

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0053686</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Symphony of Chicago West</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																															
Address: <u>5130 W Jackson Blvd</u> <u>Chicago</u> <u>60644</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(773) 921-8000</u> Fax # <u>(773) 921-3980</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067																																				
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Date of Initial License for Current Owners: <u>7/1/1994</u>																																																	
Type of Ownership:																																																	
<table><tr><td><input type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other _____</td><td></td><td></td></tr></table>		<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	IRS Exemption Code _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other _____		
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		<input 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:		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																																															
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Symphony of Chicago West

0053686 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	<u>234</u>	Skilled (SNF)	<u>234</u>	<u>85,644</u>	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	<u>234</u>	TOTALS	<u>234</u>	<u>85,644</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>66,237</u>	<u>893</u>	<u>12,707</u>	<u>79,837</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,237</u>	<u>893</u>	<u>12,707</u>	<u>79,837</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.22%

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

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

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

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒ Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

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 234 and days of care provided 3,181

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Symphony of Chicago West # 0053686 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	431,497	33,415	39,271	504,183		504,183	1,057	505,240		1
2	Food Purchase		444,696		444,696		444,696		444,696		2
3	Housekeeping	34,244	8,751	705,743	748,738		748,738		748,738		3
4	Laundry	-	41,229	3,169	44,398		44,398		44,398		4
5	Heat and Other Utilities			377,019	377,019		377,019	1,963	378,982		5
6	Maintenance	107,867	-	297,509	405,376		405,376	3,778	409,154		6
7	Other (specify):* Mgmt alloc of benef	-	-	-				281	281		7
8	TOTAL General Services	573,608	528,091	1,422,711	2,524,410		2,524,410	7,079	2,531,489		8
	B. Health Care and Programs										
9	Medical Director	-	-	24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	5,091,433	270,215	279,432	5,641,080		5,641,080	129,822	5,770,902		10
10a	Therapy	-	-	-							10a
11	Activities	133,649	-	-	133,649		133,649		133,649		11
12	Social Services	160,109	-	-	160,109		160,109		160,109		12
13	CNA Training	-	-	-							13
14	Program Transportation	-	-	-							14
15	Other (specify):* Mgmt alloc of benef	-	-	-				47,333	47,333		15
16	TOTAL Health Care and Programs	5,385,191	270,215	303,432	5,958,838		5,958,838	177,155	6,135,993		16
	C. General Administration										
17	Administrative	127,019	-	880,191	1,007,210		1,007,210	(880,191)	127,019		17
18	Directors Fees			-							18
19	Professional Services			442,089	442,089		442,089	19,470	461,559		19
20	Dues, Fees, Subscriptions & Promotions			51,341	51,341		51,341	(7,766)	43,575		20
21	Clerical & General Office Expenses	318,925	20,817	157,930	497,672		497,672	167,291	664,963		21
22	Employee Benefits & Payroll Taxes			991,216	991,216		991,216		991,216		22
23	Inservice Training & Education			-							23
24	Travel and Seminar			3,524	3,524		3,524	415	3,939		24
25	Other Admin. Staff Transportation		-	-				7,573	7,573		25
26	Insurance-Prop.Liab.Malpractice			828,349	828,349		828,349	1,404	829,753		26
27	Other (specify):* Mgmt alloc of benef			-				32,989	32,989		27
28	TOTAL General Administration	445,944	20,817	3,354,640	3,821,401		3,821,401	(658,815)	3,162,586		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,404,743	819,123	5,080,783	12,304,649		12,304,649	(474,581)	11,830,068		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	D. Ownership											
30	Depreciation			117,214	117,214		117,214	103,347	220,561			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			26,603	26,603		26,603	(17,533)	9,070			32
33	Real Estate Taxes			675,557	675,557		675,557	5,155	680,712			33
34	Rent-Facility & Grounds			2,779,813	2,779,813		2,779,813	3,525	2,783,338			34
35	Rent-Equipment & Vehicles			131,330	131,330		131,330	4,781	136,111			35
36	Other (specify):*			-								36
37	TOTAL Ownership			3,730,517	3,730,517		3,730,517	99,275	3,829,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	27,265	27,265		27,265	(2,159)	25,106			38
39	Ancillary Service Centers	-	205,419	1,263,952	1,469,371		1,469,371	(2,777)	1,466,594			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			593,768	593,768		593,768		593,768			42
43	Other (specify):* Non-Allowable Co	220,925	-	818,413	1,039,338		1,039,338	(1,039,338)				43
44	TOTAL Special Cost Centers	220,925	205,419	2,703,398	3,129,742		3,129,742	(1,044,274)	2,085,468			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,625,668	1,024,542	11,514,698	19,164,908		19,164,908	(1,419,580)	17,745,328			45

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(23,055)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	74,694	30		9
10	Interest and Other Investment Income	(17,571)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(45,669)	43		18
19	Entertainment				19
20	Contributions	(4,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(699,954)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,497)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(303,327)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,022,879)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(396,701)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (396,701)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,419,580)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (154,969)	43	1
2	Laboratory Costs	(25,618)	43	2
3	X-Ray Costs	(12,164)	43	3
4	Theft and Damage Loss	(180)	43	4
5	Lobbying Expense	(15,342)	20	5
6	Admissions Salary	(69,732)	43	6
7	Non-allowable legal	(12,997)	19	7
8	Other income	(3,445)	21	8
9	Non-allowable Branding	(8,880)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(303,327)		49

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	\$			\$	\$	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			\$			\$	\$ * 0	14

