGAN PARK	CHICAGO				24
25			SYMPHONY OF ORCHARD VALLEY	AURORA				25
26			SYMPHONY OF SOUTH SHORE	CHICAGO				26
27			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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	$	85,644	$ 2,336	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	444,128	444,128	85,644	20,719	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,835,856	28	111,048		85,644	5,180	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,835,856	28	80,529		85,644	3,757	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	2,884,957	2,884,957	85,644	134,585	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,835,856	28	505,476		85,644	23,581	6
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,835,856	28	526,402		85,644	24,557	7
8	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	1,612,976	1,612,976	85,644	75,246	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,835,856	28	168,752		85,644	7,872	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,835,856	28	155,112		85,644	7,236	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,835,856	28	5,199,066	5,199,066	85,644	242,540	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,835,856	28	879,035		85,644	41,008	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,835,856	28	32,418		85,644	1,512	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,835,856	28	192,674		85,644	8,988	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,835,856	28	73,017		85,644	3,406	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,835,856	28	1,204,673		85,644	56,199	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,835,856	28	138,011		85,644	6,438	17
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,835,856	28	331,638		85,644	15,471	18
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,835,856	28	88,385		85,644	4,123	19
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	140,244		85,644	6,542	20
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	23,351		85,644	1,089	21
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,835,856	28	77,202		85,644	3,602	22
23										23
24										24
25	TOTALS					$ 14,919,170	$ 10,141,128		$ 695,990	25

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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			$	$		$ 71,230	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					$	$		$ 71,230	25

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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			$	$		$ 25,984	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					$	$		$ 25,984	25

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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			$	$		$ 151,582	1
2	26	Liability Insurance	Direct						492,217	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					$	$		$ 643,799	25

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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	The Private Bank		X	Note Payable			$	$			$ 167,135	1
2												2
3												3
4												4
5												5
	Working Capital											
6	RCA		X	Note Payable				266,344				6
7												7
8												8
9	TOTAL Facility Related						$	$ 266,344			$ 167,135	9
	B. Non-Facility Related*											
10	Interest Income		X								(29,348)	10
11	Allocated from Maestro Consul	X									15,471	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,877)	14
15	TOTALS (line 9+line14)						$	$ 266,344			$ 153,258	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 OF CHICAGO WEST # 0053686 **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.**	$ 418,950	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.)		$ 457,510	2
3. Under or (over) accrual (line 2 minus line 1).		$ 38,560	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 498,655	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.		$ 537,215	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	333,859	8
	2013	341,563	9
	2014	348,840	10
	2015	414,808	11
	2016	453,387	12

2017 Accrual = $490,148 x 1.01 = $498,655 (Rounded)

Allocated from Maestro Consulting Services $4,123

	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 OF CHICAGO WEST COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053686

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.	16-16-209-002-0000	Long Term Care Property	$ 490,147.93	$ 453,386.93
2.	10-27-319-028-0000	Home Office Allocation	$ 88,384.90	$ 4,123.22
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 578,532.83	$ 457,510.15

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 OF CHICAGO WEST COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053686

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 OF CHICAGO WEST # 0053686 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

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).

Medical Clinic - Costs are not included on Schedule V

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	89,364	1987	$ 71,619	1
2	Allocated from Maestro 7257 Lincoln		2004	7,464	2
3	TOTALS	89,364		$ 79,083	3

