

		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>0053710</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Symphony at Aria</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>4600 N Frontage Road</u> <u>Hillside</u> <u>60162</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 544-9933</u> Fax # <u>(708) 544-9966</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>9/28/2012</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Amanda Springborn</u>		Telephone Number: <u>(314) 925-3838</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) _____ (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 # <u>(847) 517-7067</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Symphony at Aria# 0053710 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 bedsN/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>198</u>	Skilled (SNF)	<u>198</u>	<u>72,468</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>198</u>	TOTALS	<u>198</u>	<u>72,468</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>39,026</u>	<u>2,297</u>	<u>10,239</u>	<u>51,562</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>39,026</u>	<u>2,297</u>	<u>10,239</u>	<u>51,562</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 71.15%

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)

N/A

F. Does the facility maintain a daily midnight census?

YesG. 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 09/28/2012

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

YES ☒Date 09/28/2012NO ☐

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

YES ☒NO ☐

If YES, enter number

of beds certified

198

and days of care provided

3,632

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

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

Facility Name & ID Number Symphony at Aria # 0053710 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	501,238	36,522	35,892	573,652		573,652	894	574,546			1
2	Food Purchase		300,389		300,389		300,389		300,389			2
3	Housekeeping	420,813	54,084	-	474,897		474,897		474,897			3
4	Laundry	69,854	30,961	6,364	107,179		107,179		107,179			4
5	Heat and Other Utilities			239,335	239,335		239,335	1,661	240,996			5
6	Maintenance	77,460	-	147,562	225,022		225,022	3,197	228,219			6
7	Other (specify):* Mgmt Co. Emp Ben.	-	-	-				237	237			7
8	TOTAL General Services	1,069,365	421,956	429,153	1,920,474		1,920,474	5,989	1,926,463			8
	B. Health Care and Programs											
9	Medical Director	-	-	20,250	20,250		20,250		20,250			9
10	Nursing and Medical Records	4,535,825	261,873	27,474	4,825,172		4,825,172	137,557	4,962,729			10
10a	Therapy	-	-	-								10a
11	Activities	235,697	-	-	235,697		235,697		235,697			11
12	Social Services	130,802	-	-	130,802		130,802		130,802			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):* Mgmt Co. Emp Ben.	-	-	-				40,051	40,051			15
16	TOTAL Health Care and Programs	4,902,324	261,873	47,724	5,211,921		5,211,921	177,608	5,389,529			16
	C. General Administration											
17	Administrative	132,837	-	681,476	814,313		814,313	(681,476)	132,837			17
18	Directors Fees			-								18
19	Professional Services			352,882	352,882		352,882	13,237	366,119			19
20	Dues, Fees, Subscriptions & Promotions			50,653	50,653		50,653	(2,252)	48,401			20
21	Clerical & General Office Expenses	388,659	16,728	50,645	456,032		456,032	130,769	586,801			21
22	Employee Benefits & Payroll Taxes			1,047,434	1,047,434		1,047,434		1,047,434			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			-				352	352			24
25	Other Admin. Staff Transportation		-	2,896	2,896		2,896	6,408	9,304			25
26	Insurance-Prop.Liab.Malpractice			855,036	855,036		855,036	1,188	856,224			26
27	Other (specify):* Mgmt Co. Emp Ben.			-				27,914	27,914			27
28	TOTAL General Administration	521,496	16,728	3,041,022	3,579,246		3,579,246	(503,860)	3,075,386			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,493,185	700,557	3,517,899	10,711,641		10,711,641	(320,263)	10,391,378			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			122,268	122,268		122,268	63,696	185,964			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			47,850	47,850		47,850	(31,356)	16,494			32
33	Real Estate Taxes			842,278	842,278		842,278	32,492	874,770			33
34	Rent-Facility & Grounds			2,498,560	2,498,560		2,498,560	2,983	2,501,543			34
35	Rent-Equipment & Vehicles			171,835	171,835		171,835	4,811	176,646			35
36	Other (specify):*			-								36
37	TOTAL Ownership			3,682,791	3,682,791		3,682,791	72,626	3,755,417			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	24,420	24,420		24,420	(3,412)	21,008			38
39	Ancillary Service Centers	-	109,441	1,765,225	1,874,666		1,874,666	(332)	1,874,334			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			399,637	399,637		399,637		399,637			42
43	Other (specify):* Non-Allowable Cos	157,711	-	767,455	925,166		925,166	(925,166)				43
44	TOTAL Special Cost Centers	157,711	109,441	2,956,737	3,223,889		3,223,889	(928,910)	2,294,979			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,650,896	809,998	10,157,427	17,618,321		17,618,321	(1,176,547)	16,441,774			45

