

		FOR BHF USE					

LL1

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>0053728</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Symphony at 87th Street</u>		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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>2940 West 87th St</u> <u>Chicago</u> <u>60652</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(773) 434-8787</u> Fax # <u>(773) 434-8717</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>11/1/2015</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐		☐	Corporation	☐	Other _____	☐		☒	"Sub-S" Corp.	☐		☐		☐	Limited Liability Co.	☐		☐		☐	Trust	☐		☐		☐	Other _____	☐	
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☐		☐	Trust	☐																																													
☐		☐	Other _____	☐																																													
IRS Exemption Code _____																																																	
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 at 87th Street

0053728 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>210</u>	Skilled (SNF)	<u>210</u>	<u>76,860</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>210</u>	TOTALS	<u>210</u>	<u>76,860</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>38,543</u>	<u>1,869</u>	<u>16,892</u>	<u>57,304</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>38,543</u>	<u>1,869</u>	<u>16,892</u>	<u>57,304</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.56%

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 07/01/1999

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

YES

☒

Date

New Construction

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

210

and days of care provided

5,486

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 at 87th Street # 0053728 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	407,763	40,284	26,819	474,866		474,866	948	475,814		1
2	Food Purchase		358,806		358,806		358,806		358,806		2
3	Housekeeping	-	6,456	757,387	763,843		763,843		763,843		3
4	Laundry	-	30,358	2,051	32,409		32,409		32,409		4
5	Heat and Other Utilities			235,437	235,437		235,437	1,762	237,199		5
6	Maintenance	130,256	-	128,402	258,658		258,658	3,390	262,048		6
7	Other (specify):* Mgmt Alloc of Benefi	-	-	-				252	252		7
8	TOTAL General Services	538,019	435,904	1,150,096	2,124,019		2,124,019	6,352	2,130,371		8
	B. Health Care and Programs										
9	Medical Director	-	-	18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	5,078,372	211,006	28,981	5,318,359		5,318,359	147,404	5,465,763		10
10a	Therapy	-	-	-							10a
11	Activities	220,042	-	-	220,042		220,042		220,042		11
12	Social Services	182,834	-	-	182,834		182,834		182,834		12
13	CNA Training	-	-	-							13
14	Program Transportation	-	-	-							14
15	Other (specify):* Mgmt Alloc of Benefi	-	-	-				42,478	42,478		15
16	TOTAL Health Care and Programs	5,481,248	211,006	46,981	5,739,235		5,739,235	189,882	5,929,117		16
	C. General Administration										
17	Administrative	142,091	-	766,426	908,517		908,517	(766,426)	142,091		17
18	Directors Fees			-							18
19	Professional Services			461,029	461,029		461,029	(30,079)	430,950		19
20	Dues, Fees, Subscriptions & Promotions			59,796	59,796		59,796	(5,674)	54,122		20
21	Clerical & General Office Expenses	402,889	21,752	59,025	483,666		483,666	141,456	625,122		21
22	Employee Benefits & Payroll Taxes			1,070,336	1,070,336		1,070,336		1,070,336		22
23	Inservice Training & Education			-							23
24	Travel and Seminar			4,581	4,581		4,581	373	4,954		24
25	Other Admin. Staff Transportation		-	313	313		313	6,796	7,109		25
26	Insurance-Prop.Liab.Malpractice			676,620	676,620		676,620	1,260	677,880		26
27	Other (specify):* Mgmt Alloc of Benefits			-				29,606	29,606		27
28	TOTAL General Administration	544,980	21,752	3,098,126	3,664,858		3,664,858	(622,688)	3,042,170		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,564,247	668,662	4,295,203	11,528,112		11,528,112	(426,454)	11,101,658		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			113,947	113,947		113,947	89,683	203,630			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			23,720	23,720		23,720	(4,867)	18,853			32
33	Real Estate Taxes			825,601	825,601		825,601	5,954	831,555			33
34	Rent-Facility & Grounds			2,656,751	2,656,751		2,656,751	3,164	2,659,915			34
35	Rent-Equipment & Vehicles			142,936	142,936		142,936	8,145	151,081			35
36	Other (specify):*			-								36
37	TOTAL Ownership			3,762,955	3,762,955		3,762,955	102,079	3,865,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	50,471	50,471		50,471	(5,212)	45,259			38
39	Ancillary Service Centers	-	163,959	1,400,283	1,564,242		1,564,242	(335)	1,563,907			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			429,825	429,825		429,825		429,825			42
43	Other (specify):* Non-Allowable Co	184,972	-	1,610,193	1,795,165		1,795,165	(1,795,165)				43
44	TOTAL Special Cost Centers	184,972	163,959	3,490,772	3,839,703		3,839,703	(1,800,712)	2,038,991			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,749,219	832,621	11,548,930	19,130,770		19,130,770	(2,125,087)	17,005,683			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 at 87th Street

0053728

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.)