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	234			1980	$ 3,173,042	$	39	$ 81,360	$ 81,360	$ 2,665,707	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	198,972		20			198,972	9
10	Various			1988	17,097		20			17,097	10
11	Various			1989	19,023		20			19,023	11
12	Various			1990	33,869		20			33,869	12
13	Various			1991	10,518		20			10,518	13
14	Various			1993	3,315		20			3,315	14
15	Various			1994	110,244		20			110,244	15
16	Various			1995	57,890		20	2	2	57,890	16
17	Various			1996	131,988		20	35	35	131,884	17
18	Various			1997	126,299		20	2,813	2,813	125,097	18
19	Various			1998	35,115		20	1,753	1,753	34,285	19
20	Various			1999	67,125		20	3,359	3,359	62,097	20
21	Various			2000	182,497		20	9,126	9,126	161,839	21
22	Various			2001	24,742		20	1,237	1,237	20,475	22
23	Various			2002	119,751		20			119,751	23
24	Various			2003	107,313		20	989	989	105,172	24
25	Various			2004	9,849		20	76	76	9,748	25
26	Various			2005	170,025		20	5,427	5,427	132,725	26
27	Various			2006	347,480		20	15,426	15,426	342,900	27
28	Various			2007	2,721		20	272	272	2,721	28
29	Various			2008	2,900		20	290	290	2,803	29
30	Various			2009	136,688		20	12,108	12,108	117,897	30
31	Various			2010	35,779		20	2,601	2,601	27,205	31
32	Various			2011	350,322		20	34,854	34,854	235,639	32
33	Various			2012	10,373		20	911	911	4,808	33
34	Various			2013	2,752		20	138	138	585	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 OF CHICAGO WEST # 0053686 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)		610,839			31,719	31,719	267,346	67
68	Related Party Allocations (Pages 12H & 12I)		112,237	2,132		4,210	2,078	50,188	68
69	Financial Statement Depreciation			15,068			(15,068)		69
70	TOTAL (lines 4 thru 69)		$ 6,210,764	$ 17,200		$ 208,706	$ 191,506	$ 5,071,798	70