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

Facility Name & ID Number

Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	1	Dietary	\$	Maestro Consulting Services	100%	\$ 1,057	\$ 1,057	15
16	V	5	Utilities		Maestro Consulting Services	100%	1,963	1,963	16
17	V	6	Maintenance Salaries		Maestro Consulting Services	100%	0		17
18	V	6	Maintenance Expenses		Maestro Consulting Services	100%	3,778	3,778	18
19	V	7	Employee Benefits - Maintenance		Maestro Consulting Services	100%	281	281	19
20	V	10	Clinical Salaries		Maestro Consulting Services	100%	164,552	164,552	20
21	V	10	Contract Nursing		Maestro Consulting Services	100%	158	158	21
22	V	15	Employee Benefits - Clinical		Maestro Consulting Services	100%	47,333	47,333	22
23	V	17	Administrative - Other	880,191	Maestro Consulting Services	100%	0	(880,191)	23
24	V	19	Professional Fees		Maestro Consulting Services	100%	41,347	41,347	24
25	V	20	Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100%	7,576	7,576	25
26	V	21	Clerical & General Salaries		Maestro Consulting Services	100%	114,687	114,687	26
27	V	21	Clerical & General Expenses		Maestro Consulting Services	100%	56,049	56,049	27
28	V	24	Seminars and Education		Maestro Consulting Services	100%	415	415	28
29	V	25	Transportation		Maestro Consulting Services	100%	7,573	7,573	29
30	V	26	Insurance		Maestro Consulting Services	100%	1,404	1,404	30
31	V	27	Employee Benefits - Administrative		Maestro Consulting Services	100%	32,989	32,989	31
32	V	30	Depreciation		Maestro Consulting Services	100%	28,653	28,653	32
33	V	32	Interest Expense		Maestro Consulting Services	100%	38	38	33
34	V	33	Real Estate Tax		Maestro Consulting Services	100%	5,155	5,155	34
35	V	34	Building Rental		Maestro Consulting Services	100%	3,525	3,525	35
36	V	35	Equipment Rental		Maestro Consulting Services	100%	10,158	10,158	36
37	V	35	Auto Lease		Maestro Consulting Services	100%	5,844	5,844	37
38	V								38
39	Total			\$ 880,191			\$ 534,535	\$ * (345,656)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing & Medical Records	\$ 4,952	Integra Healthcare Equipment LLC	19%	\$ 4,209	\$ (743)	15
16	V	35	Equipment Rental	74,809	Integra Healthcare Equipment LLC	19%	63,588	(11,221)	16
17	V	39	Oxygen	18,516	Integra Healthcare Equipment LLC	19%	15,739	(2,777)	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			\$ 98,277			\$ 83,536	\$ * (14,741)	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	38	Transportation	\$ 14,394	Lifeline Ambulance, LLC	4%	\$ 12,235	\$ (2,159)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 14,394			\$ 12,235	\$ * (2,159)	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	10	Dialysis	\$ 227,634	Concerto Dialysis LLC	20%	\$ 193,489	\$ (34,145)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 227,634			\$ 193,489	\$ * (34,145)	39

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

Facility Name & ID Number

Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SYMCARE HEALTHCARE, LLC	0.9999	SYMPHONY OF CALIFORNIA GARDENS	CHICAGO	MAESTRO CONSUL	LINCOLNWOOD	MANAGEMENT	1
2	SYMCARE HMG, LLC	0.0001	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AV	LINCOLNWOOD	BUILDING RENTA	2
3			NORTHWOODS CARE CENTRE	BELVIDERE	MAPLELEAF INSUR	GRAND CAYMAN	LIABILITY/WORK	3
4			SYCAMORE VILLAGE	SWANSEA	INTEGRA HEALTHC	ELMHURST	DME & MEDICAL	4
5			SYMPHONY ARIA	HILLSIDE	INTEGRA RESPIRA	ELMHURST	RESPIRATORY SH	5
6			SYMPHONY AT 87TH STREET	CHICAGO	LIFELINE AMBULA	CHICAGO	AMBULANCE	6
7			SYMPHONY AT MIDWAY	CHICAGO	CONCERTO DIALYS	LINCOLNWOOD	DIALYSIS	7
8			SYMPHONY AT THE TILLERS	OSWEGO				8
9			SYMPHONY OF BRONZEVILLE	CHICAGO				9
10			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				10
11			SYMPHONY OF CHESTERTON	CHESTERTON, IN				11
12			SYMPHONY OF CHICAGO WEST	CHICAGO				12
13			SYMPHONY OF CRESTWOOD	CRESTWOOD				13
14			SYMPHONY OF CROWN POINT	CROWN POINT, IN				14
15			SYMPHONY OF DYER	DYER, IN				15
16			SYMPHONY OF EVANSTON	EVANSTON				16
17			SYMPHONY OF GLENDALE	GLENDALE, WI				17
18			SYMPHONY OF HANOVER PARK	HANOVER PARK				18
19			SYMPHONY OF JOLIET	JOLIET				19
20			SYMPHONY OF LINCOLN PARK	CHICAGO				20
21			SYMPHONY OF MORGAN PARK	CHICAGO				21
22			SYMPHONY OF ORCHARD VALLEY	AURORA				22
23			SYMPHONY RESIDENCES OF LINCOLN PA	CHICAGO				23
24			WOODCARE V INC	BRIGHTON, MI				24
25			CLIFFSIDE COMPANY LLC	ST. JOSEPH, MI				25
26			SYMPHONY APPLEWOOD	WOODHAVEN, MI				26
27			SYMPHONY LINDEN	LINDEN, MI				27
28			SYMPHONY TRI-CITIES	BAY CITY, MI				28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	No owners receive compensation from this facility								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Bed Days Available	27	\$ 20,270	\$ 19,367	85,644	\$ 1,057	1
2	5	Utilities	Bed Days Available	27	37,663		85,644	1,963	2
3	6	Maintenance Salaries	Bed Days Available	27			85,644		3
4	6	Maintenance Expenses	Bed Days Available	27	72,471		85,644	3,778	4
5	7	Employee Benefits - Maintenance	Bed Days Available	27	5,383		85,644	281	5
6	10	Clinical Salaries	Bed Days Available	27	3,156,734	3,156,734	85,644	164,552	6
7	10	Contract Nursing	Bed Days Available	27	3,034		85,644	158	7
8	15	Employee Benefits - Clinical	Bed Days Available	27	908,028		85,644	47,333	8
9	17	Administrative - Other	Bed Days Available	27			85,644		9
10	19	Professional Fees	Bed Days Available	27	793,188		85,644	41,347	10
11	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	27	145,343		85,644	7,576	11
12	21	Clerical & General Salaries	Bed Days Available	27	2,200,120	2,200,120	85,644	114,687	12
13	21	Clerical & General Expenses	Bed Days Available	27	1,075,235		85,644	56,049	13
14	24	Seminars and Education	Bed Days Available	27	7,970		85,644	415	14
15	25	Transportation	Bed Days Available	27	145,272		85,644	7,573	15
16	26	Insurance	Bed Days Available	27	26,926		85,644	1,404	16
17	27	Employee Benefits - Administrative	Bed Days Available	27	632,860		85,644	32,989	17
18	30	Depreciation	Bed Days Available	27	549,679		85,644	28,653	18
19	32	Interest Expense	Bed Days Available	27	738		85,644	38	19
20	33	Real Estate Tax	Bed Days Available	27	98,893		85,644	5,155	20
21	34	Building Rental	Bed Days Available	27	67,631		85,644	3,525	21
22	35	Equipment Rental	Bed Days Available	27	194,869		85,644	10,158	22
23	35	Auto Lease	Bed Days Available	27	112,113		85,644	5,844	23
24									24
25	TOTALS				\$ 10,254,420	\$ 5,376,221		\$ 534,535	25

