

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: <u>0053660</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Symphony of Bronzeville</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>3400 South Indiana</u> <u>Chicago</u> <u>60616</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(312) 842-5000</u> Fax # <u>(312) 842-3790</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ *</td></tr><tr><td rowspan="5">Paid Preparer</td><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ *	Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	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											
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	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																								
Date of Initial License for Current Owners: <u>11/1/2015</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number

Symphony of Bronzeville

#

0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	302	Skilled (SNF)	302	110,532	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	302	TOTALS	302	110,532	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			32,916	32,916	8
9	SNF/PED					9
10	ICF	43,858	2,720	20,970	67,548	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,858	2,720	53,886	100,464	14

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

90.89%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

07/01/1994

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

07/01/1994

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

302

and days of care provided

8,898

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/16

Fiscal Year:

12/31/16

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	436,331	72,113	25,435	533,879		533,879		533,879			1
2	Food Purchase		560,562		560,562		560,562	(152)	560,410			2
3	Housekeeping		407,363		407,363		407,363		407,363			3
4	Laundry		266,041	35,104	301,145		301,145		301,145			4
5	Heat and Other Utilities			351,935	351,935		351,935	(9,855)	342,080			5
6	Maintenance	83,560		298,180	381,740		381,740	36,217	417,957			6
7	Other (specify):*							5,122	5,122			7
8	TOTAL General Services	519,891	1,306,079	710,654	2,536,624		2,536,624	31,332	2,567,956			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	6,223,420	643,782	153,580	7,020,782		7,020,782	136,905	7,157,687			10
10a	Therapy	18,275	66	14,146	32,487		32,487	(430)	32,057			10a
11	Activities	145,286	19,345	2,420	167,051		167,051		167,051			11
12	Social Services	264,008			264,008		264,008		264,008			12
13	CNA Training											13
14	Program Transportation			32,850	32,850		32,850	(3,656)	29,194			14
15	Other (specify):*							30,592	30,592			15
16	TOTAL Health Care and Programs	6,650,989	663,193	244,996	7,559,178		7,559,178	163,411	7,722,589			16
	C. General Administration											
17	Administrative	152,491		1,005,391	1,157,882		1,157,882	(949,255)	208,627			17
18	Directors Fees											18
19	Professional Services			483,573	483,573		483,573	29,249	512,822			19
20	Dues, Fees, Subscriptions & Promotions			70,990	70,990		70,990	(2,961)	68,029			20
21	Clerical & General Office Expenses	278,557	2,326	949,640	1,230,523		1,230,523	(402,654)	827,869			21
22	Employee Benefits & Payroll Taxes			1,408,950	1,408,950		1,408,950		1,408,950			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,985	2,985		2,985	1,832	4,817			24
25	Other Admin. Staff Transportation			235	235		235	4,541	4,776			25
26	Insurance-Prop.Liab.Malpractice			765,516	765,516		765,516	5,310	770,826			26
27	Other (specify):*							70,706	70,706			27
28	TOTAL General Administration	431,048	2,326	4,687,280	5,120,654		5,120,654	(1,243,232)	3,877,422			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,601,928	1,971,598	5,642,930	15,216,456		15,216,456	(1,048,488)	14,167,968			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,162	8,162		8,162	391,497	399,659			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			186,430	186,430		186,430	(1,166)	185,264			32
33	Real Estate Taxes			351,432	351,432		351,432	6,977	358,409			33
34	Rent-Facility & Grounds			2,464,956	2,464,956		2,464,956	(2,455,849)	9,107			34
35	Rent-Equipment & Vehicles			73,844	73,844		73,844	8,840	82,684			35
36	Other (specify):*											36
37	TOTAL Ownership			3,084,824	3,084,824		3,084,824	(2,049,701)	1,035,123			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		480,857	1,294,282	1,775,139		1,775,139	(11,961)	1,763,178			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			721,585	721,585		721,585		721,585			42
43	Other (specify):*	47,785		182,312	230,097		230,097	(230,097)	(0)			43
44	TOTAL Special Cost Centers	47,785	480,857	2,198,179	2,726,821		2,726,821	(242,058)	2,484,763			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,649,713	2,452,455	10,925,933	21,028,101		21,028,101	(3,340,248)	17,687,853			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,980)	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	388,691	30		9
10	Interest and Other Investment Income	(1,166)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(152)	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	(165,129)	21		18
19	Entertainment				19
20	Contributions	(14,950)	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	(373,901)	21		24
25	Fund Raising, Advertising and Promotional	(1,588)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,069,895)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,251,070)		\$	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)	(89,178)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (89,178)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,340,248)		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