	1	2	3	
	Amount	Refer-	BHF USE	
		ence	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	(18,500)	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	63,968	30	9
10	Interest and Other Investment Income	(4,902)	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	(42,181)	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	(1,448,207)	43	24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,869)	43	26
27	CNA Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule See PG5A	(368,007)	Var.	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,826,198)	\$	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	2	
	Amount	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)	(298,889)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (298,889)	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,125,087)	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	
	Yes	No	Amount	Reference	
38		X	\$		38
39					39
40		X			40
41		X			41
42		X			42
43		X			43
44					44
45		X			45
46		X			46
47			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (112,900)	43	1
2	Laboratory Costs	(33,825)	43	2
3	X-Ray Costs	(18,358)	43	3
4	Real Estate Taxes	1,328	33	4
5	Admissions Salary	(76,182)	43	5
6	Nonallowable Legal	(54,964)	19	6
7	Lobbying Expense	(12,473)	20	7
8	Valet Parking	(36,643)	43	8
9	Misc. Income	(11,769)	21	9
10	Offset Internet Marketing	(12,221)	19	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42	Total	(368,007)		42

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		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 at 87th Street

0053728

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 LLC	100%	\$ 948	\$ 948	15
16	V	5	Utilities		MAESTRO CONSULTING SERVICES LLC	100%	1,762	1,762	16
17	V	6	Maintenance Salaries		MAESTRO CONSULTING SERVICES LLC	100%	0		17
18	V	6	Maintenance Expenses		MAESTRO CONSULTING SERVICES LLC	100%	3,390	3,390	18
19	V	7	Employee Benefits - Maintenance		MAESTRO CONSULTING SERVICES LLC	100%	252	252	19
20	V	10	Clinical Salaries		MAESTRO CONSULTING SERVICES LLC	100%	147,675	147,675	20
21	V	10	Contract Nursing		MAESTRO CONSULTING SERVICES LLC	100%	142	142	21
22	V	15	Employee Benefits - Clinical		MAESTRO CONSULTING SERVICES LLC	100%	42,478	42,478	22
23	V	17	Administrative - Other	766,426	MAESTRO CONSULTING SERVICES LLC	100%	0	(766,426)	23
24	V	19	Professional Fees		MAESTRO CONSULTING SERVICES LLC	100%	37,106	37,106	24
25	V	20	Dues, Fees, Subscriptions, Etc.		MAESTRO CONSULTING SERVICES LLC	100%	6,799	6,799	25
26	V	21	Clerical & General Salaries		MAESTRO CONSULTING SERVICES LLC	100%	102,924	102,924	26
27	V	21	Clerical & General Expenses		MAESTRO CONSULTING SERVICES LLC	100%	50,301	50,301	27
28	V	24	Seminars and Education		MAESTRO CONSULTING SERVICES LLC	100%	373	373	28
29	V	25	Transportation		MAESTRO CONSULTING SERVICES LLC	100%	6,796	6,796	29
30	V	26	Insurance		MAESTRO CONSULTING SERVICES LLC	100%	1,260	1,260	30
31	V	27	Employee Benefits - Administrative		MAESTRO CONSULTING SERVICES LLC	100%	29,606	29,606	31
32	V	30	Depreciation		MAESTRO CONSULTING SERVICES LLC	100%	25,715	25,715	32
33	V	32	Interest Expense		MAESTRO CONSULTING SERVICES LLC	100%	35	35	33
34	V	33	Real Estate Tax		MAESTRO CONSULTING SERVICES LLC	100%	4,626	4,626	34
35	V	34	Building Rental		MAESTRO CONSULTING SERVICES LLC	100%	3,164	3,164	35
36	V	35	Equipment Rental		MAESTRO CONSULTING SERVICES LLC	100%	9,116	9,116	36
37	V	35	Auto Lease		MAESTRO CONSULTING SERVICES LLC	100%	5,245	5,245	37
38	V								38
39	Total			\$ 766,426			\$ 479,713	\$ * (286,713)	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 Supplies	\$ 2,111	Integra Healthcare Equipment	19%	\$ 1,794	\$ (317)	15
16	V	35	Equipment Rental	41,437	Integra Healthcare Equipment	19%	35,221	(6,216)	16
17	V	39	Oxygen Supplies	2,234	Integra Healthcare Equipment	19%	1,899	(335)	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			\$ 45,782			\$ 38,914	\$ * (6,868)	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 Supplies	\$ 639	Lifeline Ambulance	4%	\$ 543	\$ (96)	15
16	V	38	Transportation	34,744	Lifeline Ambulance	4%	29,532	(5,212)	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			\$ 35,383			\$ 30,075	\$ * (5,308)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 148,952	Maple Leaf Insurance	100%	\$ 148,952	\$	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			\$ 148,952			\$ 148,952	\$ * 0	39

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

Facility Name & ID Number

Symphony at 87th Street

0053728

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	BOOKKEEPING	1
2	Symcare HMG, LLC	0.0001	CLIFFSIDE COMPANY LLC	ST. JOSEPH, MI	7257 N. LINCOLN AV	LINCOLNWOOD	BUILDING RENT	2
3			NORTHWOODS CARE CENTRE	BELVIDERE	MAPLELEAF INSUR	GRAND CAYMAN	INSURANCE	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				7
8			SYMPHONY AT THE TILLERS	OSWEGO				8
9			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				9
10			SYMPHONY OF CHESTERTON	CHESTERTON, IN				10
11			SYMPHONY OF CHICAGO WEST	CHICAGO				11
12			SYMPHONY OF CRESTWOOD	CRESTWOOD				12
13			SYMPHONY OF CROWN POINT	CROWN POINT, IN				13
14			SYMPHONY OF DYER	DYER, IN				14
15			SYMPHONY OF EVANSTON	EVANSTON				15
16			SYMPHONY OF GLENDALE	GLENDALE, WI				16
17			SYMPHONY OF HANOVER PARK	HANOVER PARK				17
18			SYMPHONY OF JOLIET	JOLIET				18
19			SYMPHONY OF LINCOLN PARK	CHICAGO				19
20			SYMPHONY OF MORGAN PARK	CHICAGO				20
21			SYMPHONY OF ORCHARD VALLEY	AURORA				21
22			SYMPHONY OF SOUTH SHORE	CHICAGO				22
23			SYMPHONY RESIDENCES OF LINCOLN PA	CHICAGO				23
24			WOODCARE V INC	BRIGHTON, MI				24
25			MAPLECREST CARE CENTRE	BELVIDERE				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 at 87th Street# 0053728