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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	10	Nursing & Medical Records	Direct Allocation		\$	\$		\$ 4,209	1
2	35	Equipment Rental	Direct Allocation					63,588	2
3	39	Oxygen	Direct Allocation					15,739	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				\$	\$		\$ 83,536	25

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lifeline Ambulance, LLC

Street Address

2424 S. Wabash Avenue

City / State / Zip Code

Chicago, IL 60616

Phone Number

(312) 949-9595

Fax Number

(312) 949-9262

1	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	38	Transportation	Direct Allocation		\$	\$		\$ 12,235	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				\$	\$		\$ 12,235	25

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Concerto Dialysis LLC

Street Address

4600 W. Touhy Ave. Suite 100

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(547) 233-1200

Fax Number

(

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Dialysis	Direct Allocation		\$	\$		\$ 193,489	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				\$	\$		\$ 193,489	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Omnicare		X	Pharmacy Services	67,444	11/27/2017	\$ 2,170,337	\$ -	10/20/2020	0.075	\$ 395	1
2	LifeMed	X		Pharmacy Services	38,731	1/1/2018	6,197,033	150,943	01/01/2024	0.075	12,808	2
3	Select Rehab		X	Operational	159,503	12/31/2018	12,216,125	446,900	12/31/2023	0.002	10,355	3
4	Integra	X		Medical Supplies/rental	50,680	7/1/2019	1,162,530	18,094	6/30/2021	0.043802	1,629	4
5												5
	Working Capital											
6	State of Illinois		X	Advance Payment	18,254	5/1/2019	926,300	926,300	8/1/2021			6
7	National Government Services		X	Medicare AAP	25,537	4/7/2020	612,877	612,877	4/7/23			7
8												8
9	TOTAL Facility Related				\$360,148.61		\$ 23,285,202	\$ 2,155,114			\$ 25,187	9
	B. Non-Facility Related*											
10	Cyber Ins										133	10
11	Worthy Ins										1,283	11
12								Interest Income Offset			(17,571)	12
13								Maestro Allocation			38	13
14	TOTAL Non-Facility Related						\$	\$			\$ (16,117)	14
15	TOTALS (line 9+line14)						\$ 23,285,202	\$ 2,155,114			\$ 9,070	15

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYMPHONY OF CHICAGO WEST COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053686

CONTACT PERSON REGARDING THIS REPORT Ari Krupp

TELEPHONE (410) 258-7363 FAX #: N/A

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 nursin 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-16-209-002-0000	Nursing Home	\$ 609,628.92	\$ 609,628.92
2. 10-27-319-028-0000	Home Office Allocation	\$ 85,535.22	\$ 5,155.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 695,164.14	\$ 614,783.92

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

A. Square Feet:

110,407

B. General Construction Type:

Exterior

Brick

Frame

Brick/Concrete

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(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).
Medical Clinic - Costs are not included on Schedule V

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

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		-		\$ -	1
2	Allocated from Maestro 7257 Lincoln		2004	8340	2
3	TOTALS			\$ 8,340	3

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8	Allocated from Maestro 7257			2004	75,063		35	2,145	2,145	36,728	8
	Improvement Type**										
9	Various			1987	198,972		20			198,972	9
10	Various			1988	17,097		20			17,097	10
11	Various			1989	19,023		20			19,023	11
12	Various			1990	33,869		20			33,869	12
13	Various			1991	10,518		20			10,518	13
14	Various			1993	3,315		20			3,315	14
15	Various			1994	110,244		20			110,244	15
16	Various			1995	57,890		20			57,890	16
17	Various			1996	131,988		20			131,988	17
18	Various			1997	126,299		20			126,299	18
19	Various			1998	35,115		20			35,115	19
20	Various			1999	67,125		20			67,125	20
21	Various			2000	182,497		20	2,406	2,406	182,497	21
22	Various			2001	24,742		20	1,237	1,237	24,186	22
23	Various			2002	119,751		20			119,751	23
24	Various			2003	107,313		20	163	163	107,313	24
25	Various			2004	9,849		20			9,849	25
26	Various			2005	170,025		20	8,501	8,501	152,081	26
27	Various			2006	347,480		20			347,480	27
28	Various			2007	2,721		20			2,721	28
29	Various			2008	2,900		20			2,900	29
30	Various			2009	136,688		20			136,688	30
31	Various			2010	35,779		20	1,789	1,789	34,196	31
32	Various			2011	350,322		20	17,516	17,516	322,863	32
33	Various			2012	10,373		20	519	519	7,149	33
34	Various			2013	2,752		20	138	138	999	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,389,709	\$		\$ 34,414	\$ 34,414	\$ 2,298,853	70