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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		$ 6,210,764	$ 17,200		$ 208,706	$ 191,506	$ 5,071,798	1
2	Skylight Glass Replacement	2014	7,380		20	738	738	2,706	2
3	Parking Lot Paving	2014	13,250		20	883	883	3,239	3
4	Fire Alarm System	2014	9,655		20	1,379	1,379	4,827	4
5	Electrical Outlets	2014	5,300		20	530	530	1,767	5
6	Plumbing-Replace P-Trap In Boiler Room, Replace Corridor Pipe	2014	20,945		20	2,095	2,095	6,982	6
7	Replace Door Operators On 3 Elevators	2014	36,600		20	1,830	1,830	5,795	7
8	Repaired Elevators	2015	7,578		20	379	379	1,137	8
9	Demolition Of Existing Walk-In Freezer/Cooler/Electrical	2015	7,240		20	362	362	1,086	9
10	Electrical Services For Walk-In Freezer/Cooler	2015	3,200		20	160	160	480	10
11	New Door Frame And New Glass Doors At Main Entrance	2015	11,580		20	579	579	1,737	11
12	New Walk-In Cooler/Freezer	2015	18,318		20	916	916	2,748	12
13	Wired Call System	2015	86,995		20	4,350	4,350	13,049	13
14	Furnish/Install New Pump And Pump Motor Valve And Tank	2016	10,450		20	523	523	1,046	14
15	Plumbing - 1St/2Nd Floor Drain And Piping	2016	2,750		20	138	138	276	15
16	Roof Work - Repair Leaks Rooms 416/430, Lower Roof Leaks - Ea	2016	3,800		20	190	190	380	16
17	Wired Nurse Call System	2016	7,248		20	362	362	724	17
18	3 Elevators - Furnish And Apply Car Top Hand Rails	2016	3,732		20	187	187	374	18
19	Electrical Work - Replace/Rewire Disconect, Supply New Fuse Dis	2016	4,620		20	231	231	462	19
20	Plumbing - Camera And Rod Kitchen Waste Lines	2016	3,630		20	182	182	364	20
21	New Door Sill $3,200	2017	3,200		20	160	160	160	21
22	Fire Sprinkler $3,810	2017	3,810		20	191	191	191	22
23	Telephone System/Install/Main	2017	26,860		20	1,343	1,343	1,343	23
24	Plumbing To Repair Rodding Of Grease Line	2017	2,720		20	136	136	136	24
25	Install New Slop Sink	2017	2,670		20	134	134	134	25
26	Plumbing Repiping And Replace 4 Gate Valves	2017	5,265		20	263	263	263	26
27	Repaired Trane Rtu	2017	5,283		20	264	264	264	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	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)		$ 6,524,843	$ 17,200		$ 227,211	$ 210,010	$ 5,123,467	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	2004	11,647		20	582	582	10,489	9
10	Various	2005	61,061		20	3,053	3,053	42,422	10
11	Universal Wide Style Handrail	2007	3,458		20	173	173	1,903	11
12	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	1,375	12
13	Duro Last Roofing System	2007	17,750		20	888	888	9,765	13
14	Fire Alram (Repair)	2007	4,364		20	218	218	2,401	14
15	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	2,167	15
16	Walkway	2007	5,500		20	275	275	3,025	16
17	Renovated Parking Lot	2007	6,800		20	340	340	3,740	17
18	Fire Alarm Control Panel	2007	9,252		20	463	463	5,090	18
19	Duro Lasting Roof Work	2007	17,750		20	888	888	9,765	19
20	Bristol/Modules For Chiller	2007	5,832		20	292	292	3,209	20
21	Compresor Replacer	2007	2,823		20	141	141	1,551	21
22	Telephone System	2008	21,774		20	2,177	2,177	21,773	22
23	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	1,347	23
24	Elevator Car Doors	2008	3,875		20	194	194	1,938	24
25	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	12,910	25
26	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	2,430	26
27	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	13,910	27
28	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	4,900	28
29	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	23,740	29
30	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	14,793	30
31	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	4,837	31
32	Capital Report Reconciliation	2008	(300)		20	(15)	(15)	(150)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 335,757	$		$ 17,877	$ 17,877	$ 199,329	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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		$ 335,757	$		$ 17,877	$	$ 199,329	1
2	K-020 IDPH Corrections-Demo & Carpentry, Painting,HVAC,								2
3	Plumbing - All Resident Rooms and Doctor Office Next Door	2012	85,025		20	4,251	4,251	25,508	3
4	Remove and Install Data Cables	2013	6,500		20	413	413	2,067	4
5	Remove and Installed Nre Fire Alarm Control Panel	2013	37,210		20	1,861	1,861	9,303	5
6	RECEPTACLES FOR KIOSKS	2013	4,055		20	203	203	1,014	6
7	SPRINKLER HEAD INSTALLATION	2013	2,850		20	143	143	713	7
8	Removed and Installed Cedar Fence on East & South Side of Build	2013	23,055		20	1,153	1,153	5,764	8
9	FIRE ALARM SYSTEM	2013	7,416		20	371	371	1,854	9
10	Install 15 Openings Power Outlets In 2Nd Flr Rooms For Wall Mo	2014	2,550		20	128	128	511	10
11	Replace 4 Doors With 20-Minute Fire Doors, Custom Match And S	2014	2,700		20	135	135	540	11
12	Construct Outside Patio Roof, Detach Structure From Building, E	2014	2,545		20	127	127	509	12
13	Install Alarm Bell On South Passenger Elevator; Code Data Plates	2014	7,176		20	359	359	1,435	13
14	Caulking Windows	2014	22,500		20	1,125	1,125	4,500	14
15	Labor & Materials To Resurface 250 Doors, Remove Doors From	2014	22,500		20	1,125	1,125	4,500	15
16	Roof Installation	2014	49,000		20	2,450	2,450	9,800	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 610,839	$		$ 31,719	$ 13,843	$ 267,346	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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 N. Lincoln Ave	2004	67,177	1,722	35	1,919	197	27,111	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting Services	2003	546		20	27	27	386	9
10	Allocated from Maestro Consulting Services	2004	11,094		20	553	553	7,613	10
11	Allocated from Maestro Consulting Services	2005	658		20	33	33	423	11
12	Allocated from Maestro Consulting Services	2006	892		20	45	45	507	12
13	Allocated from Maestro Consulting Services	2008	940		20	47	47	435	13
14	Allocated from Maestro Consulting Services	2009	15,135		20	757	757	6,515	14
15	Allocated from Maestro Consulting Services	2010	2,326		20	116	116	873	15
16	Allocated from Maestro Consulting Services	2011	126		20	6	6	43	16
17	Allocated from Maestro Consulting Services	2012	140		20	7	7	40	17
18	Allocated from Maestro Consulting Services	2014	1,749		20	87	87	315	18
19	Allocated from Maestro Consulting Services	2015	492		20	25	25	57	19
20	Allocated from Maestro Consulting Services	2016	2,156	276	20	216	(60)	299	20
21	Allocated from Maestro Consulting Services	2017	288		20	14	14	14	21
22									22
23	Allocated from Maestro 7257 N. Lincoln Ave	2015	1,059	91	20	71	(20)	165	23
24	Allocated from Maestro 7257 N. Lincoln Ave	2005	6,124	43	20	220	177	4,491	24
25	Allocated from Maestro 7257 N. Lincoln Ave	2004	1,335		20	67	67	901	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 112,237	$ 2,132		$ 4,210	$ 2,078	$ 50,188	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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		$ 112,237	$ 2,132		$ 4,210	$ 2,078	$ 50,188	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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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)		$ 112,237	$ 2,132		$ 4,210	$ 2,078	$ 50,188	34