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 at 87th Street# 0053728

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		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	1	Dietary	Bed Days Available	1,642,974	27	\$ 20,270	\$ 19,367	76,860	\$ 948	1
2	5	Utilities	Bed Days Available	1,642,974	27	37,663		76,860	1,762	2
3	6	Maintenance Salaries	Bed Days Available	1,642,974	27			76,860		3
4	6	Maintenance Expenses	Bed Days Available	1,642,974	27	72,471		76,860	3,390	4
5	7	Employee Benefits - Dietary/Main	Bed Days Available	1,642,974	27	5,383		76,860	252	5
6	10	Clinical Salaries	Bed Days Available	1,642,974	27	3,156,734	3,156,734	76,860	147,675	6
7	10	Contract Nursing	Bed Days Available	1,642,974	27	3,034		76,860	142	7
8	15	Employee Benefits - Clinical	Bed Days Available	1,642,974	27	908,028		76,860	42,478	8
9	17	Administrative - Other	Bed Days Available	1,642,974	27			76,860		9
10	19	Professional Fees	Bed Days Available	1,642,974	27	793,188		76,860	37,106	10
11	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	1,642,974	27	145,343		76,860	6,799	11
12	21	Clerical & General Salaries	Bed Days Available	1,642,974	27	2,200,120	2,200,120	76,860	102,924	12
13	21	Clerical & General Expenses	Bed Days Available	1,642,974	27	1,075,235		76,860	50,301	13
14	24	Seminars and Education	Bed Days Available	1,642,974	27	7,970		76,860	373	14
15	25	Transportation	Bed Days Available	1,642,974	27	145,272		76,860	6,796	15
16	26	Insurance	Bed Days Available	1,642,974	27	26,926		76,860	1,260	16
17	27	Employee Benefits - Administrative	Bed Days Available	1,642,974	27	632,860		76,860	29,606	17
18	30	Depreciation	Bed Days Available	1,642,974	27	549,679		76,860	25,715	18
19	32	Interest Expense	Bed Days Available	1,642,974	27	738		76,860	35	19
20	33	Real Estate Tax	Bed Days Available	1,642,974	27	98,893		76,860	4,626	20
21	34	Building Rental	Bed Days Available	1,642,974	27	67,631		76,860	3,164	21
22	35	Equipment Rental	Bed Days Available	1,642,974	27	194,869		76,860	9,116	22
23	35	Auto Lease	Bed Days Available	1,642,974	27	112,113		76,860	5,245	23
24										24
25	TOTALS					\$ 10,254,420	\$ 5,376,221		\$ 479,713	25

Facility Name & ID Number Symphony at 87th Street# 0053728

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

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 Supplies	Direct		\$	\$		\$ 1,794	1
2	35	Equipment Rental	Direct					35,221	2
3	39	Oxygen Supplies	Direct					1,899	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				\$	\$		\$ 38,914	25

Facility Name & ID Number Symphony at 87th Street # 0053728 Report Period Beginning: 1/1/2020 Ending: 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. Wasbash Ave
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		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	10	Nursing Supplies	Direct			\$			\$ 543	1
2	38	Transportation	Direct						29,532	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					\$	\$		\$ 30,075	25

Facility Name & ID Number Symphony at 87th Street# 0053728

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

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		\$	\$		\$ 148,952	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				\$	\$		\$ 148,952	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	67444.34	11/27/2017	\$ 2,170,337	\$ -	10/20/2020	0.075	\$ 861	1	
2	LifeMed	X		Pharmacy Services	38731	1/1/2018	6,197,033	52,404	01/01/2024	0.075	4,447	2	
3	Select Rehab		X	Operational	159503	12/31/2018	12,216,125	690,850	45291	0.002	16,008	3	
4	Integra	X		Medical Supplies/rental	50679.73	7/1/2019	1,162,530	16,838	6/30/2021	0.043802	1,516	4	
5												5	
	Working Capital												
6	State of Illinois		X	Advance Payment	\$2,258.99	5/1/2019	1,280,000	1,280,000	8/1/2021		-	6	
7	NGS		X	Medicare AAP	\$48,554.88	4/7/2020	1,165,317	1,165,317	4/7/2023		-	7	
8												8	
9	TOTAL Facility Related				\$367,171.94		\$ 24,191,342	\$ 3,205,409			\$ 22,831	9	
	B. Non-Facility Related*												
10	Worthy Ins										770	10	
11	Cyber Ins										119	11	
12								Interest Income offset			(4,902)	12	
13								Allocated from Maestro			35	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,978)	14	
15	TOTALS (line 9+line14)						\$ 24,191,342	\$ 3,205,409			\$ 18,853	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 AT 87TH STREET COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053728

