

		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:** 0053660

**Facility Name:** Symphony of Bronzeville

**Address:** 3400 South Indiana Chicago 60616  
Number City Zip Code

**County:** Cook

**Telephone Number:** (312) 842-5000 **Fax #** (312) 842-3790

**HFS ID Number:** \_\_\_\_\_

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____ (Date) _____
	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) _____ * _____ (Date) _____
	* Subject to the attached Accountants Consulting Report
	(Print Name and Title) _____
	(Firm Name & Address) <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

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 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

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

YES  NO

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

Date started 07/01/1994

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

YES  Date 07/01/1994 NO

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

YES  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  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  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
	<b>A. General Services</b>										
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	<b>TOTAL General Services</b>	<b>519,891</b>	<b>1,306,079</b>	<b>710,654</b>	<b>2,536,624</b>		<b>2,536,624</b>	<b>31,332</b>	<b>2,567,956</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
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	<b>TOTAL Health Care and Programs</b>	<b>6,650,989</b>	<b>663,193</b>	<b>244,996</b>	<b>7,559,178</b>		<b>7,559,178</b>	<b>163,411</b>	<b>7,722,589</b>		<b>16</b>
	<b>C. General Administration</b>										
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	<b>TOTAL General Administration</b>	<b>431,048</b>	<b>2,326</b>	<b>4,687,280</b>	<b>5,120,654</b>		<b>5,120,654</b>	<b>(1,243,232)</b>	<b>3,877,422</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>7,601,928</b>	<b>1,971,598</b>	<b>5,642,930</b>	<b>15,216,456</b>		<b>15,216,456</b>	<b>(1,048,488)</b>	<b>14,167,968</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Symphony of Bronzeville

#0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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	<b>TOTAL Ownership</b>			3,084,824	3,084,824		3,084,824	(2,049,701)	1,035,123			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>	47,785	480,857	2,198,179	2,726,821		2,726,821	(242,058)	2,484,763			44
45	<b>GRAND TOTAL COST</b> (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.

Facility Name & ID Number **Symphony of Bronzeville**

# **0053660**

Report Period Beginning:

**01/01/16**

Ending:

**12/31/16**

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (3,251,070)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (89,178)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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Symphony of Bronzeville

ID# 0053660

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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	<b>Total</b>	(3,069,895)		49

Symphony of Bronzeville

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	<b>Total</b>		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	<b>TOTAL General Services</b>	<b>(12,009)</b>		<b>43,341</b>									<b>31,332</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>(60,153)</b>		<b>227,650</b>		<b>(430)</b>	<b>(3,656)</b>						<b>163,411</b>	<b>16</b>
	<b>C. General Administration</b>													
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	<b>TOTAL General Administration</b>	<b>(871,379)</b>		<b>(371,852)</b>									<b>(1,243,232)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(943,541)</b>		<b>(100,861)</b>		<b>(430)</b>	<b>(3,656)</b>						<b>(1,048,488)</b>	<b>29</b>



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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
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	<b>TOTAL Ownership</b>	<b>(2,077,431)</b>		<b>27,730</b>									<b>(2,049,701)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>(230,097)</b>			<b>(11,961)</b>								<b>(242,058)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(3,251,070)</b>		<b>(73,131)</b>	<b>(11,961)</b>	<b>(430)</b>	<b>(3,656)</b>						<b>(3,340,248)</b>	<b>45</b>

Facility Name & ID Number

Symphony of Bronzeville

# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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  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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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 UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 3,125	\$ 3,125 15
16	V	6 MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	28,610	28,610 16
17	V	6 MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	6,484	6,484 17
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	5,122	5,122 18
19	V	10 CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	197,058	197,058 19
20	V	15 EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	30,592	30,592 20
21	V	17 ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	56,136	56,136 21
22	V	17 ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%		
23	V	19 PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	56,931	56,931 23
24	V	20 DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	23,350	23,350 24
25	V	21 CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	368,809	368,809 25
26	V	21 CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	45,924	45,924 26
27	V	24 SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,832	1,832 27
28	V	25 TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	4,541	4,541 28
29	V	26 INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	5,310	5,310 29
30	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	70,706	70,706 30
31	V	30 DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,806	2,806 31
32	V	33 REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	6,977	6,977 32
33	V	34 BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	9,107	9,107 33
34	V	35 EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,937	3,937 34
35	V	35 AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,903	4,903 35
36	V						
37	V	17 BOOKKEEPING FEES	1,005,391	MAESTRO CONSULTING SERVICES LLC	100.00%		(1,005,391) 37
38	V						
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)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 118,079			\$ 106,118	\$ * (11,961)

\* 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	10A Respiratory Services	\$ 3,560	Intergra Respiratory Service LLC		\$ 3,130	\$ (430)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 3,560			\$ 3,130	\$ * (430)

\* 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)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 27,720			\$ 24,064	\$ * (3,656)

\* 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	<b>Total</b>		\$			\$	\$ *	39

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



Facility Name & ID Number

Symphony of Bronzeville

# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name &amp; ID Number

Symphony of Bronzeville

#

0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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	<b>TOTALS</b>				\$	\$		\$	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	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	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	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	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

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

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.