Report Period Beginning:

Ending:

ID#

0053660

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Sequestration	\$ (259,137)	21	1
2	Veterans Expense	(58,263)	10	2
3	Community Relations Staff	(36,678)	43	3
4	Guest Relations	(11,107)	43	4
5	Bank Charges	(1,411)	21	5
6	Marketing Consultant	(149,412)	43	6
7	Marketing Services	(32,901)	43	7
8	Additional R&M	10,873	06	8
9	Capitalized R&M	(9,750)	06	9
10	PAC Dues	(9,773)	20	10
11	Sale/Leaseback Agreement	(2,464,956)	34	11
12	Non-Allowable Legal	(27,682)	19	12
13	Patient Needs	(1,890)	10	13
14	Recovery Fee	(17,809)	21	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,069,895)		49

ID#

0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(152)											(152)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,980)		3,125									(9,855)	5
6	Maintenance	1,123		35,094									36,217	6
7	Other (specify):*			5,122									5,122	7
8	TOTAL General Services	(12,009)		43,341									31,332	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(60,153)		197,058									136,905	10
10a	Therapy					(430)							(430)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation						(3,656)						(3,656)	14
15	Other (specify):*			30,592									30,592	15
16	TOTAL Health Care and Programs	(60,153)		227,650		(430)	(3,656)						163,411	16
	C. General Administration													
17	Administrative			(949,255)									(949,255)	17
18	Directors Fees													18
19	Professional Services	(27,682)		56,931									29,249	19
20	Fees, Subscriptions & Promotions	(26,311)		23,350									(2,961)	20
21	Clerical & General Office Expenses	(817,387)		414,733									(402,654)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,832									1,832	24
25	Other Admin. Staff Transportation			4,541									4,541	25
26	Insurance-Prop.Liab.Malpractice			5,310									5,310	26
27	Other (specify):*			70,706									70,706	27
28	TOTAL General Administration	(871,379)		(371,852)									(1,243,232)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(943,541)		(100,861)		(430)	(3,656)						(1,048,488)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	388,691		2,806									391,497	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,166)											(1,166)	32
33	Real Estate Taxes			6,977									6,977	33
34	Rent-Facility & Grounds	(2,464,956)		9,107									(2,455,849)	34
35	Rent-Equipment & Vehicles			8,840									8,840	35
36	Other (specify):*													36
37	TOTAL Ownership	(2,077,431)		27,730									(2,049,701)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(11,961)								(11,961)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(230,097)											(230,097)	43
44	TOTAL Special Cost Centers	(230,097)			(11,961)								(242,058)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,251,070)		(73,131)	(11,961)	(430)	(3,656)						(3,340,248)	45