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(19,377)	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	39,451	30		9
10	Interest and Other Investment Income	(31,389)	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	(80,193)	43		18
19	Entertainment				19
20	Contributions	(4,375)	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	(621,036)	43		24
25	Fund Raising, Advertising and Promotional	(111)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See PG5A</u>	(216,055)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (933,085)		\$	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)	(243,462)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (243,462)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,176,547)		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	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	\$ (101,560)	43	1
2	Laboratory Costs	(21,960)	43	2
3	X-Ray Costs	(11,669)	43	3
4	Non-allowable lobbying dues	(8,663)	20	4
5	Admissions	(59,783)	43	5
6	Valet Parking	(3,696)	43	6
7	Non-allowable legal	(13,796)	19	7
8	Damage Loss	(1,406)	43	8
9	Misc. Income	(13,699)	21	9
10	Real Estate penalties	28,130	33	10
11	Non-allowable professional fees marketing	(7,953)	19	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				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(216,055)		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 Supplement		

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

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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.

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%	\$ 894	\$ 894	15
16	V	5	UTILITIES		MAESTRO CONSULTING SERVICES LLC	100%	1,661	1,661	16
17	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100%			17
18	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100%	3,197	3,197	18
19	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100%	237	237	19
20	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100%	139,237	139,237	20
21	V	10	CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100%	134	134	21
22	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100%	40,051	40,051	22
23	V	17	ADMINISTRATIVE MANAGEMENT FEE	681,476	MAESTRO CONSULTING SERVICES LLC	100%		(681,476)	23
24	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100%	34,986	34,986	24
25	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100%	6,411	6,411	25
26	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100%	97,042	97,042	26
27	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100%	47,426	47,426	27
28	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100%	352	352	28
29	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100%	6,408	6,408	29
30	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100%	1,188	1,188	30
31	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100%	27,914	27,914	31
32	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100%	24,245	24,245	32
33	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100%	33	33	33
34	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100%	4,362	4,362	34
35	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100%	2,983	2,983	35
36	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100%	8,595	8,595	36
37	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100%	4,945	4,945	37
38	V								38
39	Total			\$ 681,476			\$ 452,301	\$ * (229,175)	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 and Medical Records	\$ 9,689	Integra Healthcare Equipment, LLC	19%	\$ 8,236	\$ (1,453)	15
16	V	35	Rent-Equipment and Vehicles	58,191	Integra Healthcare Equipment, LLC	19%	49,462	(8,729)	16
17	V	39	Oxygen Supplies	2,212	Integra Healthcare Equipment, LLC	19%	1,880	(332)	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			\$ 70,092			\$ 59,578	\$ * (10,514)	39

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐

 NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	38	Transportation	\$ 22,748	Lifeline Ambulance LLC	4%	\$ 19,336	\$ (3,412)	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			\$ 22,748			\$ 19,336	\$ * (3,412)	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	\$ 137,374	Maple Leaf Insurance	100%	\$ 137,374	\$	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			\$ 137,374			\$ 137,374	\$ * 0	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	\$ 2,405	Concerto Dialysis LLC	20%	\$ 2,044	\$ (361)	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			\$ 2,405			\$ 2,044	\$ * (361)	39

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

Facility Name & ID Number

Symphony at Aria

0053710

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 LLC	CHICAGO	MAESTRO CONSULT	LINCOLNWOOD	MANAGEMENT	1
2	Symcare HMG LLC	0.0001	MAPLE CREST 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 AT 87TH STREET	CHICAGO	INTEGRA RESPIRAT	ELMHURST	RESPIRATORY SE	5
6			SYMPHONY AT MIDWAY	CHICAGO	LIFELINE AMBULAN	CHICAGO	AMBULANCE	6
7			SYMPHONY AT THE TILLERS	OSWEGO	CONCERTO DIALYS	LINCOLNWOOD	DIALYSIS	7
8			SYMPHONY OF BRONZEVILLE	CHICAGO				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 PARK	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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	No owners receive compensation from this facility.										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 Aria# 0053710 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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		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 Aria# 0053710 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 ☐