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	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	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	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	<b>TOTALS</b>				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25



Facility Name & ID Number

Symphony of Bronzeville

# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	The Private Bank		X	Note Payable			\$	\$		\$ 186,430	1									
2											2									
3											3									
4											4									
5				-							5									
<b>Working Capital</b>																				
6	RCA		X	Note Payable				210,855			6									
7											7									
8				-							8									
9	<b>TOTAL Facility Related</b>						\$	\$ 210,855		\$ 186,430	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(1,166)	10									
11											11									
12											12									
13				-							13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (1,166)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 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.)

Facility Name & ID Number

Symphony of Bronzeville

# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									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.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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 (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.		\$	<u>380,834</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>428,023</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>47,189</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>311,220</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>358,409</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u>449,743</u>	8
	2012	<u>276,571</u>	9
	2013	<u>280,314</u>	10
	2014	<u>285,961</u>	11
	2015	<u>421,046</u>	12

2016 Accrual = \$421,046 x 0.74 = \$311,220

Allocated from Maestro Consulting - \$6,977

\*The beginning accrual on line 1 was adjusted, since the ending accrual on the 2015 cost report only represented 2 months.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

**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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</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. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <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.

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

**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 Applicable to Nursing Home</u>
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Symphony of Bronzeville

# 0053660 Report Period Beginning:

01/01/16 Ending:

12/31/16

**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	<u>Facility</u>	<u>80,457</u>	<u>1984</u>	<u>\$ 240,000</u>	<u>1</u>
2	<u>Allocated from 7257 N. Lincoln Avenue</u>		<u>2004</u>	<u>9,631</u>	<u>2</u>
3	<b>TOTALS</b>	<b>80,457</b>		<b>\$ 249,631</b>	<b>3</b>

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		
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
	<b>Improvement Type**</b>									
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	<b>TOTAL (lines 4 thru 69)</b>		\$ 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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		\$ 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		\$ 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		\$ 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.

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	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 <b>Building Company</b>		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 <b>Leasehold Improvements:</b>								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 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	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		\$	\$		\$	\$	\$	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)	\$	\$		\$	\$	\$	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	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	<b>Related Party</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<u>Allocated from 7257 N. Lincoln</u>	2004	86,681	2,223	35	2,477	254	32,505	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<u>Allocated from Maestro Consulting</u>	2003	705		20	35	35	463	9
10	<u>Allocated from Maestro Consulting</u>	2004	14,315		20	777	777	9,109	10
11	<u>Allocated from Maestro Consulting</u>	2005	849		20	42	42	503	11
12	<u>Allocated from Maestro Consulting</u>	2006	1,151		20	58	58	596	12
13	<u>Allocated from Maestro Consulting</u>	2008	1,213		20	61	61	501	13
14	<u>Allocated from Maestro Consulting</u>	2009	19,529		20	916	916	7,430	14
15	<u>Allocated from Maestro Consulting</u>	2010	3,001		20	150	150	976	15
16	<u>Allocated from Maestro Consulting</u>	2011	162		20	8	8	48	16
17	<u>Allocated from Maestro Consulting</u>	2012	181		20	9	9	43	17
18	<u>Allocated from Maestro Consulting</u>	2014	2,257		20	113	113	294	18
19	<u>Allocated from Maestro Consulting</u>	2015	635		20	32	32	42	19
20	<u>Allocated from Maestro Consulting</u>	2016	2,782	108	20	108		108	20
21									21
22	<u>Allocated from 7257 N. Lincoln</u>	2015	1,366	130	20	91	(39)	121	22
23	<u>Allocated from 7257 N. Lincoln</u>	2005	7,902	56	20	283	227	5,511	23
24	<u>Allocated from 7257 N. Lincoln</u>	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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		\$ 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
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)	\$ 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.



