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: 0053744

Facility Name: SYMPHONY OF MORGAN PARK

Address: 10935 S. Halsted Street (Number) Chicago (City) 60028 (Zip Code)

County: Cook

Telephone Number: (773) 928-2000 **Fax #** (773) 928-9670

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	294	Skilled (SNF)	294	107,310	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	294	TOTALS	294	107,310	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			12,129	12,129	8
9	SNF/PED					9
10	ICF	65,879	3,463	6,755	76,097	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,879	3,463	18,884	88,226	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.22%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/1976

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 294 and days of care provided 6,757

Medicare Intermediary Wisconsin Physician 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 MORGAN PARK # 0053744 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	385,599	143,689	19,607	548,895		548,895		548,895			1
2	Food Purchase		429,494		429,494	(35,350)	394,144	(272)	393,872			2
3	Housekeeping	315,965		54,632	370,597		370,597		370,597			3
4	Laundry	38,652	3,888	258,629	301,169		301,169		301,169			4
5	Heat and Other Utilities			283,838	283,838		283,838	(40,247)	243,591			5
6	Maintenance	85,790		208,851	294,641		294,641	33,808	328,449			6
7	Other (specify):*							4,720	4,720			7
8	TOTAL General Services	826,006	577,071	825,557	2,228,634	(35,350)	2,193,284	(1,991)	2,191,293			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	5,674,295	359,391	149,106	6,182,792		6,182,792	180,400	6,363,192			10
10a	Therapy			26,269	26,269		26,269		26,269			10a
11	Activities	183,849		1,210	185,059		185,059		185,059			11
12	Social Services	220,558			220,558		220,558		220,558			12
13	CNA Training											13
14	Program Transportation			24,550	24,550		24,550	(2,674)	21,876			14
15	Other (specify):*							30,854	30,854			15
16	TOTAL Health Care and Programs	6,078,702	359,391	225,135	6,663,228		6,663,228	208,580	6,871,808			16
	C. General Administration											
17	Administrative	169,246		804,758	974,004		974,004	(710,218)	263,786			17
18	Directors Fees											18
19	Professional Services			400,489	400,489		400,489	9,273	409,762			19
20	Dues, Fees, Subscriptions & Promotions			70,846	70,846		70,846	(8,975)	61,871			20
21	Clerical & General Office Expenses	182,739	1,493	1,487,638	1,671,870		1,671,870	(945,356)	726,514			21
22	Employee Benefits & Payroll Taxes			1,190,953	1,190,953	35,350	1,226,303		1,226,303			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,259	2,259		2,259	1,900	4,159			24
25	Other Admin. Staff Transportation			425	425		425	11,293	11,718			25
26	Insurance-Prop.Liab.Malpractice			355,824	355,824		355,824	4,280	360,104			26
27	Other (specify):*							70,609	70,609			27
28	TOTAL General Administration	351,985	1,493	4,313,192	4,666,670	35,350	4,702,020	(1,567,194)	3,134,826			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,256,693	937,955	5,363,884	13,558,532		13,558,532	(1,360,605)	12,197,927			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 MORGAN PARK #0053744 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,828	10,828		10,828	256,836	267,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			192,567	192,567		192,567	(6,863)	185,704			32
33	Real Estate Taxes			706,229	706,229		706,229	2,492	708,721			33
34	Rent-Facility & Grounds			2,066,717	2,066,717		2,066,717	(2,058,497)	8,220			34
35	Rent-Equipment & Vehicles			59,017	59,017		59,017	5,894	64,911			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,035,358	3,035,358		3,035,358	(1,800,138)	1,235,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		437,990	1,665,992	2,103,982		2,103,982	(34,113)	2,069,869			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			655,666	655,666		655,666		655,666			42
43	Other (specify):*	42,753		114,786	157,539		157,539	(157,539)	(0)			43
44	**TOTAL Special Cost Centers**	42,753	437,990	2,436,444	2,917,187		2,917,187	(191,652)	2,725,535			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,299,446	1,375,945	10,835,686	19,511,077		19,511,077	(3,352,395)	16,158,682			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 MORGAN PARK # 0053744 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 Reference	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	(43,182)	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	248,747	30		9
10	Interest and Other Investment Income	(26,301)	32		10
11	Discounts, Allowances, Rebates & Refunds	(103)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	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	(20,185)	21		18
19	Entertainment				19
20	Contributions	(3,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,174,014)	21		24
25	Fund Raising, Advertising and Promotional	(295)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,366,547)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,385,299)		$	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)	32,904		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 32,904		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,352,395)		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 MORGAN PARK