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. CENSUS DAYS	1,642,974	27	\$ 20,270	\$ 19,367	72,468	\$ 894	1
2	5	UTILITIES	AVAIL. CENSUS DAYS	1,642,974	27	37,663		72,468	1,661	2
3	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,642,974	27			72,468		3
4	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,642,974	27	72,471		72,468	3,197	4
5	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,642,974	27	5,383		72,468	237	5
6	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,642,974	27	3,156,734	3,156,734	72,468	139,237	6
7	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,642,974	27	3,034		72,468	134	7
8	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,642,974	27	908,028		72,468	40,051	8
9	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,642,974	27			72,468		9
10	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,642,974	27	793,188		72,468	34,986	10
11	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,642,974	27	145,343		72,468	6,411	11
12	21	CLERICAL & GENERAL SALAR	AVAIL. CENSUS DAYS	1,642,974	27	2,200,120	2,200,120	72,468	97,042	12
13	21	CLERICAL & GENERAL EXPEN	AVAIL. CENSUS DAYS	1,642,974	27	1,075,235		72,468	47,426	13
14	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,642,974	27	7,970		72,468	352	14
15	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,642,974	27	145,272		72,468	6,408	15
16	26	INSURANCE	AVAIL. CENSUS DAYS	1,642,974	27	26,926		72,468	1,188	16
17	27	EMPLOYEE BENEFITS - ADMIN	AVAIL. CENSUS DAYS	1,642,974	27	632,860		72,468	27,914	17
18	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,642,974	27	549,679		72,468	24,245	18
19	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,642,974	27	738		72,468	33	19
20	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,642,974	27	98,893		72,468	4,362	20
21	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,642,974	27	67,631		72,468	2,983	21
22	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,642,974	27	194,869		72,468	8,595	22
23	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,642,974	27	112,113		72,468	4,945	23
24										24
25	TOTALS					\$ 10,254,420	\$ 5,376,221		\$ 452,301	25

Facility Name & ID Number Symphony at Aria # 0053710 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 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 and Medical Records	Direct Allocation			\$	\$		\$ 8,236	1
2	35	Rent-Equipment and Vehicles	Direct Allocation						49,462	2
3	39	Oxygen Supplies	Direct Allocation						1,880	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					\$	\$		\$ 59,578	25

Facility Name & ID Number Symphony at Aria# 0053710 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. Wabash Avenue

City / State / Zip Code

Chicago, IL 60616

Phone Number

(312) 949-9595

Fax Number

(312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	38	Transportation	Direct Allocation			\$	\$		\$ 19,336	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					\$	\$		\$ 19,336	25

Facility Name & ID Number Symphony at Aria# 0053710 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

Maple Leaf Insurance

Street Address

PO Box 69, 720 West Bay Rd

City / State / Zip Code

Grand Cayman, KY1-1102

Phone Number

(

Fax Number

(

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 137,374	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					\$	\$		\$ 137,374	25

Facility Name & ID Number Symphony at Aria # 0053710 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 Concerto Dialysis LLC
Street Address 4600 W. Touhy Ave, Suite 100
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 233-1200
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	10	Dialysis	Direct Allocation			\$	\$		\$ 2,044	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					\$	\$		\$ 2,044	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	0.0750	\$ 487	1		
2	LifeMed	X		Pharmacy Services	38,731	1/1/2018	6,197,033	366,055	1/1/2024	0.0750	31,061	2		
3												3		
4	Select Rehab		X	Operational	159,503	12/31/2018	12,216,125	618,417	12/31/2023	0.0020	14,329	4		
5	Integra	X		Medical Supplies/Rental	50,680	7/1/2019	1,162,530	11,100	6/30/2021	0.0438	999	5		
	Working Capital													
6	State of Illinois		X	Advance Payment	3,386	5/1/2019	344,300	344,300	8/1/2021		-	6		
7	NGS		X	Medicare AAP	34,532	4/7/2020	828,756	828,756	4/7/2023		-	7		
8	CIBC Bank USA		X	Payroll & Oper Exp	55,492	6/23/2020	1,331,812	1,331,812	6/23/2022	0.0100	-	8		
9	TOTAL Facility Related				\$409,767.74		\$ 24,250,893	\$ 3,500,440				\$ 46,876	9	
	B. Non-Facility Related*													
10	Cyber Ins										113	10		
11	Worthy Ins										860	11		
12								Interest Income offset				(31,388)	12	
13								Allocated from Mgmt. Co.				33	13	
14	TOTAL Non-Facility Related						\$	\$				\$ (30,382)	14	
15	TOTALS (line 9+line14)						\$ 24,250,893	\$ 3,500,440				\$ 16,494	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	792,852	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2019		\$	430,471	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(362,381)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	1,232,789	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
		Alloc. Fr. Mgmt. Co.		4,362	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	874,770	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	<u>684,950</u>	8		
	2016	<u>707,045</u>	9		
	2017	<u>759,244</u>	10		
	2018	<u>782,675</u>	11		
	2019	<u>805,483</u>	12		
Accrual Calculation :					
Real estate taxes paid (\$805,483 X 1.0649%) + second installment \$375,012 = \$1,232,789					