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XL 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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,389,709	\$		\$ 34,414	\$ 34,414	\$ 2,298,853	1
2	Skylight Glass Replacement	2014	7,380		20	369	369	4,551	2
3	Parking Lot Paving	2014	13,250		20	663	663	5,667	3
4	Fire Alarm System	2014	9,655		20	483	483	8,068	4
5	Electrical Outlets	2014	5,300		20	265	265	3,092	5
6	Plumbing-Replace P-Trap In Boiler Room, Replace Corridor Pipe	2014	20,945		20	1,047	1,047	12,219	6
7	Replace Door Operators On 3 Elevators	2014	36,600		20	1,830	1,830	11,285	7
8	Repaired Elevators	2015	7,578		20	379	379	2,274	8
9	Demolition Of Existing Walk-In Freezer/Cooler/Electrical	2015	7,240		20	362	362	2,172	9
10	Electrical Services For Walk-In Freezer/Cooler	2015	3,200		20	160	160	960	10
11	New Door Frame And New Glass Doors At Main Entrance	2015	11,580		20	579	579	3,474	11
12	New Walk-In Cooler/Freezer	2015	18,318		20	916	916	5,496	12
13	Wired Call System	2015	86,995		20	4,350	4,350	26,099	13
14	Furnish/Install New Pump And Pump Motor Valve And Tank	2016	10,450		20	523	523	2,614	14
15	Plumbing - 1St/2Nd Floor Drain And Piping	2016	2,750		20	138	138	689	15
16	Roof Work - Repair Leaks Rooms 416/430, Lower Roof Leaks - Ea	2016	3,800		20	190	190	950	16
17	Wired Nurse Call System	2016	7,248		20	362	362	1,811	17
18	3 Elevators - Furnish And Apply Car Top Hand Rails	2016	3,732		20	187	187	935	18
19	Electrical Work - Replace/Rewire Disconnect, Supply New Fuse Disc	2016	4,620		20	231	231	1,155	19
20	Plumbing - Camera And Rod Kitchen Waste Lines	2016	3,630		20	182	182	910	20
21	New Door Sill \$3,200	2017	3,200		20	160	160	640	21
22	Fire Sprinkler \$3,810	2017	3,810		20	191	191	762	22
23	Telephone System/Install/Main	2017	26,860		20	1,343	1,343	5,372	23
24	Plumbing To Repair Rodding Of Grease Line	2017	2,720		20	136	136	544	24
25	Install New Slop Sink	2017	2,670		20	134	134	534	25
26	Plumbing Repiping And Replace 4 Gate Valves	2017	5,265		20	263	263	1,053	26
27	Repaired Trane Rtu	2017	5,283		20	264	264	1,057	27
28	Replace flooring, doors, millwork-Clinical Bldg	2018	87,200	6,188	20	6,188		18,564	28
29	Replace tile flooring, 4" wall base, insulate, drywall & paint,	2018	116,073	6,502	20	6,502		19,506	29
30	electrical, light fixtures - 1st & 2nd Floor								30
31	Camera System install-Throughout Facility	2018	33,986	2,926	20	2,926		8,778	31
32	R&M-Replace phone jacks, face-plates, gang boxes, patch cords-CI	2018	2,969		20	148	148	444	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,944,016	\$ 15,616		\$ 65,882	\$ 50,266	\$ 2,450,526	34

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,944,016	\$ 15,616		\$ 65,882	\$ 50,266	\$ 2,450,526	1
2									2
3	Leasehold Improvements:								3
4	Various	2004	11,647		20			11,647	4
5	Various	2005	61,061		20	3,053	3,053	51,581	5
6	Universal Wide Style Handrail	2007	3,458		20	173	173	2,421	6
7	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	1,750	7
8	Duro Last Roofing System	2007	17,750		20	888	888	12,427	8
9	Fire Alram (Repair)	2007	4,364		20	218	218	3,055	9
10	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	2,758	10
11	Walkway	2007	5,500		20	275	275	3,850	11
12	Renovated Parking Lot	2007	6,800		20	340	340	4,760	12
13	Fire Alarm Control Panel	2007	9,252		20	463	463	6,478	13
14	Duro Lasting Roof Work	2007	17,750		20	888	888	12,427	14
15	Bristol/Modules For Chiller	2007	5,832		20	292	292	4,084	15
16	Compresor Replacer	2007	2,823		20	141	141	1,975	16
17	Telephone System	2008	21,774		20			21,774	17
18	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	1,751	18
19	Elevator Car Doors	2008	3,875		20	194	194	2,520	19
20	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	16,783	20
21	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	3,159	21
22	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	18,083	22
23	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	6,370	23
24	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	30,862	24
25	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	19,231	25
26	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	6,287	26
27	Capital Report Reconciliation	2008	(300)		20	(15)	(15)	(195)	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,279,773	\$ 15,616		\$ 80,999	\$ 65,383	\$ 2,696,364	34