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. 19-36-322-011-0000	Long Term Care Property	\$ 91,281.75	\$ 91,281.75
2. 19-36-322-012-0000	Long Term Care Property	\$ 115,833.03	\$ 115,833.03
3. 19-36-322-013-0000	Long Term Care Property	\$ 178,615.12	\$ 178,615.12
4. 19-36-322-014-0000	Long Term Care Property	\$ 128,389.43	\$ 128,389.43
5. 19-36-322-015-0000	Long Term Care Property	\$ 115,833.03	\$ 115,833.03
6. 19-36-322-016-0000	Long Term Care Property	\$ 16,457.73	\$ 16,457.73
7. 19-36-322-017-0000	Long Term Care Property	\$ 3,383.20	\$ 3,383.20
8. 19-36-322-018-0000	Long Term Care Property	\$ 3,192.07	\$ 3,192.07
9. 10-27-319-028-0000	Allocated-7257 N. Lincoln	\$ 85,535.22	\$ 4,626.00
10.		\$	\$
TOTALS		\$ 738,520.58	\$ 657,611.36

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: 66,911

B. General Construction Type: Exterior BrickFrame SteelNumber 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	
	1Allocated from Maestro	-	2004	\$7,485	1
	2				2
	3TOTALS			\$7,485	3

Facility Name & ID Number Symphony at 87th Street# 0053728

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8		Allocated from Maestro 7257		2004	67,365		35	1,925	1,925	32,961	8
		Improvement Type**									
9		Various		1999	89,068		20			89,068	9
10		Various		2000	45,130		20	2,257	2,257	25,137	10
11		Various		2001	40,213		20	2,011	2,011	38,939	11
12		Various		2002	12,014		20	601	601	11,804	12
13		Various		2003	20,012		20	1,001	1,001	18,283	13
14		Various		2004	27,005		20			27,005	14
15		Various		2005	16,125		20	437	437	16,125	15
16		Various		2006	109,609		20			109,609	16
17		Various		2010	320,346		20	16,017	16,017	308,233	17
18		Various		2011	169,484		20	8,474	8,474	154,897	18
19		Various		2012	43,995		20	1,534	1,534	43,995	19
20		Core Glosswhite Tile		2009	2,753		20	138	138	1,656	20
21		Paint & Remodeling of 7 Shower Rooms		2009	17,363		20	868	868	10,416	21
22		Flooring		2011	194,042		20	9,702	9,702	97,020	22
23		Casework/Countertops		2011	68,125		20	3,406	3,406	34,060	23
24		Demolition/Carpentry		2011	74,500		20	3,725	3,725	37,250	24
25		Buildout		2011	65,045		20	3,252	3,252	32,520	25
26		Wallpaper/Paint		2011	59,430		20	2,972	2,972	29,720	26
27		VCT Tile Removal & Installation-Resident Rooms 1st,2nd & 3rd FL		2014	44,000		20	2,200	2,200	15,400	27
28		Install New Vinyl Base in Resident Rooms with New Tiles-1,2&3rd FL		2014	3,900		20	195	195	1,365	28
29		2nd Floor - Replaced Wood Door and Window		2014	2,812		20	141	141	986	29
30											30
31											31
32											32
33											33
34											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.