ID# 0053744

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (120)	21	1
2	Sequestration	(106,029)	21	2
3	Veterans' Expenses	(17,904)	10	3
4	Dir of Customer Experience	(42,753)	43	4
5	Bank Charges	(105)	21	5
6	Marketing Consultant	(101,677)	43	6
7	Marketing Materials	(13,109)	43	7
8	Patient Needs	(418)	10	8
9	Sales Tax	(1,156)	21	9
10	Rent for sale/leaseback	(2,066,717)	34	10
11	Non-Allowable Legal Fees	(618)	19	11
12	PAC Dues	(14,521)	20	12
13	Non Facility Related R/E Taxes	(2,688)	33	13
14	Additiional R&M	1,268	06	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,366,547)		49

SYMPHONY OF MORGAN PARK

ID# 0053744

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 MORGAN PARK # 0053744 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	(272)											(272)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(43,182)		2,935									(40,247)	5
6	Maintenance	1,268		32,540									33,808	6
7	Other (specify):*			4,720									4,720	7
8	TOTAL General Services	(42,186)		40,195									(1,991)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(18,321)		198,722									180,400	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation						(2,674)						(2,674)	14
15	Other (specify):*			30,854									30,854	15
16	TOTAL Health Care and Programs	(18,321)		229,575			(2,674)						208,580	16
	C. General Administration													
17	Administrative			(710,218)									(710,218)	17
18	Directors Fees													18
19	Professional Services	(618)		9,891									9,273	19
20	Fees, Subscriptions & Promotions	(18,066)		9,091									(8,975)	20
21	Clerical & General Office Expenses	(1,301,609)		356,252									(945,356)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,900									1,900	24
25	Other Admin. Staff Transportation			11,293									11,293	25
26	Insurance-Prop.Liab.Malpractice			4,280									4,280	26
27	Other (specify):*			70,609									70,609	27
28	TOTAL General Administration	(1,320,293)		(246,901)									(1,567,194)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,380,800)		22,869			(2,674)						(1,360,605)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 **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	248,747		8,089									256,836	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,301)		19,438									(6,863)	32
33	Real Estate Taxes	(2,688)		5,180									2,492	33
34	Rent-Facility & Grounds	(2,066,717)		8,220									(2,058,497)	34
35	Rent-Equipment & Vehicles			5,894									5,894	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(1,846,959)		46,821									(1,800,138)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(34,113)							(34,113)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(157,539)											(157,539)	43
44	**TOTAL Special Cost Centers**	(157,539)				(34,113)							(191,652)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,385,299)		69,691		(34,113)	(2,674)						(3,352,395)	45

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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%	$ 2,935	$ 2,935	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	26,031	26,031	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	6,509	6,509	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,720	4,720	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	169,094	169,094	19
20	V	10	CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100.00%	29,627	29,627	20
21	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	30,854	30,854	21
22	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	94,540	94,540	22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	9,891	9,891	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	9,091	9,091	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	304,730	304,730	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	51,522	51,522	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,900	1,900	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	11,293	11,293	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,280	4,280	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	70,609	70,609	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	8,089	8,089	31
32	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	19,438	19,438	32
33	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	5,180	5,180	33
34	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	8,220	8,220	34
35	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	1,369	1,369	35
36	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,525	4,525	36
37	V								37
38	V	17	Management Fees	804,758	MAESTRO CONSULTING SERVICES LLC	100.00%		(804,758)	38
39	Total			$ 804,758			$ 874,449	$ * 69,691	39