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	<u>UTILITIES</u>	\$	<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	\$ 3,125	\$	3,125 15
16	V	6	<u>MAINTENANCE SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	28,610		28,610 16
17	V	6	<u>MAINTENANCE EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	6,484		6,484 17
18	V	7	<u>EMPLOYEE BENEFITS - MAINTENANCE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	5,122		5,122 18
19	V	10	<u>CLINICAL SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	197,058		197,058 19
20	V	15	<u>EMPLOYEE BENEFITS - CLINICAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	30,592		30,592 20
21	V	17	<u>ADMINISTRATIVE SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	56,136		56,136 21
22	V	17	<u>ADMINISTRATIVE EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%			
23	V	19	<u>PROFESSIONAL FEES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	56,931		56,931 23
24	V	20	<u>DUES, FEES, SUBSCRIPTIONS, ETC.</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	23,350		23,350 24
25	V	21	<u>CLERICAL & GENERAL SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	368,809		368,809 25
26	V	21	<u>CLERICAL & GENERAL EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	45,924		45,924 26
27	V	24	<u>SEMINARS AND EDUCATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	1,832		1,832 27
28	V	25	<u>TRANSPORTATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	4,541		4,541 28
29	V	26	<u>INSURANCE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	5,310		5,310 29
30	V	27	<u>EMPLOYEE BENEFITS - ADMINISTRATIVE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	70,706		70,706 30
31	V	30	<u>DEPRECIATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	2,806		2,806 31
32	V	33	<u>REAL ESTATE TAX</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	6,977		6,977 32
33	V	34	<u>BUILDING RENTAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	9,107		9,107 33
34	V	35	<u>EQUIPMENT RENTAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	3,937		3,937 34
35	V	35	<u>AUTO LEASE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%	4,903		4,903 35
36	V								36
37	V	17	<u>BOOKKEEPING FEES</u>	1,005,391	<u>MAESTRO CONSULTING SERVICES LLC</u>	100.00%			(1,005,391) 37
38	V								38
39	Total			\$ 1,005,391			\$ 932,260	\$ *	(73,131) 39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Supplies	\$ 118,079	Intergra Healthcare Equipment LLC		\$ 106,118	\$ (11,961)	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			\$ 118,079			\$ 106,118	\$ * (11,961)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Respiratory Services	\$ 3,560	Intergra Respiratory Service LLC		\$ 3,130	\$ (430)	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			\$ 3,560			\$ 3,130	\$ * (430)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Transportation	\$ 27,720	Lifeline Ambulance LLC		\$ 24,064	\$ (3,656)	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			\$ 27,720			\$ 24,064	\$ * (3,656)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 294,509	MAPLE LEAF INSURANCE	100.00%	\$ 294,509	\$	15
16	V	26	Liability Insurance	535,280	MAPLE LEAF INSURANCE	100.00%	535,280		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			\$ 829,789			\$ 829,789	\$ *	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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 SERV	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 RESIDENCES OF LINCOLN PARK	CHICAGO				11
12			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				12
13			SYMPHONY OF CHESTERTON	CHESTERTON, IN				13
14			SYMPHONY OF CHICAGO WEST	CHICAGO				14
15			SYMPHONY OF CRESTWOOD	CRESTWOOD				15
16			SYMPHONY OF CROWN POINT	CROWN POINT, IN				16
17			SYMPHONY OF DECATUR	DECATUR				17
18			SYMPHONY OF DYER	DYER, IN				18
19			SYMPHONY OF EVANSTON	EVANSTON				19
20			SYMPHONY OF GLENDALE	GLENDALE, WI				20
21			SYMPHONY OF HANOVER PARK	HANOVER PARK				21
22			SYMPHONY OF JOLIET	JOLIET				22
23			SYMPHONY OF LINCOLN	LINCOLN				23
24			SYMPHONY OF LINCOLN PARK	CHICAGO				24
25			SYMPHONY OF MORGAN PARK	CHICAGO				25
26			SYMPHONY OF ORCHARD VALLEY	AURORA				26
27			SYMPHONY OF SOUTH SHORE	CHICAGO				27
28								28
29								29
30								30

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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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 Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,836,222	28	\$ 51,919	\$	110,532	\$ 3,125	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	110,532	28,610	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		110,532	6,484	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		110,532	5,122	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	110,532	197,058	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		110,532	30,592	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	110,532	56,136	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			110,532		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		110,532	56,931	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		110,532	23,350	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	110,532	368,809	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		110,532	45,924	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		110,532	1,832	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		110,532	4,541	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		110,532	5,310	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		110,532	70,706	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		110,532	2,806	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		110,532	6,977	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		110,532	9,107	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		110,532	3,937	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		110,532	4,903	21
22										22
23										23
24										24
25	TOTALS					\$ 15,487,256	\$ 10,808,353		\$ 932,260	25

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Integra Healthcare Equipment, LLC
Street Address 747 Church Road
City / State / Zip Code Elmhurst, IL 60126
Phone Number (630) 834-3700
Fax Number (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	DME & Medical Supplies	Direct Allocation		\$	\$		\$ 106,118	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				\$	\$		\$ 106,118	25