Facility Name & ID Number Symphony at 87th Street# 0053728

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	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	
37	<u>Installed 4" And 6" Check Valves And Cast Iron Pipe For Pump St</u>	<u>2015</u>	<u>\$ 12,450</u>	<u>\$</u>	<u>20</u>	<u>\$ 623</u>	<u>\$ 623</u>	<u>\$ 3,735</u>	37
38	<u>Patched Cracks On Roof</u>	<u>2015</u>	<u>3,500</u>		<u>20</u>	<u>175</u>	<u>175</u>	<u>1,050</u>	38
39	<u>Custom Built Backsplash For 2Nd And 3Rd Floor Dinning Room</u>	<u>2015</u>	<u>2,982</u>		<u>20</u>	<u>149</u>	<u>149</u>	<u>895</u>	39
40	<u>Doors & Window(1) Replacement</u>	<u>2016</u>	<u>3,799</u>		<u>20</u>	<u>190</u>	<u>190</u>	<u>839</u>	40
41	<u>Roof Repair</u>	<u>2016</u>	<u>20,210</u>		<u>20</u>	<u>1,011</u>	<u>1,011</u>	<u>4,295</u>	41
42	<u>Hvac Repair</u>	<u>2016</u>	<u>4,227</u>		<u>20</u>	<u>211</u>	<u>211</u>	<u>933</u>	42
43	<u>Fan Coil Motor</u>	<u>2016</u>	<u>2,526</u>		<u>20</u>	<u>126</u>	<u>126</u>	<u>568</u>	43
44	<u>Architectural Services-Upgrade Of Mechanical Room</u>	<u>2016</u>	<u>29,415</u>		<u>20</u>	<u>1,471</u>	<u>1,471</u>	<u>5,883</u>	44
45	<u>Plumbing - Piping Replacement In Kitchen</u>	<u>2017</u>	<u>7,240</u>		<u>20</u>	<u>362</u>	<u>362</u>	<u>1,448</u>	45
46	<u>Plumbing - Repairs In Kitchen Piping- Floor Drains</u>	<u>2017</u>	<u>7,640</u>		<u>20</u>	<u>382</u>	<u>382</u>	<u>1,528</u>	46
47	<u>Coupling/Risers On Pumps-Cooling System-3Rd Floor Rooms</u>	<u>2017</u>	<u>3,290</u>		<u>20</u>	<u>164</u>	<u>164</u>	<u>657</u>	47
48	<u>Remove and replace lochinvar boiler-basement</u>	<u>2018</u>	<u>29,303</u>	<u>5,154</u>	<u>20</u>	<u>1,465</u>	<u>(3,689)</u>	<u>11,773</u>	48
49	<u>Compressor-Kitchen. New compressor, plumbing.</u>	<u>2018</u>	<u>4,455</u>	<u>525</u>	<u>20</u>	<u>223</u>	<u>(302)</u>	<u>1,273</u>	49
50	<u>Phone upgrade-Connection system, analog adapter, installation</u>	<u>2018</u>	<u>33,110</u>	<u>1,655</u>	<u>20</u>	<u>1,656</u>	<u>1</u>	<u>3,329</u>	50
51	<u>Parking lot repair-cleaning holes, and saw cutting major</u>								51
52	<u>holes and putting new asphalt surgace</u>	<u>2018</u>	<u>3,400</u>		<u>20</u>	<u>170</u>	<u>170</u>	<u>510</u>	52
53	<u>Elevator-Three elevators furnish and install new solid state</u>	<u>2019</u>	<u>5,565</u>	<u>278</u>	<u>20</u>	<u>278</u>	<u>0</u>	<u>525</u>	53
54	<u>starters and replace existing line starter relays.</u>								54
55	<u>Rewire entire south east side of 3rd floor due to need more power</u>	<u>2019</u>	<u>4,128</u>	<u>206</u>	<u>20</u>	<u>206</u>	<u>0</u>	<u>322</u>	55
56	<u>Install 3 inch Zoeller ejector pump - mechanical room</u>	<u>2019</u>	<u>5,630</u>	<u>282</u>	<u>20</u>	<u>282</u>		<u>377</u>	56
57	<u>Plumbing services to replace boiler - mechanical room</u>	<u>2019</u>	<u>17,160</u>	<u>858</u>	<u>20</u>	<u>858</u>		<u>955</u>	57
58	<u>New lights on parking poles</u>	<u>2019</u>	<u>3,740</u>	<u>187</u>	<u>20</u>	<u>187</u>		<u>195</u>	58
59	<u>Install 16 new cat6 solid cable lines, clean existing</u>	<u>2019</u>	<u>20,932</u>	<u>1,047</u>	<u>20</u>	<u>1,047</u>	<u>(0)</u>	<u>3,148</u>	59
60	<u>data cables and terminate old equipment throughout facility</u>								60
61	<u>Elevator--install valve on south elevator</u>	<u>2020</u>	<u>2,975</u>	<u>119</u>	<u>15</u>	<u>119</u>		<u>119</u>	61
62	<u>1st floor renovation-hallway, lobby, PT, replace wallpaper, tiles</u>	<u>2020</u>	<u>30,000</u>	<u>858</u>	<u>15</u>	<u>858</u>		<u>858</u>	62
63	<u>paint walls, cabinets lobby, flooring, lights electrical</u>								63
64									64
65	<u>Roof Repairs-1 ply rubber roof over damaged areas near A/C units</u>	<u>2020</u>	<u>14,500</u>	<u>100</u>	<u>15</u>	<u>100</u>		<u>100</u>	65
66	<u>drains and vents.</u>								66
67									67
68	<u>Reconcile to book depreciation</u>			<u>20,067</u>			<u>(20,067)</u>		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,764,513	\$ 31,336		\$ 73,167	\$ 41,831	\$ 1,181,763	70