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	$ 198,926	Maple Leaf		$ 198,926	$	15
16	V	26	Liability Insurance	572,567	Maple Leaf		572,567		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			$ 771,493			$ 771,493	$ *	39

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 and Medical Supplies	$ 160,381	Integra Healthcare Equipment LLC		$ 126,268	$ (34,113)	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			$ 160,381			$ 126,268	$ * (34,113)	39

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	$ 24,187	Lifeline Ambulance		$ 21,513	$ (2,674)	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			$ 24,187			$ 21,513	$ * (2,674)	39

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Symcare Healthcare, LLC	99.99%	CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSULTING SERVI	LINCOLNWOOD	MANAGEMENT	1
2	Symcare HMG, LLC	0.01%	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3			MCKINLEY COURT	DECATUR	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	3
4			MONROE PAVILION	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	4
5			NORTHWOODS CARE CENTRE	BELVIDERE	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERVICES	5
6			SYCAMORE VILLAGE	SWANSEA	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7			SYMPHONY ARIA	HILLSIDE				7
8			SYMPHONY AT 87TH STREET	CHICAGO				8
9			SYMPHONY AT MIDWAY	CHICAGO				9
10			SYMPHONY AT THE TILLERS	OSWEGO				10
11			SYMPHONY OF BRONZEVILLE	CHICAGO				11
12			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				12
13			SYMPHONY OF CHESTERTON	CHESTERTON, IN				13
14			SYMPHONY OF CHICAGO WEST	CHICAGO				14
15			SYMPHONY OF CRESTWOOD	CRESTWOOD				15
16			SYMPHONY OF CROWN POINT	CROWN POINT, IN				16
17			SYMPHONY OF DECATUR	DECATUR				17
18			SYMPHONY OF DYER	DYER, IN				18
19			SYMPHONY OF EVANSTON	EVANSTON				19
20			SYMPHONY OF GLENDALE	GLENDALE, WI				20
21			SYMPHONY OF HANOVER PARK	HANOVER PARK				21
22			SYMPHONY OF JOLIET	JOLIET				22
23			SYMPHONY OF LINCOLN	LINCOLN				23
24			SYMPHONY OF LINCOLN PARK	CHICAGO				24
25			SYMPHONY OF 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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	$	107,604	$ 2,935	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	444,128	444,128	107,604	26,031	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,835,856	28	111,048		107,604	6,509	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,835,856	28	80,529		107,604	4,720	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	2,884,957	2,884,957	107,604	169,094	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,835,856	28	505,476		107,604	29,627	6
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,835,856	28	526,402		107,604	30,854	7
8	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	1,612,976	1,612,976	107,604	94,540	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,835,856	28	168,752		107,604	9,891	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,835,856	28	155,112		107,604	9,091	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,835,856	28	5,199,066	5,199,066	107,604	304,730	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,835,856	28	879,035		107,604	51,522	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,835,856	28	32,418		107,604	1,900	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,835,856	28	192,674		107,604	11,293	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,835,856	28	73,017		107,604	4,280	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,835,856	28	1,204,673		107,604	70,609	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,835,856	28	138,011		107,604	8,089	17
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,835,856	28	331,638		107,604	19,438	18
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,835,856	28	88,385		107,604	5,180	19
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	140,244		107,604	8,220	20
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	23,351		107,604	1,369	21
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,835,856	28	77,202		107,604	4,525	22
23										23
24										24
25	TOTALS					$ 14,919,170	$ 10,141,128		$ 874,449	25

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 69720 West Bay Rd
City / State / Zip Code: Grand Cayman Ky. 11102
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 comp	Direct Allocation			$	$		$ 198,926	1
2	26	Liability insurance	Direct Allocation						572,567	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					$	$		$ 771,493	25

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME and Medical Equipment				$	$		$ 126,268	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					$	$		$ 126,268	25

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Transportation	Direct Allocation			$	$		$ 21,513	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					$	$		$ 21,513	25