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,279,773	\$ 15,616		\$ 80,999	\$ 65,383	\$ 2,696,364	1
2	K-020 IDPH Corrections-Demo & Carpentry, Painting,HVAC,								2
3	Plumbing - All Resident Rooms and Doctor Office Next Door	2012	85,025		20	4,251	4,251	38,261	3
4	Remove and Install Data Cables	2013	6,500		20	325	325	3,218	4
5	Remove and Installed Nre Fire Alarm Control Panel	2013	37,210		20	1,861	1,861	14,886	5
6	RECEPTACLES FOR KIOSKS	2013	4,055		20	203	203	1,623	6
7	SPRINKLER HEAD INSTALLATION	2013	2,850		20	143	143	1,142	7
8	Removed and Installed Cedar Fence on East & South Side of Build	2013	23,055		20	1,153	1,153	9,223	8
9	FIRE ALARM SYSTEM	2013	7,416		20	371	371	2,967	9
10	Install 15 Openings Power Outlets In 2Nd Flr Rooms For Wall Mo	2014	2,550		20	128	128	895	10
11	Replace 4 Doors With 20-Minute Fire Doors, Custom Match And S	2014	2,700		20	135	135	945	11
12	Construct Outside Patio Roof, Detach Structure From Building, B	2014	2,545		20	127	127	890	12
13	Install Alarm Bell On South Passenger Elevator; Code Data Plates,	2014	7,176		20	359	359	2,512	13
14	Caulking Windows	2014	22,500		20	1,125	1,125	7,875	14
15	Labor & Materials To Resurface 250 Doors, Remove Doors From I	2014	22,500		20	1,125	1,125	7,875	15
16	Roof Installation	2014	49,000		20	2,450	2,450	17,150	16
17	RPZ valves janitor closet, washing machines, water supply coffee m	2019	12,250	613	20	613		1,516	17
18	Wander Guard Front door	2019	3,013	151	20	151		341	18
19	8 New recepticles in dialasys room, new conduit to	2019	5,720	286	20	286		678	19
20	electrical panel and add 8 new 120v amp circuits								20
21	15 foot of 4 inch cast iron piping in basement ceiling	2019	3,965	198	20	198		393	21
22	located in laundry room								22
23	Elevator-Fire service keys #1,2,3, door restrictor, #3	2019	16,450	823	20	823		1,401	23
24	Emergency bell and light work #2, fire service update all cars								24
25	emergency phones.								25
26	Plumbing service for new water heater	2019	61,250	12,250	5	12,250		22,160	26
27	New Compressor-piping, water coil	2019	4,358	218	20	218		731	27
28	Repair and replace exhaust piping on the generator	2019	3,100	155	20	155		230	28
29	Replace coolant in generator	2019	3,435	172	20	172		225	29
30	Elevator-3 drop keys, 2 emergency bells and light units	2019	2,530	127	20	127		190	30
31	New 220 v amp circuit juntion boxes, basement to outside AC	2020	2,590	210	11	210		210	31
32	Dialysis room renovation, flooring, painting, plumbing	2020	45,046	3,659	11	3,659		3,659	32
33	1 3 ton dual zone fujitsu mini system dialysis room	2020	14,894	1,210	11	1,210		1,210	33
34	TOTAL (lines 1 thru 33)		\$ 3,733,456	\$ 35,686		\$ 114,825	\$ 79,139	\$ 2,838,768	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,733,456	\$ 35,686		\$ 114,825	\$ 79,139	\$ 2,838,768	1
2	Fuel tank test vent isolation	2020	3,820	219	11	219		219	2
3	Fuel tank vent replacement	2020	9,480	544	11	544		544	3
4	Replace storm piping	2020	8,568	143	11	143		143	4
5	Install new boiler shut off valves & fittings	2020	4,843	13	11	13		13	5
6	Replace 100 gallon water heater basement	2020	8,990	737	5	737		737	6
7	Elevator door, wiring, install, elevator kit	2020	31,518	2,549	5	2,549		2,549	7
8									8
9									9
10									10
11	Reconcile to book depreciation			21,668			(21,668)		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)		\$ 3,800,675	\$ 61,558		\$ 119,029	\$ 57,471	\$ 2,842,972	34

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,800,675	\$ 61,558		\$ 119,029	\$ 57,471	\$ 2,842,972	1
2									2
3									3
4	Leasehold Improvements:								4
5	Allocated from Maestro Consulting	2003	611		20	31	31	523	5
6	Allocated from Maestro Consulting	2004	12,396		20	618	618	10,361	6
7	Allocated from Maestro Consulting	2005	735		20	37	37	583	7
8	Allocated from Maestro Consulting	2006	997		20	50	50	716	8
9	Allocated from Maestro Consulting	2008	1,050		20	52	52	644	9
10	Allocated from Maestro Consulting	2009	16,911		20	846	846	9,817	10
11	Allocated from Maestro Consulting	2010	2,599		20	130	130	1,365	11
12	Allocated from Maestro Consulting	2011	140		20	7	7	70	12
13	Allocated from Maestro Consulting	2012	156		20	8	8	68	13
14	Allocated from Maestro Consulting	2014	1,955		20	98	98	646	14
15	Allocated from Maestro Consulting	2015	550		20	27	27	147	15
16	Allocated from Maestro Consulting	2016	2,409		20	120	120	816	16
17	Allocated from Maestro Consulting	2017	322		20	16	16	65	17
18	Allocated from Maestro Consulting	2020	520		20	13	13	13	18
19									19
20	Allocated from 7257 N. Lincoln	2004	1,492		20	75	75	1,231	20
21	Allocated from 7257 N. Lincoln	2005	6,843		20	245	245	5,753	21
22	Allocated from 7257 N. Lincoln	2015	1,183		20	79	79	421	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)		\$ 3,851,544	\$ 61,558		\$ 121,481	\$ 59,923	\$ 2,876,211	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$754,487	\$50,736	\$70,103	\$19,367	5-10	\$671,972	71
72	Current Year Purchases	50,570	4,920	4,920		5-10	4,920	72
73	Fully Depreciated Assets	1,511,262					1,511,262	73
74	Allocated from Maestro	219,517		24,057	24,057	5-10	105,412	74
75	TOTALS	\$2,535,836	\$55,656	\$99,080	\$43,424		\$2,293,566	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Maestro	2017	\$462	\$-	\$-		5	\$462	76
77					-	-				77
78					-	-				78
79					-	-				79
80	TOTALS			\$462	\$	\$			\$462	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)	\$6,396,182	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$117,214	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$220,561	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$103,347	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,170,239	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	RESURFACE PK LOT/SIDEWALK	\$20,903	\$	\$20,903	86
87	Clinic Project- new cabinetry, counter to	4,400	220	2,420	87
88	Dr. Stalling's Office - Front reception ne	3,700	185	1,850	88
89	Xray Rm: demolish 4 door opening. furn	16,700	835	8,350	89
90	Dr. Rms-Floor, Wall, Countertop, Sink, W	8,500	425	3,825	90
91	TOTALS	\$54,203	\$1,665	\$37,348	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$245,945	92
93			93
94			94
95		\$245,945	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: Invesque
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:		234	11/1/2015	\$ 2,779,813	15	15	3
4	Additions							4
5	Allocated from Maestro Consulting Services				3,525			5
6								6
7	TOTAL		234		\$ 2,783,338			7