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYMPHONY AT ARIA COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053710

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 nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 15-17-101-014-0000	Long Term Care Property	\$ 805,483.38	\$ 805,483.38
2. 10-27-319-028-0000	Home Office Allocation	\$ 85,535.22	\$ 4,362.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 891,018.60	\$ 809,845.38

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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).
Hillside Montessori School - Child Day Care

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	Alloc. Mgmt. Co.	-	2004	\$ 7,057	1
2					2
3	TOTALS			\$ 7,057	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2012	36,080		20	1,804	1,804	13,400	9
10	Various			2013	827,751		20	41,388	41,388	308,468	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Symphony at Aria

0053710

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		\$ 863,831	\$		\$ 43,192	\$ 43,192	\$ 321,869	1
2	Coffee Station & Dining Room Bistro	2014	9,300		20	465	465	2,868	2
3	2 Boiler Pump Replacements	2014	4,084		20	204	204	1,259	3
4	Stained Concrete Sidewalk Installation	2014	4,760		20	238	238	1,745	4
5	Trane Chiller	2014	12,249		20	612	612	3,420	5
6	Card Reader Replacement Panel	2014	3,325		20	166	166	956	6
7	Electrical Work - Fire Alarm System	2014	5,250		20	263	263	1,422	7
8	Doors, Frames And Sideliters	2015	2,622		20	131	131	186	8
9	Install 2 Fans On Boiler	2015	3,485		20	174	174	3,078	9
10	Chiler - Leak Repair	2015	7,420		20	371	371	1,484	10
11	Cubicle Curtains	2016	7,562		20	378	378	1,890	11
12	Install 2 Pit Ladder In Elevator	2016	4,562		20	228	228	1,140	12
13	Chiller Repair	2016	5,049		20	252	252	1,261	13
14	Chiller Replacement	2016	110,000		20	5,500	5,500	27,500	14
15	Install 15 Sprinkler System	2016	6,823		20	341	341	1,705	15
16	Repair Heating Pallet In 2Nd Floor Pt. Replace Thermostat, Compu	2016	2,793		20	140	140	699	16
17	Furnish & Install New Submersible Motor For Elevator 1/Contact 1	2016	2,500		20	125	125	625	17
18	Concrete Ramp On Back Patio Replacement	2017	4,300		20	215	215	860	18
19	Elevator Repair- 2 New Panels	2017	3,000		20	150	150	600	19
20	Phone System Upgrade	2017	42,966		20	2,148	2,148	8,593	20
21	Cordless Phony System Update	2018	3,165	634	20	634		1,747	21
22	Waterguard Management	2018	13,480	2,701	20	2,701		6,362	22
23	Chillers & Pumps	2018	8,511	1,705	20	1,705		4,035	23
24	Repair wall, drywall, reinforce frame, cement boards.	2019	4,100	205	20	205		206	24
25	HVAC replacement-new boilers with all pumps and pipes	2019	114,214	5,711	20	5,711	(0)	12,492	25
26	Repair mutiple boilers-Pipe fittings, coupler, iron basket	2019	7,539	377	20	377	(0)	1,265	26
27	igniters, control boards								27
28	FCVC Fan Coil unit 10 right and 1 left	2019	3,645	182	20	182	0	183	28
29	Repair circuit 2 on chiller	2019	4,599	230	20	230	(0)	345	29
30	HVAC replacement-new boilers with all pumps and pipes	2020	60,457	6,056	20	6,056		6,056	30
31	Dialysis project-drawings, flooring, power supply mount	2020	197,516	1,985	20	1,985		1,985	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,523,106	\$ 19,786		\$ 75,080	\$ 55,294	\$ 417,835	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		\$ 1,523,106	\$ 19,786		\$ 75,080	\$ 55,294	\$ 417,835	1
2	Remove and replace water piping between heater and storage tank	2020	7,510	182	20	182		182	2
3	Patch to the field wall flashing roof	2020	5,995	269	20	269		269	3
4	Chiller replacement	2020	142,880	4,008	20	4,008		4,008	4
5	Water valves-backflow preventors wall boxes	2020	15,045	422	20	422		422	5
6	Roof work patch	2020	3,400	76	20	76		76	6
7	Tone out new cables relocated satellite dish	2020	2,687	30	20	30		30	7
8									8
9									9
10									10
11	Reconcile to financial statement depreciation			25,471			(25,471)		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)		\$ 1,700,624	\$ 50,244		\$ 80,067	\$ 29,823	\$ 422,822	34

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

Facility Name & ID Number Symphony at Aria

0053710

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		\$ 1,700,624	\$ 50,244		\$ 80,067	\$ 29,823	\$ 422,822	1
2									2
3	Buildings:								3
4	Allocated From Maestro-7257 Lincoln	2004	63,515		35	1,815	1,815	31,077	4
5									5
6									6
7									7
8									8
9	Leasehold Improvements:								9
10	Allocated From Maestro	2003	517		20	26	26	442	10
11	Allocated From Maestro	2004	10,489		20	523	523	8,767	11
12	Allocated From Maestro	2005	622		20	31	31	493	12
13	Allocated From Maestro	2006	843		20	42	42	606	13
14	Allocated From Maestro	2008	889		20	44	44	545	14
15	Allocated From Maestro	2009	14,310		20	715	715	8,307	15
16	Allocated From Maestro	2010	2,199		20	110	110	1,155	16
17	Allocated From Maestro	2011	119		20	6	6	59	17
18	Allocated From Maestro	2012	132		20	7	7	58	18
19	Allocated From Maestro	2014	1,654		20	83	83	546	19
20	Allocated From Maestro	2015	465		20	23	23	124	20
21	Allocated From Maestro	2016	2,038		20	102	102	690	21
22	Allocated From Maestro	2017	273		20	14	14	55	22
23	Allocated from Maestro	2020	440		20	11	11	11	23
24									24
25	Allocated From Maestro-7257 Lincoln	2015	1,001		20	67	67	356	25
26	Allocated From Maestro-7257 Lincoln	2005	5,791		20	207	207	4,868	26
27	Allocated from Maestro 7257 Lincoln	2004	1,262		20	63	63	1,042	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,807,183	\$ 50,244		\$ 83,956	\$ 33,712	\$ 482,023	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	\$538,763	\$67,902	\$77,530	\$9,628	5-10	\$450,912	71
72	Current Year Purchases	39,881	4,122	4,122		5-10	4,122	72
73	Fully Depreciated Assets	1,119,663					1,119,663	73
74	Allocated from Maestro	185,745		20,356	20,356		89,194	74
75	TOTALS	\$1,884,052	\$72,024	\$102,008	\$29,984		\$1,663,891	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	Facility	Ford E350	2015	\$9,784	\$	\$	\$	5	\$9,784	76
77	Allocated from Maestro		2017	391	-	-		5	391	77
78					-	-				78
79					-	-				79
80	TOTALS			\$10,175	\$	\$	\$		\$10,175	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,708,467	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$122,268	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$185,964	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$63,696	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,156,089	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	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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:	1973	198	11/1/2015	\$ 2,498,560	15	15	3
4	Additions							4
5								5
6	Allocated From Maestro				2,983			6
7	TOTAL		198		\$ 2,501,543			7

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 171,701
- 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			\$	\$	17
18	Allocated From Maestro			4,945	18
19					19
20					20
21	TOTAL		\$	\$ 4,945	21

10. Effective dates of current rental agreement:

Beginning11/1/2015

Ending10/31/2030

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

	Fiscal Year Ending	Annual Rent
12.	12/31/21	\$ 2,406,311
13.	12/31/22	\$ 2,460,453
14.	12/31/23	\$ 2,515,813

* 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 at Aria
IDPH License ID Number: 0053710
Fiscal Year End: 12/31/2020

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	58,034
Nursing Equipment	2,703
Building Equipment	59,589
Office Equipmment	51,509
Allocated from Maestro	8,595
Allocated from Integra	(8,729)
Total - Line 16	171,701

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	\$	8,762	\$ 630,839	\$	8,762	\$ 630,839	1					
2	Licensed Speech and Language Development Therapist	39(3)	hrs		4,107	295,701		4,107	295,701	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	39(3)	hrs		10,686	769,395		10,686	769,395	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 prescripts				107,229		107,229	9					
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												
10			hrs							10					
11	Academic Education		hrs							11					
12	Other (specify): <u>Oxygen</u>	39(2&7)					1,880		1,880	12					
13	Other (specify): <u>See Sch 16A</u>	39(3)			919	66,160		919	66,160	13					
14	TOTAL			\$	24,474	\$ 1,762,095	\$ 109,109	24,474	\$ 1,871,204	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 ARIA
IDPH License ID Number: 0053710
Fiscal Year End: 12/31/2020

Schedule 16A

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

Line 13

Description	Cost
Inhalation Thearpy	20,140
Other Ancillary Costs Medicare	635
IV Therapy	45,385
Total - Line 13	66,160

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,080	\$ 6,080	1
2	Cash-Patient Deposits	53,433	53,433	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,261,684)	2,829,117	2,829,117	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	6,290	6,290	6
7	Other Prepaid Expenses	6,917	6,917	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): Acct. Rec. Empl Loan	7,849	7,849	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,909,686	\$ 2,909,686	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	7,057	13
14	Buildings, at Historical Cost	-	63,515	14
15	Leasehold Improvements, at Historical Cost	390,789	1,743,668	15
16	Equipment, at Historical Cost	641,358	1,894,227	16
17	Accumulated Depreciation (book methods)	(324,530)	(2,156,089)	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 (spe	-	-	22
23	Other(specify): See Attached Schedule	1,766,257	1,766,257	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,473,874	\$ 3,318,635	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,383,560	\$ 6,228,321	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 588,756	\$ 588,756	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	53,433	53,433	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	433,542	433,542	30
31	Accrued Taxes Payable (excluding real estate taxes)	286,004	286,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,232,789	1,232,789	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	8,113,629	8,113,629	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,708,153	\$ 10,708,153	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,500,440	3,500,440	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)	\$ 3,500,440	\$ 3,500,440	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,208,593	\$ 14,208,593	46
47	TOTAL EQUITY (page 18, line 24)	\$ (8,825,033)	\$ (7,980,272)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,383,560	\$ 6,228,321	48

*(See instructions.)

Facility Name: Symphony at Aria
IDPH License ID Number: 0053710
Fiscal Year End: 12/31/2020

Schedule 17A

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

Description	Operating	After Consolidation
Fixed Assets - Construction in Process	-	-
CSA I/C Related/Party Due To/From Accts	158,969	158,969
Due To/From - Buffalo Grove LLC	-	-
Due To/From - Midway	-	-
Due To/From - Aria - OLD	255,198	255,198
Due To/From - Encore Realty	890,854	890,854
Accrued Payables - Health Insurance	11,468	11,468
Accrued Payable - Dental Insurance	4,698	4,698
Accrued Payables - Vision Insurance	440	440
Accrued Payables - Short Term Disability	63,807	63,807
Accrued Payables - Payroll Credit Union	152	152
Accrued Payables - 401K Loan Repayments	106	106
Accrued Payables - Garnishments	1,516	1,516
Accrued Payables - Management Fees	315,372	315,372
Accrued Payables - Interest	4,088	4,088
Accrued Payables - Rent	59,548	59,548
Sales Tax Payable - Manual	41	41
Total - Line 23	1,766,257	1,766,257

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

Description	Operating	After Consolidation
Clearing Account	8,050	8,050
Due To/From - 87th Street	-	-
Due To/From - Bronzeville Park LLC	-	-
Due To/From - Ivy LLC	-	-
Due To/From - Jackson Square LLC	150,289	150,289
Due To/From - Morgan Park	-	-
Due To/From - South Shore	-	-
Due To/From - Tillers	4,277	4,277
Due To/From - Orchard Valley	1,727	1,727
Due To/From - Glendale	104,616	104,616
Due To/From - Symcare Healthcare	-	-
Due To/From - Symcare ML	5,091,690	5,091,690
Due To/From - Maestro	158,267	158,267
Accrued Payables	27,525	27,525
Accrued Payables - Professional Fees	26,717	26,717
Accrued Payables - Life Insurance	65,708	65,708
Accrued Payables - Payroll Union Dues	7,170	7,170
Accrued Payables - 401K Deductions	506	506
Employee Purchases	55	55
Fringe Benefits - Flow Through	1,569	1,569
Accrued Payables - WC/GL Insurance	398,160	398,160
Accrued Payables - Bed Taxes	58,068	58,068
Accrued Payables - OIG Audit	198,325	198,325
Accrued Payables - Bed Taxes Add'l	21,004	21,004
Accrued Payables - Sales Tax	441	441
Deferred Rent	1,387,316	1,387,316
Deferred Income	402,149	402,149
Total - Line 36	8,113,629	8,113,629

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,173,686)	1
2	Restatements (describe):		2
3	Prior Year Journal Entries		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,173,686)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,651,347)	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)	\$ (2,651,347)	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)	\$ (8,825,033)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony at Aria

0053710

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	\$ 12,492,870	1
2	Discounts and Allowances for all Levels	(2,635,450)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,857,420	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	3,422,893	6
7	Oxygen	22,497	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,445,390	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,184,440	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	200,676	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	38,190	19
20	Radiology and X-Ray	12,921	20
21	Other Medical Services	76,749	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,512,976	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	31,389	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,389	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	119,799	28
28a		-	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 119,799	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,966,974	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,920,474	31
32	Health Care	5,211,921	32
33	General Administration	3,579,246	33
	B. Capital Expense		
34	Ownership	3,682,791	34
	C. Ancillary Expense		
35	Special Cost Centers	2,824,252	35
36	Provider Participation Fee	399,637	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,618,321	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,651,347)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,651,347)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,750,612	44
45	Private Pay - Net Inpatient Revenue	535,944	45
46	Medicare - Net Inpatient Revenue	561,056	46
47	Other-(specify) <u>Hospice</u>	468,835	47
48	Other-(specify) <u>Managed Care/MAIP</u>	540,973	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,857,420	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 Aria
IDPH License ID Number: 0053710
Fiscal Year End: 12/31/2020

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Preferred Insurance Provider Incentive - Revenue-	4,000
Other Services - Revenue-Managed Care	(133,393)
Rental Income - Operating Location Rent	235,493
Other revenue	13,699
Total - Line 28	119,799

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	1,544	1,694	\$ 88,428	\$ 52.19	1
2	Assistant Director of Nursing	1,864	2,080	105,974	50.95	2
3	Registered Nurses	31,771	35,648	1,214,548	34.07	3
4	Licensed Practical Nurses	37,346	42,071	1,270,854	30.21	4
5	CNAs & Orderlies	76,353	89,737	1,566,114	17.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,752	2,080	51,216	24.62	9
10	Activity Assistants	10,580	12,501	184,481	14.76	10
11	Social Service Workers	4,645	4,937	130,802	26.49	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,080	57,400	27.60	13
14	Head Cook	5,948	6,797	120,777	17.77	14
15	Cook Helpers/Assistants	18,896	21,142	323,061	15.28	15
16	Dishwashers					16
17	Maintenance Workers	2,146	2,425	77,460	31.94	17
18	Housekeepers	22,708	25,883	420,813	16.26	18
19	Laundry	3,393	3,941	69,854	17.72	19
20	Administrator	1,944	2,080	132,837	63.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,752	2,040	71,326	34.97	23
24	Clerical	10,935	12,373	239,033	19.32	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	5,465	6,416	120,362	18.76	31
32	Other Health C: See SCH 20A	5,272	6,145	247,845	40.34	32
33	Other(specify) <u>Admissions</u>	5,023	5,487	157,711	28.74	33
34	TOTAL (lines 1 - 33)	251,169	287,558	\$ 6,650,896 *	\$ 23.13	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 35,892	1(3)	35
36	Medical Director	Monthly	20,250	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	134	10(7)	38
39	Pharmacist Consultant	Monthly	16,409	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	3,130	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Psychiatric Consultant</u>	Monthly	5,340	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 81,155		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

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

** See instructions.

Facility Name: Symphony at Aria
IDPH License ID Number: 0053710
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	3,480	4,105	169,545	\$ 41.31
Human Resource Director	1,792	2,040	78,300	\$ 38.38
Total - Line 32 Other Health Care (specify):	5,272	6,145	247,845	

STATE OF ILLINOIS

Facility Name & ID NumberSymphony at Aria

0053710

Report Period Beginning:1/1/2020

Page 21

Ending:12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Ciarra Carter-Harley

Administrator

0

\$ 132,837

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 132,837

B. Administrative - Other

Description

Amount

Management Fees - Maestro Consulting Services

\$ 681,476

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 681,476

C. Professional Services

Vendor/Payee

Type

Amount

See Supplemental Schedule

\$ 352,882

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 352,882

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 137,374

Unemployment Compensation Insurance

31,842

FICA Taxes

467,602

Employee Health Insurance

332,459

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Employee Retirement

48,201

Employee Benefits - Other

12,448

Employees' Physical Exams

7,358

401K

10,150

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,047,434

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

4,747

Health Care Worker Background Check

(Indicate # of checks performed 73)

876

Patient Background Checks

82

Health Care Council of Illinois

34,379

Miscellaneous Dues & Subscriptions

(2,184)

Miscellaneous Licenses & Fees

9,865

Remove Lobbying portion of dues

(8,663)

Allocated from Maestro

6,411

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 48,401

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Allocated from Maestro

352

Entertainment Expense

()

TOTAL (agree to Sch. V, line 24, col. 8)

\$ 352

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: Symphony at Aria
IDPH License ID Number: 0053710
Fiscal Year End: 12/31/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ABILITY Network, Inc.	Secure Exchange Managed Services	(87)
Alteryx and Definitive Healthcare	Data Analytics	3,173
CATS- APPLICANT TRACKING SYSTEM	Applicant Tracking System	404
Comcast Cable	Internet	26,057
Creative Technology Solutions	IT Support	3,197
Enterprise	Immune System tracker	295
FORMATION HEALTHCARE GROUP	Monthly Subscription Fee	1,086
Health Data Systems Inc	Programming	3,057
Kronos	Payroll service	8,324
Managed Care Group LLC	IT Support	6,944
Microsoft Office	Computer service	5,599
Nexuscomm, LLC	Phone/fax service	6,228
PointClickCare Technologies Inc.	Cloud based software and services	41,149
Prime Care Tech-PBJ access	PBJ Reporting Module Access Fee	2,520
Telemedicine Solutions, LLC	Wound Rounds Care	14,943
Allscripts LLC	Referral system	4,598
apptoi-applcant tracing system	apptoi-applcant tracking system	76
CDW	Computer service	1,577
Core Data and Data Robot/Intellilogix	Data Storage	453
Darktrace Limited	Cyber Security	2,171
Data Robot-cloud professional	Data Storage	2,092
Definitive Healthcare	Information services	267
EMMI Solutions	Data Analytics	(337)
Enquire Solutions LLC	Marketing solution	1,040
enVista LLC	IT Support	755
Intellicomp Technologies Inc.	IT Support	22,408
Navigator Group Purchasing, In	Data Analytics	284
Petty Cash	IT Support	215
Pay Access-Payroll	Payroll	142
Reputation.com, Inc.	Online Reputation Management	954
Reside Admissions LLC	Admission Process Consulting	2,824
Sprout Social Inc.	Social Media Management	2,269
Striv Technologies LLC dba Striv360	IT Support	2,580
Team TSI Corporation	Collection	4,675
Third Eye Health Inc.	Data Analytics	4,891
WenceI	Branding	6,913
RSM	Accounting Fees-Administrative	43,520
McCabe, Kirshner P.C.	Legal	10,810
MKB	Legal	68,039
Stone, Pogrund & Korey LLC	Legal	13,833
Achieve Accreditation	Accreditation	9,808
ADP, LLC	Payroll service	1,573
Corporation Service Company	Annual Filing	1,072
Geoffrey Shaw	Medical Consult	1,500
Language Line Services	Language lesson	29
Life Safety Resources, LLC	Fire protection drill	3,191
MTS Consulting, LLC	Tax Consulting	3,966
National Datacare Corporation	trust fees	4,603
Personnel Planners, Inc	Qtrly Unemployment Claims	1,283
Petty Cash - Symphony Aria, LLC.		77
Advanced Care Medical Speciali	Infectious Disease Consulting	770
SB2 Inc.	Legal Fees - appeal Medicaid/Medicare cl	5,072
Total (agree to Schedule V, line 19, column 3)		352,882
Allocated from Management Company Professional Services		34,986
Less: Non-Allowable Legal Fees		(13,796)
Less: Non-Allowable Marketing		(7,953)

Total (agree to Schedule V, line 19, column 8) 366,119

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-\$34,379

(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?

5-10 years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0

Line N/A

(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.

Aria Post Acute Care #52019

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 399,637

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?

Yes

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?

100% Ln 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 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.