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				349,762			192,567	6
7												7
8												8
9	TOTAL Facility Related						$	$ 349,762			$ 192,567	9
	B. Non-Facility Related*											
10	Interest Income		X								(26,301)	10
11	Allocated from Maestro		X								19,438	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,863)	14
15	TOTALS (line 9+line14)						$	$ 349,762			$ 185,704	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** 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 MORGAN PARK # 0053744 **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.**	$	695,835	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.)	$	689,778	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,057)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	714,778	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.	$	708,721	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	600,585	8
	2013	621,781	9
	2014	628,520	10
	2015	633,278	11
	2016	684,598	12

2017 ending accrual = 687,286 (all tax bills) x 1.04 = $714,778

Allocated from Maestro=$5,180

	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 MORGAN PARK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053744

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.	25-16-316-001-0000	Long Term Care Property	$ 67,800.15	$ 67,800.15
2.	25-16-316-002-0000	Long Term Care Property	$ 65,145.17	$ 65,145.17
3.	25-16-332-012-0000	Long Term Care Property	$ 223,370.33	$ 223,370.33
4.	25-16-332-013-0000	Long Term Care Property	$ 328,281.91	$ 328,281.91
5.	25-16-321-001-0000	Empty Lot	$ 1,058.16	$
6.	25-16-321-002-0000	Empty Lot	$ 543.27	$
7.	25-16-321-003-0000	Empty Lot	$ 543.27	$
8.	25-16-321-004-0000	Empty Lot	$ 543.27	$
9.	See Attached	Allocated from Maestro	$ 88,384.90	$ 5,180.45
10.			$	$
		TOTALS	$ 775,670.43	$ 689,778.01

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 MORGAN PARK COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053744

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 MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,068 B. General Construction Type: Exterior Brick Frame _____ 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).

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 855,000	1
2	Allocated from 7257 Lincoln-Maestro			9,378	2
3	TOTALS			$ 864,378	3

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	294			1976	$ 7,334,294	$	39	$	$	$ 7,334,294	4
5				1994	554,636		39	27,732	27,732	468,714	5
6				1994	3,020		39	151	151	2,543	6
7				1994	106,949		39	5,347	5,347	91,517	7
8											8
	Improvement Type**										
9	Various			1978	750		20			750	9
10	Various			1979	12,807		20			12,807	10
11	Various			1980	35,915		20			35,915	11
12	Various			1981	13,910		20			13,910	12
13	Various			1982	8,814		20			8,814	13
14	Various			1983	12,936		20			12,936	14
15	Various			1984	20,560		20			20,560	15
16	Various			1985	18,883		20			18,883	16
17	Various			1986	2,456		20			2,456	17
18	Various			1987	4,000		20	79	79	3,883	18
19	Various			1988	82,596		20	2,622	2,622	76,606	19
20	Various			1989	1,225		20	39	39	1,105	20
21	Various			1990	91,597		20	1,128	1,128	76,968	21
22	Various			1993	53,620		20			53,620	22
23	Various			1995	137,949		20			137,948	23
24	Various			1996	519,100		20			519,100	24
25	Various			1997	76,548		20	1,547	1,547	76,548	25
26	Various			1998	77,488		20	3,646	3,646	75,147	26
27	Various			1999	278,572		20	13,505	13,505	261,444	27
28	Various			2000	48,393		20	2,246	2,246	39,732	28
29	Various			2001	97,460		20	4,812	4,812	79,708	29
30	Various			2002	25,280		20			25,280	30
31	Various			2003	461,684		20	9,012	9,012	436,224	31
32	Various			2004	62,146		20			62,146	32
33	Various			2005	94,134		20			94,134	33
34	Various			2006	114,124		20			114,124	34
35	Various			2007	377,501		20	22,699	22,699	284,251	35
36	Various			2008	823,017		20	41,004	41,004	406,353	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 MORGAN PARK # 0053744 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	Various	2009	$ 267,116	$	20	$ 16,929	$ 16,929	$ 167,878	37
38	Various	2010	211,043		20	13,019	13,019	101,437	38
39	Various	2011	129,999		20	6,489	6,489	52,547	39
40	Various	2012	30,043		20	2,633	2,633	15,909	40
41	Various	2013	42,223		20	4,017	4,017	18,424	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)		50,886			326	326	47,359	67
68	Related Party Allocations (Pages 12H & 12I)		141,013	2,679		5,289	2,610	63,059	68
69	Financial Statement Depreciation			10,828			(10,828)		69
70	TOTAL (lines 4 thru 69)		$ 12,424,687	$ 13,507		$ 184,270	$ 170,763	$ 11,315,035	70