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	$ 639,239	$ 657	$ 44,096	$ 43,439	10	$ 537,796	71
72	Current Year Purchases	98,698	3,649	9,156	5,507	10	9,156	72
73	Fully Depreciated Assets	1,511,262		457	457	10	1,511,261	73
74								74
75	TOTALS	$ 2,249,199	$ 4,306	$ 53,710	$ 49,404		$ 2,058,214	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		1992 FORD VAN	1990	$ 2,282	$	$	$	5	$	76
77		Allocated from Maestro Consulti	2017	413				5	413	77
78										78
79										79
80	TOTALS			$ 2,695	$	$	$		$ 413	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)	$ 8,855,820	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,506	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 280,920	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 259,414	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,182,094	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	RESURFACE PK LOT/SIDEWALK -	$ 20,903	$ 1,184	$ 20,388	86
87	Clinic Project- new cabinetry, counter top	4,400	220	1,760	87
88	Dr. Stalling's Office - Front reception new	3,700	185	1,295	88
89	Xray Rm: demolish 4 door opening. furni	16,700	835	5,845	89
90	Dr. Rms-Floor,Wall,Countertop,Sink,Wi	8,500	425	2,550	90
91	TOTALS	$ 54,203	$ 2,849	$ 31,838	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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)

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. [X] 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:		234		$ 2,773,245			3
4	Additions				(2,773,245)			4
5	Allocated from Maestro Consulting Services				6,542			5
6								6
7	TOTAL		234		$ 6,542 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 43,951 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 Services		$	$ 3,602	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,602	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 OF CHICAGO WEST # 0053686 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 OF CHICAGO WEST # 0053686 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	$		$ 600,925	$		$ 600,925	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			151,488			151,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			590,144			590,144	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				222,021		222,021	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					261,111	133,656		394,767	13
14	TOTAL			$		$ 1,603,668	$ 355,677		$ 1,959,345	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 OF CHICAGO WEST **#** 0053686 **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	$ 58,958	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,999,200		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,679		6
7	Other Prepaid Expenses	949,609		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,113,446	$	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	26,430		15
16	Equipment, at Historical Cost	138,349		16
17	Accumulated Depreciation (book methods)	(21,503)		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	783,314		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 926,590	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,040,036	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,881,718	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,878		28
29	Short-Term Notes Payable	266,344		29
30	Accrued Salaries Payable	486,862		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,344		31
32	Accrued Real Estate Taxes(Sch.IX-B)	498,655		32
33	Accrued Interest Payable	559		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,432,675		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,650,035	$	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)**	$ 5,650,035	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 390,001	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,040,036	$	48

***(See instructions.)**

Facility Name & ID Number SYMPHONY OF CHICAGO WEST **#** 0053686 **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**	$ 463,446	1
2	Restatements (describe):		2
3	Equity Adjustment	4,051	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 467,497	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(77,496)	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)**	$ (77,496)	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)**	$ 390,001	24 *