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

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: \$ 130,267 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Maestro Consulting Services		\$	\$ 5,844	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,844	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name:

Symphony of Chicago West

IDPH License ID Number:

0053686

Fiscal Year End:

12/31/2020

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	72,333
Nursing Equipment	5,145
Building Equipment	4,829
Office Equimpment	49,023
Integra Allocation	(11,221)
Maestro Allocation	10,158
Total - Line 16	130,267

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	7,148	\$ 514,629	\$	7,148	\$ 514,629	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,678	120,816		1,678	120,816	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,739	557,223		7,739	557,223	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				186,882		186,882	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2), (7)					15,760		15,760	12
13	Other (specify): <u>See Sch. 16A</u>	39(3)			886	62,325		886	62,325	13
14	TOTAL			\$	17,451	\$ 1,254,993	\$ 202,642	17,451	\$ 1,457,635	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.

Facility Name: Symphony of Chicago West
IDPH License ID Number: 0053686
Fiscal Year End: 12/31/2020

Schedule 16A

XIV. Special Services (Direct Cost)

Line 13 Other (specify)

	Rental Description	Amount
500103-MAID	Inhalation Therapy Costs-Medicaid	13,860
500103-MEDA	Inhalation Therapy Costs-Medicare A	1,926
500103-MNGD	Inhalation Therapy Costs-Managed Care	783
500103-PRVT	Inhalation Therapy Costs-Private	53
500113-MAID	I.V. Therapy Costs-Medicaid	12,020
500113-MEDA	I.V. Therapy Costs-Medicare A	19,782
500113-MNGD	I.V. Therapy Costs-Managed Care	13,905
500113-VTRN	Other Ancillary Costs-Medicare A	(369)
500103-VTRN	Other Ancillary Costs-Medicare A	365
	Total - Line 13	62,325

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,080	\$ 2,080	1
2	Cash-Patient Deposits	90,439	90,439	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,749,173)	3,698,925	3,698,925	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	5,175	5,175	6
7	Other Prepaid Expenses	18,887	18,887	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Attached Schedule	1,138,352	1,138,352	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,953,858	\$ 4,953,858	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	8,340	13
14	Buildings, at Historical Cost	-	75,063	14
15	Leasehold Improvements, at Historical Cost	371,182	3,776,481	15
16	Equipment, at Historical Cost	479,816	2,536,298	16
17	Accumulated Depreciation (book methods)	(283,169)	(5,170,239)	17
18	Deferred Charges	-	-	18
19	Organization & Pre-Operating Costs	-	-	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	-	-	20
21	Restricted Funds	-	-	21
22	Other Long-Term Assets (specify)	-	-	22
23	Other(specify): See Attached Schedule	599,585	599,585	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,167,414	\$ 1,825,528	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,121,272	\$ 6,779,386	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,075,100	\$ 1,075,100	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	91,021	91,021	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	546,944	546,944	30
31	Accrued Taxes Payable (excluding real estate taxes)	348,820	348,820	31
32	Accrued Real Estate Taxes(Sch.IX-B)	627,917	627,917	32
33	Accrued Interest Payable	-	-	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,624,196	2,624,196	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,313,998	\$ 5,313,998	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,155,114	2,155,114	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43		-	-	43
44		-	-	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,155,114	\$ 2,155,114	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,469,112	\$ 7,469,112	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,347,840)	\$ (689,726)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,121,272	\$ 6,779,386	48

*(See instructions.)