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Integra Respiratory Service LLC
Street Address 747 Church Road
City / State / Zip Code Elmhurst, IL 60126
Phone Number (630) 834-3700
Fax Number (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	10A Respiratory Services	Direct Allocation			\$	\$		\$ 3,130	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				\$	\$		\$ 3,130	25

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Lifeline Ambulance LLC
Street Address 2424 S. Wabash Avenue
City / State / Zip Code Chicago, IL 60616
Phone Number (312) 949-9595
Fax Number (312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	14	Transportation	Direct Allocation		\$	\$		\$ 24,064	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				\$	\$		\$ 24,064	25

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Maple Leaf Insurance
Street Address PO Box 69, 720 West Bay Rd
City / State / Zip Code Grand Cayman, KY1-1102
Phone Number ()
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	22	Workers Compensation	Direct Allocation		\$			\$ 294,509	1
	2	26	Liability Insurance	Direct Allocation					535,280	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				\$	\$		\$ 829,789	25

Facility Name & ID Number Symphony of Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Bronzeville # 0053660 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	The Private Bank		X	Note Payable			\$					\$ 186,430	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	RCA		X	Note Payable					210,855				6
7													7
8					-								8
9	TOTAL Facility Related						\$		\$ 210,855			\$ 186,430	9
	B. Non-Facility Related*												
10	Interest Income		X									(1,166)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$		\$			\$ (1,166)	14
15	TOTALS (line 9+line14)						\$		\$ 210,855			\$ 185,264	15

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$					8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$					15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Symphony of Bronzeville</u>	COUNTY	<u>Cook</u>
---------------	--------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0053660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>17-34-119-048-0000</u>	<u>Long Term Care Property</u>	\$ <u>137,698.46</u>	\$ <u>137,698.46</u>
2.	<u>17-34-119-049-0000</u>	<u>Long Term Care Property</u>	\$ <u>283,347.60</u>	\$ <u>283,347.60</u>
3.	<u>10-27-319-028-0001</u>	<u>Allocated from Maestro</u>	\$ <u>95,270.31</u>	\$ <u>5,734.83</u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u>516,316.37</u>	\$ <u>426,780.89</u>

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 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.

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.

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.

FACILITY NAME Symphony of Bronzeville COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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.

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?

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.)

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

72,844

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(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?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(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

☒

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	80,457	1984	\$ 240,000	1
2	Allocated from 7257 N. Lincoln Avenue		2004	9,631	2
3	TOTALS	80,457		\$ 249,631	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	302			1977	\$ 4,471,948	\$	35	\$ 127,770	\$ 127,770	\$ 4,050,605	4	
5				1984	92,611		35	2,646	2,646	86,547	5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1980	8,303		20	149	149	7,720	9	
10	Various			1981	1,872		20			1,872	10	
11	Various			1982	5,523		20			5,523	11	
12	Various			1983	1,550		20			1,550	12	
13	Various			1984	5,062		20			5,062	13	
14	Various			1985	24,500		20			24,500	14	
15	Various			1986	8,802		20			8,802	15	
16	Various			1987	5,151		20	164	164	4,749	16	
17	Various			1988	14,372		20	456	456	12,794	17	
18	Various			1989	55,710		20	1,769	1,769	47,826	18	
19	Various			1990	4,899		20	155	155	4,050	19	
20	Various			1991	9,582		20	304	304	7,618	20	
21	Various			1992	4,834		20	153	153	3,689	21	
22	Various			1993	13,785		20	353	353	8,144	22	
23	Various			1994	23,773		20	150	150	21,071	23	
24	Various			1995	20,890		20	4	4	20,888	24	
25	Various			1996	87,605		20	2,670	2,670	87,603	25	
26	Various			1997	40,122		20	1,975	1,975	39,613	26	
27	Various			1998	132,735		20	6,637	6,637	121,763	27	
28	Various			1999	419,788		20	20,989	20,989	362,761	28	
29	Various			2000	90,604		20	4,530	4,530	74,605	29	
30	Various			2001	75,436		20	3,772	3,772	58,274	30	
31	Various			2002	39,859		20			39,859	31	
32	Various			2003	55,783		20	874	874	51,302	32	
33	Various			2004	70,089		20			70,089	33	
34	Various			2005	356,449		20	8,449	8,449	301,050	34	
35	Various			2006	75,373		20	4,288	4,288	54,504	35	
36	Various			2007	41,387		20	2,069	2,069	20,694	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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2008	\$ 213,640	\$	20	\$ 19,121	\$ 19,121	\$ 165,909	37
38	Various	2009	208,483		20	14,936	14,936	116,749	38
39	Various	2010	282,649		20	30,543	30,543	223,351	39
40	Various	2011	114,479		20	11,119	11,119	64,310	40
41	Various	2012	79,757		20	7,280	7,280	32,007	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		144,452	2,517		5,246	2,729	59,327	68
69	Financial Statement Depreciation			8,162			(8,162)		69
70	TOTAL (lines 4 thru 69)		\$ 7,301,856	\$ 10,679		\$ 278,573	\$ 267,894	\$ 6,266,780	70