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

Facility Name & ID Number SYMPHONY OF CHICAGO WEST # 0053686 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	$ 16,536,371	1
2	Discounts and Allowances for all Levels	(9,494)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,526,877	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	784,634	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 784,634	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	868	19
20	Radiology and X-Ray	23	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 891	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29,348	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,348	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	15,296	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,296	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,357,046	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,216,341	31
32	Health Care	5,270,302	32
33	General Administration	3,722,685	33
	B. Capital Expense		
34	Ownership	3,582,108	34
	C. Ancillary Expense		
35	Special Cost Centers	2,060,594	35
36	Provider Participation Fee	582,512	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,434,542	40
41	**Income before Income Taxes (line 30 minus line 40)****	(77,496)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (77,496)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,948,875	44
45	Private Pay - Net Inpatient Revenue	253,925	45
46	Medicare - Net Inpatient Revenue	3,252,406	46
47	Other-(specify) MAIP	143,913	47
48	Other-(specify) Managed Care/Veteran/Hospice	2,927,758	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,526,877	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 OF CHICAGO WEST # 0053686 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	1,869	2,086	$ 103,403	$ 49.57	1
2	Assistant Director of Nursing	1,891	2,086	93,027	44.60	2
3	Registered Nurses	13,978	15,295	479,130	31.33	3
4	Licensed Practical Nurses	64,504	68,788	1,941,468	28.22	4
5	CNAs & Orderlies	114,335	122,173	1,610,241	13.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,885	2,086	39,524	18.95	9
10	Activity Assistants	7,002	7,839	98,036	12.51	10
11	Social Service Workers	7,485	8,059	227,877	28.28	11
12	Dietician					12
13	Food Service Supervisor	1,862	2,166	53,838	24.86	13
14	Head Cook	4,774	5,390	65,358	12.13	14
15	Cook Helpers/Assistants	16,603	18,923	217,548	11.50	15
16	Dishwashers					16
17	Maintenance Workers	3,523	3,797	68,939	18.16	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,864	2,040	152,104	74.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,984	14,268	224,259	15.72	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	1,942	2,085	43,986	21.10	31
32	Other Health Care(specify)					32
33	Other(specify)	5,807	6,253	102,235	16.35	33
34	TOTAL (lines 1 - 33)	262,308	283,334	$ 5,520,973 *	$ 19.49	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	$ 38,874	01-03	35
36	Medical Director	Monthly	26,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,634	92,673	10-03	38
39	Pharmacist Consultant	Monthly	29,496	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	243	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	1,733	11-03	44
45	Social Service Consultant				45
46	Other(specify) Psychiatric Consult	Monthly	15,880	10-03	46
47	Dental Consultant	Monthly	3,300	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,669	$ 208,299		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 OF CHICAGO WEST # 0053686 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Corey David	Administrator	0	$ 152,104
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 152,104

B. Administrative - Other

Description	Amount
Maestro Consulting Services - Bookkeeping Fees	$ 720,624
TOTAL (agree to Schedule V, line 17, col. 3)	$ 720,624
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 41,209
Maestro Consulting Services	Regional Alloc. Services	88,725
See Attached	Legal Fees	27,249
Achieve Accreditation	Accreditation Services	14,604
Health Dimensions Group	Management Consulting	307
Corporation Service Company	Enterprise Solutions	481
Language Line Services	Translation Services	1,277
Life Safety Resources	Fire Protection Consultant	5,643
LTC Consulting	AR & Mgmt Consulting	33,148
Medical Business Office Services	Revenue Cycle Management	28,401
SB2 Inc.	Reimbursement	322
See Supplemental Schedule		178,369
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 419,732

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,731
Unemployment Compensation Insurance	89,854
FICA Taxes	416,577
Employee Health Insurance	186,542
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	41,154
Other Employee Benefits	20,140
Physical Exams	4,839
TOTAL (agree to Schedule V, line 22, col.8)	$ 921,838

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	517
Health Care Worker Background Check	
(Indicate # of checks performed 406)	4,067
Patient Background Checks 544	5,440
Dues & Subscription	13,765
Licenses & Permits	8,810
Allocated from Maestro Consulting Services	7,236
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,825

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,464
Allocated from Maestro Consulting Services	1,512
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,976

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYMPHONY OF CHICAGO WEST **#** 0053686 **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 $24,422**

(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. $ **1,213** 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.
Jackson Square Nursing and Rehab IDPH #0039834

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **582,512**
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? **No**

(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. $ 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