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

Facility Name & ID Number Symphony at 87th Street

0053728

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 12A, Carried Forward		\$ 1,764,513	\$ 31,336		\$ 73,167	\$ 41,831	\$ 1,181,763	1
2	Leasehold Improvements:								2
3	Various	2005	96,496		20			96,496	3
4	Built In Kitchen Unit/Cabinet/Table Legs And Sink	2007	10,200		20	510	510	7,990	4
5	Replace Built-In Cabinets And Credenza Unit	2007	9,800		20	490	490	7,595	5
6	2Nd Floor - Sink	2007	4,800		20	240	240	3,720	6
7	3Rd Floor - Assisted Bathing Area	2007	5,200		20	260	260	4,030	7
8	150 Yds Tranquility Dandelion - Wall Covering	2007	2,546		20	127	127	2,458	8
9	2Nd Floor Dinning Room - Electrical	2007	3,500		20	175	175	2,713	9
10	3Rd Floor Dinning Room - Electrical	2007	3,500		20	175	175	2,713	10
11	Basement Corridor	2007	2,750		20	138	138	2,137	11
12	Lobby/Large Main Office - Carpeting	2007	8,578		20	429	429	7,088	12
13	Door Upgrades & R&M	2007	4,301		20	215	215	3,333	13
14	Replace Ejector Pumps For Flood Control System	2007	3,700		20	185	185	2,744	14
15	Vct Tiles For Bathroom	2008	4,656		20	233	233	3,029	15
16	Upholstered Cornice And Roller Shades; Remove Existing Window	2008	8,647		20	432	432	5,617	16
17	Material & Labor For Power Supply & Switch For Airconditioning S	2008	5,726		20	286	286	3,719	17
18	Installation: Sprinkler, Ddc Valve, Expansion Tank & Anitfreeze	2008	7,665		20	383	383	4,980	18
19	Replacement Motor & Compressor And Refrigerant Of Freezer	2008	5,368		20	268	268	3,485	19
20	Telephone System Tadrian	2008	23,739		20	1,187	1,187	15,431	20
21	Motor Conversion	2008	2,965		20	148	148	1,925	21
22	130 Ft Of Sdr35 Drain Tile	2008	8,910		20	446	446	5,797	22
23	Asphalt Repair Work Sealing And Striping	2008	7,600		20	380	380	4,920	23
24	Prime And Paint Outside Railings, Repair Walls, Paint Payroll Off	2008	3,220		20	161	161	2,093	24
25	Painting - 2Nd Floor Doorframes And Dining Room	2008	2,970		20	149	149	1,936	25
26	Plaster, Prime, And Paint 3Rd Floor Dining Rm Walls, Window Sil	2008	10,600		20	530	530	6,890	26
27	Part & Labor to repair Fire Sprinkler System	2009	4,224		20	211	211	2,532	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,016,174	\$ 31,336		\$ 80,925	\$ 49,589	\$ 1,387,134	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,016,174	\$ 31,336		\$ 80,925	\$ 49,589	\$ 1,387,134	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9	Leasehold Improvements:								9
10	Allocated From Maestro	2003	548		20	27	27	469	10
11	Allocated From Maestro	2004	11,125		20	555	555	9,299	11
12	Allocated From Maestro	2005	660		20	33	33	523	12
13	Allocated From Maestro	2006	894		20	45	45	642	13
14	Allocated From Maestro	2008	943		20	47	47	578	14
15	Allocated From Maestro	2009	15,177		20	759	759	8,810	15
16	Allocated From Maestro	2010	2,332		20	117	117	1,225	16
17	Allocated From Maestro	2011	126		20	6	6	63	17
18	Allocated From Maestro	2012	140		20	7	7	61	18
19	Allocated From Maestro	2014	1,754		20	88	88	579	19
20	Allocated From Maestro	2015	493		20	25	25	132	20
21	Allocated From Maestro	2016	2,162		20	108	108	732	21
22	Allocated From Maestro	2017	289		20	14	14	58	22
23	Allocated From Maestro	2020	467		20	12	12	12	23
24	Allocated From Maestro- 7257 Lincoln	2015	1,339		20	67	67	1,105	24
25	Allocated From Maestro- 7257 Lincoln	2005	6,141		20	220	220	5,163	25
26	Allocated From Maestro- 7257 Lincoln	2004	1,062		20	71	71	378	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,061,826	\$ 31,336		\$ 83,126	\$ 51,790	\$ 1,416,963	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	\$575,561	\$78,311	\$94,615	\$16,304	5-10	\$494,227	71
72	Current Year Purchases	78,501	4,300	4,300		5-10	4,300	72
73	Fully Depreciated Assets	1,966,788					1,966,788	73
74	Allocated From Maestro	197,003		21,589	21,589	5-10	94,600	74
75	TOTALS	\$2,817,853	\$82,611	\$120,504	\$37,893		\$2,559,915	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	\$414	\$	\$	\$	5	\$414	76
77										77
78										78
79										79
80	TOTALS			\$414	\$	\$	\$		\$414	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)	\$4,887,578	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$113,947	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$203,630	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$89,683	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,977,292	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$285,277	92
93			93
94			94
95		\$285,277	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:		210	11/1/2015	\$ 2,656,751	15	15	3
4	Additions							4
5								5
6	Allocated From Maestro				3,164			6
7	TOTAL		210		\$ 2,659,915			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: \$ 145,836 Description: See Attached Schedule 14A
(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		\$	\$ 5,245	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,245	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.

10. Effective dates of current rental agreement:
Beginning 11/1/2015
Ending 10/31/2030

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

	Fiscal Year Ending	Annual Rent
12.	31-Dec 12/31/21	\$ 2,558,656
13.	31-Dec 12/31/22	\$ 2,616,226
14.	21-Dec 12/31/23	\$ 2,675,091

Facility Name:

Symphony at 87th Street

IDPH License ID Number:

0053728

Fiscal Year End:

12/31/2020

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	32,378
Nursing Equipment	15,722
Office Equipment	67,351
Building Equipment	27,485
Allocated from Maestro	9,116
Allocated from Integra	(6,216)
Total - Line 16	145,836

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

ALLOCATION OF COSTS (d)

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

(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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(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	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	7,918	\$ 570,122	\$	7,918	\$ 570,122	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,053	147,823		2,053	147,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		8,092	582,633		8,092	582,633	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				163,224		163,224	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2&7)					400		400	12
13	Other (specify): See Sch 16A	39(3)			1,321	95,076		1,321	95,076	13
14	TOTAL			\$	19,384	\$ 1,395,654	\$ 163,624	19,384	\$ 1,559,278	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 at 87th Street
IDPH License: 0053728
Fiscal Year: 12/31/2020

Schedule 16A

Line 13 Other (specify)

Description	Units	Amount
Inhalation Therapy Costs-Private		513
Inhalation Therapy Costs-Medicare A		8,734
Inhalation Therapy Costs-Medicaid		9,759
I.V. Therapy Costs-Medicare A		14,801
I.V. Therapy Costs-Managed Care		27,420
I.V. Therapy Costs-Medicaid		23,383
Inhalation Therapy Costs-Managed Care		10,439
I.V. Therapy Costs-Private		27
Total - Line 13	1,321	95,076