Facility Name: Symphony of Chicago West
IDPH License ID Num 0053686
Fiscal Year End: 12/31/2020

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
120112 SJSL Due To/From - Lincoln Park LLC	186,122.00	186,122.00
120117 SJSL Due To/From - Morgan Park	77,055.00	77,055.00
120119 SJSL Due To/From - South Shore	782,583.00	782,583.00
120122 SJSL Due To/From - California Gardens Nursing and Reha	(46,884.00)	(46,884.00)
120123 SJSL Due To/From - Monroe Corp	51,541.00	51,541.00
129111 SJSL Due To/From - Jackson - OLD	446,674.00	446,674.00
Total - Line 9	1,497,091	1,497,091

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
118000 SJSL Fixed Assets - Construction in Process	245,945.00	245,945.00
120101 SJSL Due To/From - 87Th Street	35,164.00	35,164.00
120102 SJSL Due To/From - Aria LLC	150,289.00	150,289.00
120103 SJSL Due To/From - Bronzeville Park LLC	68,714.00	68,714.00
120104 SJSL Due To/From - Buffalo Grove LLC	17,420.00	17,420.00
120105 SJSL Due To/From - Crestwood LLC	180.00	180.00
120108 SJSL Due To/From - Evanston Healthcare LLC	307.00	307.00
120109 SJSL Due To/From - Hanover Park	726.00	726.00
120116 SJSL Due To/From - Midway	177,138.00	177,138.00
120118 SJSL Due To/From - Northwoods LLC	164.00	164.00
120120 SJSL Due To/From - Sycamore LLC	164.00	164.00
120121 SJSL Due To/From - Tillers	768.00	768.00
120124 SJSL Due To/From - Orchard Valley	395.00	395.00
120202 SJSL Due To/From - Crown Point LLC	164.00	164.00
120203 SJSL Due To/From - Dyer LLC	164.00	164.00
120301 SJSL Due To/From - Glendale	164.00	164.00
120401 SJSL Due To/From - Applewood	164.00	164.00
120402 SJSL Due To/From - Brighton	446.00	446.00
120403 SJSL Due to/from - Lakeland	164.00	164.00
120404 SJSL Due To/From - Linden	321.00	321.00
120405 SJSL Due To/From - Tricities	473.00	473.00
127012 SJSL Due To/From - Symphony Healthcare	2,328.00	2,328.00
127014 SJSL Due To/From - Syncare Healthcare	2,601,965.00	2,601,965.00
Total - Line 23	3,303,727	3,303,727

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
120107 SJSL Due To/From - Deerbrook LLC	-1,044.00	-1,044.00
120113 SJSL Due To/From - Maple Crest LLC	720.00	720.00
120125 SJSL Due To/From - Symphony of Cal Gardens	14,481.00	14,481.00
120201 SJSL Due To/From - Chesterton LLC	133,956.00	133,956.00
127013 SJSL Due To/From - Symphony Financial Services	526.00	526.00
127015 SJSL Due To/From - Syncare ML	2,690,568.00	2,690,568.00
128002 SJSL Due To/From - Maestro	-9,357.00	-9,357.00
200100 SJSL Accrued Payables	148,082.00	148,082.00
200101 SJSL Accrued Payables - Professional Fees	26,717.00	26,717.00
200120 SJSL Accrued Payables - Health Insurance	14,425.00	14,425.00
200121 SJSL Accrued Payable - Dental Insurance	-4,711.00	-4,711.00
200122 SJSL Accrued Payables - Vision Insurance	-229.00	-229.00
200123 SJSL Accrued Payables - Life Insurance	42,573.00	42,573.00
200124 SJSL Accrued Payables - Short Term Disability	-46,990.00	-46,990.00
200270 SJSL Accrued Payables - Payroll Union Dues	7,165.00	7,165.00
200290 SJSL Accrued Payables - 401K Deductions	-757.00	-757.00
200291 SJSL Accrued Payables - 401K Loan Repayments	-1.00	-1.00
200295 SJSL Accrued Payables - Heart and Soul Foundation	94.00	94.00
200300 SJSL Accrued Payables - Garnishments	-9,797.00	-9,797.00
200310 SJSL Employee Purchases	3,353.00	3,353.00
200350 SJSL Fringe Benefits - Flow Through	1,612.00	1,612.00
200410 SJSL Accrued Payables - WC/GL Insurance	356,505.00	356,505.00
200500 SJSL Accrued Payables - Bed Taxes	5,817.00	5,817.00
200505 SJSL Accrued Payables - OIG Audit	264,228.00	264,228.00
200510 SJSL Accrued Payables - Bed Taxes Add'l	38,974.00	38,974.00
200600 SJSL Accrued Payables - Management Fees	-4,107.00	-4,107.00
200800 SJSL Accrued Payables - Interest	-1,126.00	-1,126.00
200900 SJSL Accrued Payables - Rent	-66,249.00	-66,249.00
200950 SJSL Accrued Payables - Sales Tax	397.00	397.00
202000 SJSL Deferred Rent	1,544,048.00	1,544,048.00
202100 SJSL Deferred Income	537,204.00	537,204.00
Total - Line 36	5,687,077	5,687,077

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,282,426)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,282,426)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(65,414)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (65,414)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,347,840)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,913,865	1
2	Discounts and Allowances for all Levels	(2,336,186)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,577,679	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	2,394,275	6
7	Oxygen	23,834	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,418,109	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,460,580	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	338,237	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	30,195	19
20	Radiology and X-Ray	8,688	20
21	Other Medical Services	24,584	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,862,284	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	17,571	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,571	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	223,851	28
28a		-	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 223,851	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,099,494	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,524,410	31
32	Health Care	5,958,838	32
33	General Administration	3,821,401	33
	B. Capital Expense		
34	Ownership	3,730,517	34
	C. Ancillary Expense		
35	Special Cost Centers	2,535,974	35
36	Provider Participation Fee	593,768	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,164,908	40
41	Income before Income Taxes (line 30 minus line 40)**	(65,414)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (65,414)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 12,328,729	44
45	Private Pay - Net Inpatient Revenue	228,528	45
46	Medicare - Net Inpatient Revenue	717,196	46
47	Other-(specify) MAIP	399,941	47
48	Other-(specify) Managed Care/Veteran/Hospice	903,285	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,577,679	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.
^Entity is a cash basis taxpayer.