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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		$ 12,424,687	$ 13,507		$ 184,270	$ 170,763	$ 11,315,035	1
2	2 Make-Up Air Units	2014	30,200		20	1,510	1,510	5,663	2
3	Hand Rails	2014	5,200		20	260	260	932	3
4	Fire Alarm System	2014	6,832		20	342	342	1,224	4
5	Elevator - Hydraulic Valve	2014	5,132		20	257	257	898	5
6	Sink & Piping	2014	9,950		20	498	498	1,741	6
7	Pvc Piping	2014	2,980		20	149	149	522	7
8	Dialysis Room Wall	2014	4,900		20	245	245	837	8
9	Dialysis Room Electrical Work	2014	6,090		20	305	305	1,040	9
10	Compressor For A/C	2014	2,888		20	578	578	2,118	10
11	1 Rooftop Ac Unit	2014	3,508		20	175	175	570	11
12	Fire Alarm Work	2014	14,681		20	734	734	2,324	12
13	Fire Alarm Work	2014	2,729		20	136	136	421	13
14	Phone Port Repair	2014	3,836		20	192	192	575	14
15	Install Electrical Panel In Generator Room	2015	5,280		20	264	264	792	15
16	Topographical Plan - Parking Lot	2015	4,160		20	208	208	624	16
17	Topographical Plan - Parking Lot	2015	3,259		20	163	163	489	17
18	Hot Water Heater	2015	10,388		20	519	519	1,558	18
19	Replace Injection Pump & Thermostat Seal	2015	8,303		20	415	415	1,245	19
20	Door Operator East Elevation Courtyard	2016	3,316		20	166	166	332	20
21	Electrical Panel-Circuits From Electrical Room To Therapy Room	2016	6,300		20	315	315	630	21
22	Condensing Unit	2016	6,650		20	333	333	665	22
23	Heat Exchanger	2016	2,500		20	125	125	250	23
24	Fr Door Operator	2016	2,940		20	147	147	294	24
25	Injector Pump For Air System	2016	2,564		20	128	128	256	25
26	Door Replacement (2)	2017	4,733		20	237	237	237	26
27	Door	2017	4,733		20	237	237	237	27
28	Overlay A Complete Parking Lot On South Side	2017	18,650		20	933	933	933	28
29	Pump (1) & Thermostat (1)	2017	3,851		20	193	193	193	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,611,239	$ 13,507		$ 194,031	$ 180,524	$ 11,342,633	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	Landscaping	1994	25,996		20			25,996	9
10	Sprinkler System	1994	8,900		20			8,900	10
11	Sign- Awning	1994	9,474		20			9,474	11
12	Repair Hot Water System Causing Flood	2008	3,256		20	163	163	1,508	12
13	Installation of 240 Volt Line for Hall Heater; Removed & Replace	2008	3,260		20	163	163	1,481	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 50,886	$		$ 326	$ 326	$ 47,359	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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		$ 50,886	$		$ 326	$	$ 47,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 50,886	$		$ 326	$	$ 47,359	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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 7257 N. Lincoln-Maestro	2004	84,402	2,164	35	2,411	247	34,062	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 7257 N. Lincoln-Maestro	2015	1,330	114	20	89	(25)	207	9
10	Allocated from 7257 N. Lincoln-Maestro	2005	7,694	54	20	276	222	5,642	10
11	Allocated from 7257 N. Lincoln-Maestro	2004	1,677		20	84	84	1,132	11
12									12
13	Allocated from Maestro Consulting Services	2003	687		20	34	34	485	13
14	Allocated from Maestro Consulting Services	2004	13,938		20	695	695	9,565	14
15	Allocated from Maestro Consulting Services	2005	826		20	41	41	531	15
16	Allocated from Maestro Consulting Services	2006	1,120		20	56	56	637	16
17	Allocated from Maestro Consulting Services	2008	1,181		20	59	59	547	17
18	Allocated from Maestro Consulting Services	2009	19,015		20	951	951	8,186	18
19	Allocated from Maestro Consulting Services	2010	2,922		20	146	146	1,097	19
20	Allocated from Maestro Consulting Services	2011	158		20	8	8	55	20
21	Allocated from Maestro Consulting Services	2012	176		20	9	9	51	21
22	Allocated from Maestro Consulting Services	2014	2,198		20	110	110	396	22
23	Allocated from Maestro Consulting Services	2015	618		20	31	31	72	23
24	Allocated from Maestro Consulting Services	2016	2,709	347	20	271	(76)	376	24
25	Allocated from Maestro Consulting Services	2017	362		20	18	18	18	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 141,013	$ 2,679		$ 5,289	$ 2,610	$ 63,059	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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		$ 141,013	$ 2,679		$ 5,289	$ 2,610	$ 63,059	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)		$ 141,013	$ 2,679		$ 5,289	$ 2,610	$ 63,059	34