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

Facility Name & ID Number Symphony of Bronzeville

0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,301,856	\$ 10,679		\$ 278,573	\$ 267,894	\$ 6,266,780	1
2	Elevator Repairs-Install New Controllers, Power Units, Fixtures	2013	168,775		20	8,439	8,439	27,426	2
3	2 Commercial Steel Doors	2013	6,444		20	322	322	1,289	3
4	Conduit For Sprinkler System	2013	5,643		20	282	282	1,129	4
5	Fire Dampers	2013	4,100		20	205	205	820	5
6	New Motor & Controls For Walk In Freezer	2013	4,778		20	239	239	956	6
7	Piping	2013	3,800		20	190	190	760	7
8	2 Commercial Steel Doors & Frame	2013	6,979		20	349	349	1,396	8
9	East & West Elevator Repairs	2013	186,136		20	9,307	9,307	37,227	9
10	Removing Mulch, Installing Weed Fabric, Brick Patio	2013	5,808		20	290	290	1,162	10
11	Resurface 200 Doors	2013	18,000		20	900	900	3,600	11
12	Pump Repair	2014	3,554		20	355	355	770	12
13	Remove Dry Wall In 2Nd Flr Shower Rms, Remove & Install 2 Ne	2014	3,950		20	395	395	1,053	13
14	Water Valve Repairs	2014	2,830		20	142	142	342	14
15	Landscaping - Plants & Soil	2014	7,746		20	387	387	968	15
16	Repaired Elevator Pits	2014	2,936		20	147	147	379	16
17	1St & 3Rd Floor Door Repairs	2014	2,520		20	126	126	347	17
18	Window Glazing	2014	75,000		20	3,750	3,750	11,250	18
19	Caulk 156 Windows And Tuckpoint Around 50 Window Sill	2014	22,500		20	1,125	1,125	3,375	19
20	Parking Lot - Repair Asphalt, Routed Cracks, Sealed 2 Coatings	2014	11,500		20	575	575	1,725	20
21	Installed Pvi Water Heater	2015	21,000		20	1,050	1,050	2,100	21
22	Removed And Installed Concrete Ramp	2015	4,200		20	210	210	420	22
23	Chiller Repair - Reconfigure Panel Components/Wiring	2016	19,591		20	980	980	980	23
24	Chiller Control Board Upgrade	2016	6,628		20	331	331	331	24
25	Repair Ground Pipe Near Conference Room	2016	2,850		20	143	143	189	25
26	Plumbing - Replace 6" Pipe	2016	3,250		20	163	163	163	26
27	Plumbing - Replace Storm Pipe In Lower Level	2016	3,650		20	183	183	183	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	34

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

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		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	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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19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	34

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

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		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	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)		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	34

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

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		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	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)		\$ 7,906,024	\$ 10,679		\$ 309,156	\$ 298,477	\$ 6,367,119	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Symphony of Bronzeville