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	\$ (15,307)	\$ (15,307)	1
2	Cash-Patient Deposits	51,033	51,033	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,613,237)	2,993,498	2,993,498	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	6,398	6,398	6
7	Other Prepaid Expenses	16,727	16,727	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): Acct. Rec. employee loan	8,072	8,072	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,060,421	\$ 3,060,421	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	7,485	13
14	Buildings, at Historical Cost	-	67,365	14
15	Leasehold Improvements, at Historical Cost	161,597	1,994,461	15
16	Equipment, at Historical Cost	447,920	2,818,267	16
17	Accumulated Depreciation (book methods)	(292,888)	(3,977,292)	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	715,590	715,590	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,032,219	\$ 1,625,876	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,092,640	\$ 4,686,297	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 878,478	\$ 878,478	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	51,033	51,033	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	417,871	417,871	30
31	Accrued Taxes Payable (excluding real estate taxes)	316,307	316,307	31
32	Accrued Real Estate Taxes(Sch.IX-B)	969,728	969,728	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	3,280,599	3,280,599	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,914,016	\$ 5,914,016	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,205,409	3,205,409	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)	\$ 3,205,409	\$ 3,205,409	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,119,425	\$ 9,119,425	46
47	TOTAL EQUITY (page 18, line 24)	\$ (5,026,785)	\$ (4,433,128)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,092,640	\$ 4,686,297	48

*(See instructions.)

Facility Name: Symphony at 87th Street
IDPH License ID Number: 0053728
Fiscal Year End: 12/31/2020

Schedule 17A

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

Description	Operating	After
		Consolidation
Clearing Account	3,625	3,625
Constructions in Progress	285,277	285,277
Security Deposits	(487)	(487)
Due To/From- Aria LLC	-	-
Due To/From- Buffalo Grove LLC	-	-
Due To/From- Deerbrook LLC	(3,285)	(3,285)
Due To/From- Lincoln Park LLC	-	-
Due To/From- Morgan Park LLC	-	-
Due To/From- Symphony of Cal Gardens	1,281	1,281
Due To/From- Dyer LLC	7,987	7,987
Due To/From- Ren @ 87th- OLD	399,599	399,599
Due To/From- Beverly LP	21,593	21,593
Total - Line 23	715,590	715,590

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

Description	Operating	After
		Consolidation
Due To/From- Bronzeville Park LLC	-	-
Due To/From- Jackson Square LLC	-	-
Due To/From- Midway	-	-
Due To/From- South Shore	-	-
Due To/From- Symphony Financial Services	544	544
Due To/From- Symcare Healthcare	-	-
Due To/From- Symcare ML	809,154	809,154
Due To/From- Maestro	(21,645)	(21,645)
Accrued Payables	79,921	79,921
Accrued Payables- Professional Fees	26,717	26,717
Accrued Payables- Health Insurance	21,158	21,158
Accrued Payables- Dental Insurance	(2,374)	(2,374)
Accrued Payables- Vision Insurance	(5,105)	(5,105)
Accrued Payables- Life Insurance	74,863	74,863
Accrued Payables- Short Term Disability	(63,193)	(63,193)
Accrued Payables- Payroll Union Dues	3,391	3,391
Accrued Payables- Payroll Credit Union	(30)	(30)
Accrued Payables- 401K Deductions	2,768	2,768
Accrued Payables- 401K Loan Repayments	651	651
Accrued Payables- Heart and Soul Foundation	40	40
Accrued Payables- Garnishments	(1,670)	(1,670)
Employee Purchases	2,992	2,992
Fringe Benefits- Flow Through	199	199
Accrued Payables- WC/GL Insurance	686,545	686,545
Accrued Payables- Bed Taxes	(61,192)	(61,192)
Accrued Payables- Bed Taxes Add'l	24,378	24,378
Accrued Payables- Management Fees	1,736	1,736
Accrued Payables- Interest	3,195	3,195
Accrued Payables- Rent	(63,317)	(63,317)
Accrued Payables- Sales Tax	450	450
Sales Tax Payable- Manual	61	61
ChicagoTax Payable- Manual	1	1
Deferred Rent	1,474,656	1,474,656
Deferred Income	285,705	285,705
Total - Line 36	3,280,599	3,280,599

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,517,124)	1
2	Restatements (describe):		2
3	Prior Year Adjustment	8	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,517,116)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,509,669)	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,509,669)	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)	\$ (5,026,785)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony at 87th Street# 0053728Report Period Beginning: 1/1/2020Ending: 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	\$ 15,057,596	1
2	Discounts and Allowances for all Levels	(3,171,152)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,886,444	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	3,041,694	6
7	Oxygen	23,669	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,065,363	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,307,258	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	303,450	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	65,654	19
20	Radiology and X-Ray	19,082	20
21	Other Medical Services	43,855	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,739,299	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	4,902	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,902	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	(74,907)	28
28a		-	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (74,907)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,621,101	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,124,019	31
32	Health Care	5,739,235	32
33	General Administration	3,664,858	33
	B. Capital Expense		
34	Ownership	3,762,955	34
	C. Ancillary Expense		
35	Special Cost Centers	3,409,878	35
36	Provider Participation Fee	429,825	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,130,770	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,509,669)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,509,669)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,183,030	44
45	Private Pay - Net Inpatient Revenue	459,880	45
46	Medicare - Net Inpatient Revenue	1,553,666	46
47	Other-(specify) <u>Hospice</u>	1,109,690	47
48	Other-(specify) <u>Managed Care / MAIP</u>	580,178	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,886,444	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 at 87th Street
IDPH License ID Number: 0053728
Fiscal Year End: 12/31/2020

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Other Revenue	#NAME?
Preferred Insurance Provider Incentive	#NAME?
Preferred Insurance Provider Incentive	#NAME?
Other Services- Revenue-Managed Care	#NAME?
Total - Line 28	#NAME?