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	$ 988,387	$ 826	$ 70,014	$ 69,188	10	$ 859,139	71
72	Current Year Purchases	30,461	4,585	3,046	(1,539)	10	3,046	72
73	Fully Depreciated Assets	2,893,288		574	574	10	1,997,120	73
74								74
75	TOTALS	$ 3,912,136	$ 5,411	$ 73,634	$ 68,223		$ 2,859,306	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Maestro	2017	$ 519	$	$	$	5	$ 519	76
77										77
78										78
79										79
80	TOTALS			$ 519	$	$	$		$ 519	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)	$ 17,388,272	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,918	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 267,665	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 248,747	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,202,458	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	Land - 2012	$ 44,811	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 44,811	$	$	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 MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Main Street (Sale/Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [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:				$ 2,066,717			3
4	Additions				(2,066,717)			4
5	Allocated from Maestro				8,220			5
6								6
7	TOTAL				$ 8,220 **			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: $ 60,386 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		$	$ 4,525	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,525	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 MORGAN PARK # 0053744 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 MORGAN PARK # 0053744 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	$		$ 687,065	$		$ 687,065	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			116,106			116,106	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			617,710			617,710	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				229,950		229,950	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					245,111	208,040		453,151	13
14	TOTAL			$		$ 1,665,992	$ 437,990		$ 2,103,982	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 MORGAN PARK **#** 0053744 **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	$ 60,565	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,643,993		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,526		6
7	Other Prepaid Expenses	113,071		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,907,155	$	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	22,650		15
16	Equipment, at Historical Cost	64,064		16
17	Accumulated Depreciation (book methods)	(15,491)		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	872,938		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 944,161	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,851,316	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,446,300	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,839		28
29	Short-Term Notes Payable	349,762		29
30	Accrued Salaries Payable	426,940		30
31	Accrued Taxes Payable (excluding real estate taxes)	77,572		31
32	Accrued Real Estate Taxes(Sch.IX-B)	714,778		32
33	Accrued Interest Payable	642		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,694,990		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,767,823	$	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)**	$ 8,767,823	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (916,507)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,851,316	$	48

***(See instructions.)**

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 **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**	$ (512,903)	1
2	Restatements (describe):		2
3	**Rounding**	7	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (512,896)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(403,611)	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)**	$ (403,611)	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)**	$ (916,507)	24 *