0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	2004	86,681	2,223	35	2,477	254	32,505	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting	2003	705		20	35	35	463	9
10	Allocated from Maestro Consulting	2004	14,315		20	777	777	9,109	10
11	Allocated from Maestro Consulting	2005	849		20	42	42	503	11
12	Allocated from Maestro Consulting	2006	1,151		20	58	58	596	12
13	Allocated from Maestro Consulting	2008	1,213		20	61	61	501	13
14	Allocated from Maestro Consulting	2009	19,529		20	916	916	7,430	14
15	Allocated from Maestro Consulting	2010	3,001		20	150	150	976	15
16	Allocated from Maestro Consulting	2011	162		20	8	8	48	16
17	Allocated from Maestro Consulting	2012	181		20	9	9	43	17
18	Allocated from Maestro Consulting	2014	2,257		20	113	113	294	18
19	Allocated from Maestro Consulting	2015	635		20	32	32	42	19
20	Allocated from Maestro Consulting	2016	2,782	108	20	108		108	20
21									21
22	Allocated from 7257 N. Lincoln	2015	1,366	130	20	91	(39)	121	22
23	Allocated from 7257 N. Lincoln	2005	7,902	56	20	283	227	5,511	23
24	Allocated from 7257 N. Lincoln	2004	1,723		20	86	86	1,077	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)		\$ 144,452	\$ 2,517		\$ 5,246	\$ 2,729	\$ 59,327	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 144,452	\$ 2,517		\$ 5,246	\$ 2,729	\$ 59,327	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 144,452	\$ 2,517		\$ 5,246	\$ 2,729	\$ 59,327	34

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

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	\$ 874,103	\$	\$ 86,913	\$ 86,913	10	\$ 736,333	71
72	Current Year Purchases	33,979	291	3,387	3,096	10	3,435	72
73	Fully Depreciated Assets	1,179,005		205	205	10	1,211,693	73
74								74
75	TOTALS	\$ 2,087,087	\$ 291	\$ 90,504	\$ 90,213		\$ 1,951,460	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Maestro Consulti	2016	\$ 533	\$	\$	\$	5	\$ 533	76
77										77
78										78
79										79
80	TOTALS			\$ 533	\$	\$	\$		\$ 533	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 10,243,275	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,970	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 399,661	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 388,691	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,319,112	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 7,091	92
93			93
94			94
95		\$ 7,091	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

☒ YES

☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1977	302		\$2,464,956			3
4	Additions				(2,464,956)			4
5	Allocated from Maestro Consulting Services				9,107			5
6								6
7	TOTAL		302		\$9,107			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:

☐ YES☐ NO

Terms:

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: \$77,781

Description:See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Maestro Consulting		\$	\$4,903	17
18					18
19					19
20					20
21	TOTAL		\$-	\$4,903	21

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

☒ 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.

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	\$		\$ 439,610	\$		\$ 439,610	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			252,490			252,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			484,228			484,228	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				316,036		316,036	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					117,954	164,821		282,775	13
14	TOTAL			\$		\$ 1,294,282	\$ 480,857		\$ 1,775,139	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,289	\$	1
2	Cash-Patient Deposits	51,136		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,803,062		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,927		6
7	Other Prepaid Expenses	133,937		7
8	Accounts Receivable (owners or related parties)	1,612,905		8
9	Other(specify): <u>See Attached Schedule</u>	293,666		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,913,922	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	26,219		15
16	Equipment, at Historical Cost	63,242		16
17	Accumulated Depreciation (book methods)	(8,512)		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): <u>See Attached Schedule</u>	7,091		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 88,040	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,001,962	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,931,541	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,136		28
29	Short-Term Notes Payable	210,855		29
30	Accrued Salaries Payable	357,788		30
31	Accrued Taxes Payable (excluding real estate taxes)	55,245		31
32	Accrued Real Estate Taxes(Sch.IX-B)	311,220		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	5,696,797		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,614,582	\$	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)	\$ 10,614,582	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (612,620)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,001,962	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 63,973	1
2	Restatements (describe):		2
3	Equity Adjustment	6,971	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 70,944	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(683,564)	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)	\$ (683,564)	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)	\$ (612,620)	24 *

* This must agree with page 17, line 47.