XVII. Income Statement

Line 37 Other Expenses (specify):

Description	Amount
Total - Line 37	-

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	1,924	2,204	\$ 129,059	\$ 58.56	1
2	Assistant Director of Nursing	1,964	2,188	91,726	41.92	2
3	Registered Nurses	17,070	20,244	769,090	37.99	3
4	Licensed Practical Nurses	48,908	57,758	1,782,154	30.86	4
5	CNAs & Orderlies	93,339	107,830	1,906,262	17.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,627	4,231	104,658	24.74	9
10	Activity Assistants	5,605	6,690	115,384	17.25	10
11	Social Service Workers	5,975	6,546	182,834	27.93	11
12	Dietician					12
13	Food Service Supervisor	1,828	1,949	62,395	32.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,887	5,254	85,872	16.34	15
16	Dishwashers	14,459	15,987	259,496	16.23	16
17	Maintenance Workers	4,495	4,932	130,256	26.41	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,904	2,080	142,091	68.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,248	3,620	78,434	21.67	23
24	Clerical	9,511	10,118	265,535	26.24	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	7,395	8,614	175,403	20.36	31
32	Other Health Care MDS Coordinator	5,118	6,023	224,676	37.30	32
33	Other(specify) Admins./HR	9,414	10,986	243,894	22.20	33
36	TOTAL (lines 1 - 35)	240,671	277,254	\$ 6,749,219 *	\$ 24.34	36

* 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	\$ 26,819	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	142	10(7)	38
39	Pharmacist Consultant	Monthly	19,545	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	1,029	39 (3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatric	Monthly	6,000	10(3)	46
47	Dental Consultant	Monthly	3,600	39(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 75,135		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 at 87th Street
IDPH License ID Number: 0053728
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
Total - Line 32 Other Health	-	-	-	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Coordinator	3,655	4,282	76,182	\$ 17.79
Human Resource Director	1,944	2,204	58,922	\$ 26.73
Marketing Consultant	3,815	4,500	108,790	\$ 24.18
Total - Line 33 Other (speci	9,414	10,986	243,894	\$ 22.20

Facility Name: Symphony at 87th Street
IDPH License ID Number: 0053728
Fiscal Year End: 12/31/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
MICROSOFT OFFICE	Computer service	5,938
ABILITY Network, Inc.	Secure Exchange Managed Services	(90)
Allscripts	Referral System	7,203
ALTERYX	Data Analytics	3,205
CATS- APPLICANT TRACKING SYSTEM	Applicant Tracking System	696
CDW	Data Storage	1,672
Comcast Cable	Internet and cable	27,932
CORE DATA MANAGEMENT SUITE-AC	Data Storage	480
Creative Technology Solutions	IT Support	3,204
Darktrace Limited	Cyber Security	2,577
Data Robot-cloud professional	Data Storage	2,107
EMMI Solutions-Data analysis	Data Analytics	(344)
enVista LLC	IT Support	801
FORMATION HEALTHCARE GROUP	Monthly Subscription Fee	1,017
HealthStream Inc	Healthcare Workforce Consulting	105
Health Data Systems Inc	Programming	3,057
Intellicomp Technologies Inc.	IT Support	21,313
International Micro Design	IT Support	92
Kronos	IT Support	7,591
Managed Care Group LLC	IT Support	9,074
Navigator Group Purchasing, In	Data Analytics	301
Nexuscomm, LLC	Phone/fax service	10,380
PatientPing, Inc.	referral System	7,015
Pay Access-Payroll	Payroll	151
Petty Cash	IT Support	65
PointClickCare Technologies Inc.	Cloud based software and services	42,226
Prime Care Tech-PBJ access	PBJ Reporting Module Access Fee	2,520
Reputation.com, Inc.	Online Reputation Management	973
Reside Admissions LLC	Admission Process Consulting	5,590
Sprout Social Inc.	Social Media Management	2,338
Striv Technologies LLC dba Striv360	IT Support	2,400
Team TSI Corporation	Collection	4,769
Telemedicine Solutions, LLC	Wound Rounds Care	14,446
Third Eye Health Inc.	Data Analytics	7,559
WENCEL WORLDWIDE	Branding	7,032
RSM	Accounting fees	52,049
Duane Morris LLP	Legal	15,692
MKB	Legal	74,984
Stone, Pogrund & Korey LLC	Legal	62,623
The Stuttley Group,LLC	Legal	3,163
Valee L. Salone, Esq.	Legal	1,009
Achieve Accreditation	Accreditation	8,137
ADP	Payroll service	1,610
Advanced Care Medical Speciali	Infectious Disease Consulting	811
Corporation Service Company	Annual Filing	1,460
Fernandez Films, Ltd	Photography	450
Language Line Services	Language lesson	1,030
LTC Consulting Services	Consulting	(353)
MTS Consulting, LLC	Tax Consulting	2,067
National Datacare Corporation	trust service charge	5,162
Personnel Planners, Inc	Qtrly Unemployment Claims	1,941
Real Estate Analysis Corporation	real estate valuation	5,500
SB2	Legal Fees -appeal Medicaid/Medicare cl	5,189
Team TSI Corporation	Collection	13,110
Total (agree to Schedule V, line 19, column 3)		461,029
Allocated from Maestro Professional Services		37,106
Less: Marketing		(12,221)
Less: Non-Allowable Legal Fees		(54,964)
Total (agree to Schedule V, line 19, column 8)		430,950

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 IL: \$24,946
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 1,030.00 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 11/1/2015
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Renaissance at 87th St., IDPH 0042093, Date 11/01/15
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 429,825
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. \$ - 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? 1
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? 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? 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.