Facility Name & ID Number Symphony of Bronzeville

# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 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:	<u>1977</u>	<u>302</u>		\$ <u>2,464,956</u>			<u>3</u>
4	Additions				<u>(2,464,956)</u>			<u>4</u>
5	<u>Allocated from Maestro Consulting Services</u>				<u>9,107</u>			<u>5</u>
6								<u>6</u>
7	<b>TOTAL</b>		<b>302</b>		\$ <b>9,107</b>			<b>7</b>

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 \$ \_\_\_\_\_

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	<u>Allocated from Maestro Consulting</u>		\$ _____	\$ <u>4,903</u>	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	<b>TOTAL</b>		\$ -	\$ <b>4,903</b>	<b>21</b>

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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): <u>See Supplemental</u>						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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
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): <b>See Attached Schedule</b>	293,666		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 9,913,922	\$	10
	<b>B. Long-Term Assets</b>			
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): <b>See Attached Schedule</b>	7,091		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 88,040	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,001,962	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
36	<b>See Attached Schedule</b>	5,696,797		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 10,614,582	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 10,614,582	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (612,620)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,001,962	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>63,973</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity Adjustment</b>	<b>6,971</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>70,944</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(683,564)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(683,564)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(612,620)</b>	<b>24</b> *

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

Facility Name & ID Number Symphony of Bronzeville# 0053660Report Period Beginning: 01/01/16Ending: 12/31/16**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 20,004,335	1
2	Discounts and Allowances for all Levels	(125,970)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 19,878,365	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	422,967	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 422,967	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 42,039	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,166	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,166	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 20,344,537	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,536,624	31
32	Health Care	7,559,178	32
33	General Administration	5,120,654	33
<b>B. Capital Expense</b>			
34	Ownership	3,084,824	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,005,236	35
36	Provider Participation Fee	721,585	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 21,028,101	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(683,564)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (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) <u>Managed Care / Veterans</u>	2,202,596	47
48	Other-(specify) <u>Hospice</u>	1,077,703	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 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.

Facility Name & ID Number Symphony of Bronzeville

# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

\*\* See instructions.

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) <u>Cardiologist</u>	Monthly	12,000	10-03	46
47	<u>Psychiatric</u>	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



Facility Name & ID Number Symphony of Bronzeville

# 0053660

Report Period Beginning: 01/01/16

Ending: 12/31/16

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>Niquitta Williams</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 152,491</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 294,509</u>	<u>IDPH License Fee</u>	<u>\$ 382</u>		
				<u>Unemployment Compensation Insurance</u>	<u>138,124</u>	<u>Advertising: Employee Recruitment</u>	<u>382</u>		
				<u>FICA Taxes</u>	<u>551,736</u>	<u>Health Care Worker Background Check</u>	<u>8,239</u>		
				<u>Employee Health Insurance</u>	<u>363,403</u>	(Indicate # of checks performed <u>824</u> )			
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>3,030</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and Subscriptions</u>	<u>25,435</u>		
				<u>Pension Plan Contributions</u>	<u>39,551</u>	<u>Licenses and Fees</u>	<u>7,593</u>		
				<u>Employee Physical Exams</u>	<u>5,251</u>	<u>Allocated from Maestro Consulting</u>	<u>23,350</u>		
				<u>Other Employee Benefits</u>	<u>16,377</u>				
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 152,491</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>\$ 1,408,951</b>		
<b>(List each licensed administrator separately.)</b>				<b>(agree to Sch. V, line 20, col. 8)</b>			<b>\$ 68,028</b>		
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>				<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount	
<u>Maestro Consulting - Bookkeeping Fees</u>			<u>\$ 1,005,391</u>				<u>Out-of-State Travel</u>	<u>\$</u>	
							<u>In-State Travel</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 1,005,391</b>	<b>TOTAL</b>			<b>\$</b>	<u>Seminar Expense</u>	<u>2,985</u>
<b>(Attach a copy of any management service agreement)</b>								<u>Allocated from Maestro Consulting</u>	<u>1,832</u>
<b>C. Professional Services</b>									
Vendor/Payee	Type		Amount						
<u>Ability Network</u>	<u>Data Processing</u>		<u>\$ 6,252</u>						
<u>Creative Technology</u>	<u>Information Technology</u>		<u>26,639</u>						
<u>Dart Chart Systems</u>	<u>Mngd Care Reimbursement</u>		<u>337</u>						
<u>Ehealth Data Solutions</u>	<u>Network Service Vendor</u>		<u>1,704</u>						
<u>Emmi Solutions</u>	<u>Data Processing</u>		<u>193</u>						
<u>Formation HC Group</u>	<u>Clinical Consulting</u>		<u>989</u>						
<u>FYI Systems</u>	<u>Data Processing</u>		<u>626</u>						
<u>Health Data Solutions</u>	<u>Data Processing</u>		<u>7,609</u>						
<u>Telemedicine Solutions</u>	<u>Wound Care Management</u>		<u>23,991</u>						
<u>Matrixcare</u>	<u>Data Processing</u>		<u>16,344</u>						
<u>PointClickCare</u>	<u>E.H.R. Software</u>		<u>10,629</u>						
<u>See Supplemental Schedule</u>			<u>388,259</u>						
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 483,573</b>						
<b>(For legal fee disclosure, see page 39 of instructions)</b>									

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Symphony of Bronzeville# 0053660

Report Period Beginning:

01/01/16

Ending:

12/31/16**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 benefits 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