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

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 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	$ 18,350,003	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 18,350,003	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	726,542	6
7	Oxygen	8	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 726,550	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	103	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,814	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	861	19
20	Radiology and X-Ray	344	20
21	Other Medical Services	370	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,301	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,301	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	120	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 120	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,107,466	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,228,634	31
32	Health Care	6,663,228	32
33	General Administration	4,666,670	33
	B. Capital Expense		
34	Ownership	3,035,358	34
	C. Ancillary Expense		
35	Special Cost Centers	2,261,521	35
36	Provider Participation Fee	655,666	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,511,077	40
41	**Income before Income Taxes (line 30 minus line 40)****	(403,611)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (403,611)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,486,627	44
45	Private Pay - Net Inpatient Revenue	688,763	45
46	Medicare - Net Inpatient Revenue	4,218,903	46
47	Other-(specify) Hospice	624,364	47
48	Other-(specify) MAIP/Managed Care/Veteran	2,331,346	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 18,350,003	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 MORGAN PARK # 0053744 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	1,893	2,066	$ 110,473	$ 53.47	1
2	Assistant Director of Nursing	1,945	1,994	84,434	42.34	2
3	Registered Nurses	23,655	25,072	938,620	37.44	3
4	Licensed Practical Nurses	78,631	83,952	2,224,264	26.49	4
5	CNAs & Orderlies	156,727	167,505	2,167,475	12.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,748	1,862	29,975	16.10	9
10	Activity Assistants	12,560	13,604	153,874	11.31	10
11	Social Service Workers	8,952	9,952	220,558	22.16	11
12	Dietician					12
13	Food Service Supervisor	3,949	4,341	74,527	17.17	13
14	Head Cook	3,570	4,021	54,795	13.63	14
15	Cook Helpers/Assistants	21,037	22,928	256,277	11.18	15
16	Dishwashers					16
17	Maintenance Workers	3,761	4,166	85,790	20.59	17
18	Housekeepers	24,126	26,513	315,965	11.92	18
19	Laundry	2,933	3,244	38,652	11.91	19
20	Administrator	1,965	2,086	169,246	81.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,302	16,919	182,739	10.80	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	1,909	2,086	39,663	19.01	31
32	Other Health Care(specify)					32
33	Other(specify)	6,713	7,398	152,118	20.56	33
34	TOTAL (lines 1 - 33)	371,376	399,709	$ 7,299,445 *	$ 18.26	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	418	$ 19,607	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	104,225	10-03	38
39	Pharmacist Consultant	Monthly	25,876	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	525	26,269	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,210	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	12,780	10-03	47
48	Dental Consultant	Monthly	6,225	10-03	48
49	TOTAL (lines 35 - 48)	965	$ 220,192		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 MORGAN PARK # 0053744 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonzetta Williams	Administrator	0	$ 169,246
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,246

B. Administrative - Other

Description	Amount
Management Fees-Symphony	$ 804,758
TOTAL (agree to Schedule V, line 17, col. 3)	$ 804,758
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 59,814
RSM US LLP	Accounting	3,457
See Attached	Legal	14,577
Achieve Accreditation	Accreditation Maintenance	11,412
Care Cost	Cost Management	1,982
Corporation Services Company	Statutory Representation	481
Gabriel Environment Services	Form RD-25	317
HRM Consultants, Inc.	Aging Project	595
Language Line Services	Translating Services	519
LTC Consulting Services	Healthcare Consulting	24,387
McCabe, Kirshner P.C.	Compliance Audit	675
See Supplemental Schedule		282,272
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 400,489

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 205,771
Unemployment Compensation Insurance	130,523
FICA Taxes	542,743
Employee Health Insurance	234,396
Employee Meals	35,350
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan Contributions	54,786
Employee Physical Exams	10,000
Other Employee Benefits	12,734
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,226,303

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	$ 1,327
Advertising: Employee Recruitment	418
Health Care Worker Background Check	7,058
(Indicate # of checks performed 705)	
Patient Background Checks 618	6,175
Dues & Subscriptions	26,602
Licenses & Permits	11,200
Allocated from Maestro	9,091
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,871

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,260
Allocated from Maestro	1,900
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,160

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYMPHONY OF MORGAN PARK # 0053744 **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: $29,042**

(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. $ **2,654** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Renaissance Park South #0049098

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **655,666**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **35,350** Has any meal income been offset against related costs? **None** 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