Facility Name: Symphony of Chicago West
IDPH License ID Number: 0053686
Fiscal Year End: 12/31/2020

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Other revenue	3,445.00
Medical Equipment Rental - Revenue-Medicaid	63,989.00
Preferred Insurance Provider Incentive - Revenue-	139,682.00
Other Services - Revenue-Managed Care	-33,495.00
Transportation - Other Revenue-Other	9,680.00
Rental Income - Other Revenue-Other	40,550.00
Total - Line 28	223,851

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	1,840	2,031	\$ 115,536	\$ 56.90	1
2	Assistant Director of Nursing	1,128	1,185	48,492	40.94	2
3	Registered Nurses	13,407	14,972	525,828	35.12	3
4	Licensed Practical Nurses	55,460	66,629	1,986,304	29.81	4
5	CNAs & Orderlies	106,739	122,160	2,112,026	17.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,690	5,338	133,649	25.04	10
11	Social Service Workers	6,328	6,797	160,109	23.56	11
12	Dietician					12
13	Food Service Supervisor	1,656	1,816	53,961	29.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,876	5,374	101,370	18.86	15
16	Dishwashers	16,789	18,441	276,166	14.98	16
17	Maintenance Workers	4,201	4,443	107,867	24.28	17
18	Housekeepers	1,842	2,114	34,244	16.20	18
19	Laundry					19
20	Administrator	1,920	2,160	127,019	58.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,848	2,092	59,534	28.45	23
24	Clerical	10,475	12,160	200,365	16.48	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	3,763	4,158	89,078	21.42	31
32	Other Health Care See Sch 20A	7,532	8,650	273,195	31.58	32
33	Other(specify) Admission & Com	5,906	6,412	220,925	34.45	33
34	TOTAL (lines 1 - 33)	250,400	286,932	\$ 6,625,668 *	\$ 23.09	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	Monthly	\$ 39,271	1(3)	35
36	Medical Director	Monthly	24,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	158	10(7)	38
39	Pharmacist Consultant	Monthly	29,980	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	4,534	39 (3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatric Consult	Monthly	11,860	10 (3)	46
47	Dental Consultant	Monthly	4,425	39 (3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 114,228		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name: Symphony of Chicago West
IDPH License ID Number: 0053686
Fiscal Year End: 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS Coordinator	5,764	6,650	214,169	\$ 32.21
Human Resource Director	1,768	2,000	59,026	\$ 29.51
Total - Line 32 Other Health Care (specify):	7,532	8,650	273,195	

Facility Name: Symphony of Chicago West
IDPH License ID Number: 0053686
Fiscal Year End: 12/31/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ABILITY CHOICE	Secure Exchange Managed Services	(102)
Allscripts LLC	Referral System	5,379
Alteryx, Inc.	Data Analytics	3,943
aplooi-applciant tracing system	aplooi-applciant tracking system	76
CATS- APPLICANT TRACKING SY	Applicant Tracking System	404
CDW	Computer service	1,863
Comcast Cable	Internet and cable	32,791
Creative Technology Solutions	IT Support	3,253
Darktrace Limited	Cyber Security	2,782
Data Robot-Cloud Professional	Data Storage	2,153
EMMI Solutions	Data Analytics	(392)
Enquire Solutions LLC	Marketing solution	1,230
ENTERPRISE IMMUNE SYSTEM	Immune System tracker	231
enVista, LLC		893
FORMATION HEALTHCARE	Monthly Subscription Fee	1,268
Health Data Systems Inc	Programming	3,057
Intellicomp Technologies Inc.	IT Support	23,714
IntelliLogix	IT Support	535
KRONOS SUPPORT SERVICES	Payroll service	7,376
Managed Care Group LLC	IT Support	7,084
Microsoft Corp	Computer service	6,617
Navigator Group Purchasing, In		336
Nexuscomm, LLC	Phone/fax service	5,800
Pay access	Payroll	168
Petty Cash	Phone	16
PointClickCare Technologies Inc.	Cloud based software and services	43,317
PRIME CARE TECHNOLOGIES	PBJ Reporting Module Access Fee	2,520
Reputation.com, Inc.	Online Reputation Management	1,108
Reside Admissions LLC	Admission Process Consulting	3,403
Scott Norton	HR Services	215
Sprout Social Inc.	Social Media Management	2,648
Striv Technologies LLC dba Striv360	IT Support	2,215
Team TSI Corporation	Collection	5,430
Telemedicine Solutions, LLC	Wound Rounds Care	11,271
Third Eye Health Inc.	Data Analytics	69
Wencel	Branding	7,650
RSM	Accounting fees	43,520
MKB	Legal Counsel	106,509
Stone, Pogrund & Korey LLC	Collection, guardianship etc	7,097
Advanced Care Medical Speciali	Infectious Disease Consult	907
Abbey Road Tax Consultants, LLC	Real Estate appeal-Accounting	8,036
Achieve Accreditation		9,876
ADP Employment Tax Service	Payroll service	1,830
Corporation Service Company	Annual Filing	1,264
Language Line Services	Language lesson	317
MTS Consulting, LLC	Tax Consulting	50,419
National Datacare Corporation	trust service charge	8,282
Personnel Planners, Inc	Qtrly Unemployment Claims	2,073
Real Estate Analysis Corporation	Real Estate valuaion	5,500
	Legal Fees -appeal	
SB2	Medicaid/Medicare claims	5,899
Transworld Systems Inc	Collection	240
Total (agree to Schedule V, line 19, column 3)		442,089
Allocated from Management Company Professional Services		41,347
Less: Non-Allowable Legal Fees		(12,997)
Less: Non-Allowable Branding/Marketing		(8,880)
Total (agree to Schedule V, line 19, column 8)		461,559

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. Health Care Council of Illinois \$30,684
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 11/1/2015
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Jackson Square Nursing and Rehab IDPH #0039834
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 593,768
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. \$ 0 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
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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? Yes
Firm Name: RSM US LLP
- (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.