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$20,004,335	1
2	Discounts and Allowances for all Levels	(125,970)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$19,878,365	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	422,967	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$422,967	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	39,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	631	19
20	Radiology and X-Ray	1,343	20
21	Other Medical Services	752	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$42,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,166	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$1,166	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$20,344,537	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,536,624	31
32	Health Care	7,559,178	32
33	General Administration	5,120,654	33
	B. Capital Expense		
34	Ownership	3,084,824	34
	C. Ancillary Expense		
35	Special Cost Centers	2,005,236	35
36	Provider Participation Fee	721,585	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$21,028,101	40
41	Income before Income Taxes (line 30 minus line 40)**	(683,564)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$(683,564)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$11,479,298	44
45	Private Pay - Net Inpatient Revenue	197,744	45
46	Medicare - Net Inpatient Revenue	4,921,024	46
47	Other-(specify)Managed Care / Veterans	2,202,596	47
48	Other-(specify)Hospice	1,077,703	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$19,878,365	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,976	2,189	\$ 116,810	\$ 53.36	1
2	Assistant Director of Nursing	1,788	1,996	76,762	38.46	2
3	Registered Nurses	42,916	46,533	1,656,122	35.59	3
4	Licensed Practical Nurses	82,218	87,871	2,239,823	25.49	4
5	CNAs & Orderlies	173,947	186,246	2,082,227	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,489	1,636	18,275	11.17	8
9	Activity Director	3,433	3,600	67,256	18.68	9
10	Activity Assistants	6,206	6,918	78,030	11.28	10
11	Social Service Workers	9,233	9,893	234,267	23.68	11
12	Dietician					12
13	Food Service Supervisor	4,739	5,081	89,269	17.57	13
14	Head Cook	3,037	3,449	44,670	12.95	14
15	Cook Helpers/Assistants	25,439	28,474	302,392	10.62	15
16	Dishwashers					16
17	Maintenance Workers	3,923	4,330	83,560	19.30	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,326	2,537	152,491	60.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,138	2,240	51,513	23.00	23
24	Clerical	12,972	14,535	227,044	15.62	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	1,425	1,760	21,994	12.50	31
32	Other Health Care(specify)					32
33	Other(specify)	4,535	4,731	107,208	22.66	33
34	TOTAL (lines 1 - 33)	383,741	414,019	\$ 7,649,713 *	\$ 18.48	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	540	\$ 25,435	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	603	32,367	10-03	38
39	Pharmacist Consultant	Monthly	91,513	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	14,146	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,420	11-03	44
45	Social Service Consultant				45
46	Other(specify) Cardiologist	Monthly	12,000	10-03	46
47	Psychiatric	Monthly	17,700	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,187	\$ 237,581		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSymphony of Bronzeville# 0053660Report Period Beginning:01/01/16Ending:12/31/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Niquitta Williams	Administrator	0	\$ 152,491
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 152,491

B. Administrative - Other

Description	Amount
Maestro Consulting - Bookkeeping Fees	\$ 1,005,391
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Data Processing	\$ 6,252
Creative Technology	Information Technology	26,639
Dart Chart Systems	Mngd Care Reimbursement	337
Ehealth Data Solutions	Network Service Vendor	1,704
Emmi Solutions	Data Processing	193
Formation HC Group	Clinical Consulting	989
FYI Systems	Data Processing	626
Health Data Solutions	Data Processing	7,609
Telemedicine Solutions	Wound Care Management	23,991
Matrixcare	Data Processing	16,344
PointClickCare	E.H.R. Software	10,629
See Supplemental Schedule		388,259
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 483,573

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 294,509
Unemployment Compensation Insurance	138,124
FICA Taxes	551,736
Employee Health Insurance	363,403
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan Contributions	39,551
Employee Physical Exams	5,251
Other Employee Benefits	16,377
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$
Advertising: Employee Recruitment	382
Health Care Worker Background Check (Indicate # of checks performed 824)	8,239
Patient Background Checks 303	3,030
Dues and Subscriptions	25,435
Licenses and Fees	7,593
Allocated from Maestro Consulting	23,350
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,985
Allocated from Maestro Consulting	1,832
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,817

* Attach copy of IMRF notifications

**See instructions.

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 - \$29,616
- (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. \$ 3,060 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? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Bronzeville Park Nursing & Living Center, #0040592, 11/01/15
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 721,585
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 benefit on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees