

		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>0051839</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>SYMPHONY MAPLE CREST</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>4452 Squaw Prairie</u> <u>Belvidere</u> <u>61008</u>																																																	
Number City Zip Code																																																	
County: <u>Boone</u>																																																	
Telephone Number: <u>(815) 547-6377</u> Fax # <u>(815) 547-3857</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td colspan="2">(Print Name and Title) _____</td></tr><tr><td colspan="2">(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td colspan="2">(Telephone) <u>(847) 517-7070</u> Fax # <u>(847)517-7067</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(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 # <u>(217) 782-1630</u>																															
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Date of Initial License for Current Owners: <u>01/01/2012</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 colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____	
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		☐	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: _____																																																	

Facility Name & ID Number SYMPHONY MAPLE CREST

0051839 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>86</u>	Skilled (SNF)	<u>86</u>	<u>31,476</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>86</u>	TOTALS	<u>86</u>	<u>31,476</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>13,860</u>	<u>6,542</u>	<u>6,853</u>	<u>27,255</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>13,860</u>	<u>6,542</u>	<u>6,853</u>	<u>27,255</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.59%

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

N/A (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 01/01/2012

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

YES ☒

Date 12/31/2011

NO ☐

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

YES ☒

NO ☐

If YES, enter number
of beds certified 86 and days of care provided 4,643

Medicare Intermediary

Wisconsin Physicians Service

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.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	249,243	15,347	8,298	272,888		272,888	388	273,276		1
2	Food Purchase		149,377		149,377		149,377		149,377		2
3	Housekeeping	(92)	210,290	-	210,198		210,198		210,198		3
4	Laundry	(78)	13,398	1,269	14,589		14,589		14,589		4
5	Heat and Other Utilities			78,952	78,952		78,952	722	79,674		5
6	Maintenance	50,439	-	92,593	143,032		143,032	1,388	144,420		6
7	Other (specify):* Mgmt alloc of benef	-	-	-				103	103		7
8	TOTAL General Services	299,512	388,412	181,112	869,036		869,036	2,601	871,637		8
	B. Health Care and Programs										
9	Medical Director	-	-	21,484	21,484		21,484		21,484		9
10	Nursing and Medical Records	2,300,622	105,396	11,131	2,417,149		2,417,149	58,202	2,475,351		10
10a	Therapy	-	-	-							10a
11	Activities	80,562	-	-	80,562		80,562		80,562		11
12	Social Services	43,604	-	-	43,604		43,604		43,604		12
13	CNA Training	-	-	-							13
14	Program Transportation	-	-	-							14
15	Other (specify):* Mgmt alloc of benef	-	-	-				17,396	17,396		15
16	TOTAL Health Care and Programs	2,424,788	105,396	32,615	2,562,799		2,562,799	75,598	2,638,397		16
	C. General Administration										
17	Administrative	35,318	-	351,317	386,635		386,635	(351,317)	35,318		17
18	Directors Fees			-							18
19	Professional Services			237,473	237,473		237,473	6,408	243,881		19
20	Dues, Fees, Subscriptions & Promotions			26,325	26,325		26,325	(3,915)	22,410		20
21	Clerical & General Office Expenses	126,256	13,202	26,036	165,494		165,494	56,399	221,893		21
22	Employee Benefits & Payroll Taxes			456,945	456,945		456,945		456,945		22
23	Inservice Training & Education			-							23
24	Travel and Seminar			256	256		256	153	409		24
25	Other Admin. Staff Transportation		-	1,406	1,406		1,406	2,783	4,189		25
26	Insurance-Prop.Liab.Malpractice			310,841	310,841		310,841	516	311,357		26
27	Other (specify):* Mgmt alloc of benef			-				12,124	12,124		27
28	TOTAL General Administration	161,574	13,202	1,410,599	1,585,375		1,585,375	(276,849)	1,308,526		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,885,874	507,010	1,624,326	5,017,210		5,017,210	(198,650)	4,818,560		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			56,925	56,925		56,925	23,377	80,302			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			6,412	6,412		6,412	60,917	67,329			32
33	Real Estate Taxes			53,514	53,514		53,514	1,895	55,409			33
34	Rent-Facility & Grounds			697,168	697,168		697,168	4,379	701,547			34
35	Rent-Equipment & Vehicles			47,827	47,827		47,827	5,766	53,593			35
36	Other (specify):*			-								36
37	TOTAL Ownership			861,846	861,846		861,846	96,334	958,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	102,667	772,139	874,806		874,806		874,806			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			184,634	184,634		184,634		184,634			42
43	Other (specify):* Non-Allowable Cos	99,247	-	(185,741)	(86,494)		(86,494)	86,494				43
44	TOTAL Special Cost Centers	99,247	102,667	771,032	972,946		972,946	86,494	1,059,440			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,985,121	609,677	3,257,204	6,852,002		6,852,002	(15,822)	6,836,180			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 MAPLE CREST

0051839

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VI. ADJUSTMENT DETAIL

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

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,388)	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	707	30		9
10	Interest and Other Investment Income	(32)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(802)	43		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	(3,307)	43		18
19	Entertainment				19
20	Contributions	(8,795)	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	35,821	43		24
25	Fund Raising, Advertising and Promotional	(2,951)	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 See PG5A	55,079	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 65,332		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(81,154)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (81,154)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (15,822)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (56,689)	43	1
2	Laboratory Costs	(6,666)	43	2
3	X-Ray Costs	(21,011)	43	3
4	Theft Damage and Loss	(1,006)	43	4
5	Admissions Coordinator	(23,321)	43	5
6	Director of Customer Experience	(10,220)	43	6
7	Community Relations	(13,950)	43	7
8	Other Income	(6,350)	21	8
9	Lobbying Expense	(6,699)	20	9
10	Nonallowable branding fees	(7,069)	19	10
11	Nonallowable Legal	(1,719)	19	11
12	Gain Loss on Sale of Assets	(30,610)	43	12
13	Gain/Loss Deferred Rent	231,553	43	13
14	Closing Costs & PY Adjustments	8,836	43	14
15				15
16				16
17				17
18				18
19				19
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	55,079		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

☒ YES
 ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	32	Interest	\$	Symphony Propco Holding	100	\$ 60,935	\$ 60,935	1
2	V	32	Amortization		Symphony Propco Holding	100	3,083	3,083	2
3	V	30	Depreciation		Symphony Propco Holding	100	12,139	12,139	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			\$			\$ 76,157	\$ * 76,157	14

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

Facility Name & ID Number SYMPHONY MAPLE CREST

0051839

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Maestro Consulting Services	100%	\$ 388	\$ 388	15
16	V	5	Utilities		Maestro Consulting Services	100%	722	722	16
17	V	6	Maintenance Salaries		Maestro Consulting Services	100%	0		17
18	V	6	Maintenance Expenses		Maestro Consulting Services	100%	1,388	1,388	18
19	V	7	Employee Benefits - Maintenance		Maestro Consulting Services	100%	103	103	19
20	V	10	Clinical Salaries		Maestro Consulting Services	100%	60,477	60,477	20
21	V	10	Contract Nursing		Maestro Consulting Services	100%	58	58	21
22	V	15	Employee Benefits - Clinical		Maestro Consulting Services	100%	17,396	17,396	22
23	V	17	Administrative - Other	351,317	Maestro Consulting Services	100%	0	(351,317)	23
24	V	19	Professional Fees		Maestro Consulting Services	100%	15,196	15,196	24
25	V	20	Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100%	2,784	2,784	25
26	V	21	Clerical & General Salaries		Maestro Consulting Services	100%	42,150	42,150	26
27	V	21	Clerical & General Expenses		Maestro Consulting Services	100%	20,599	20,599	27
28	V	24	Seminars and Education		Maestro Consulting Services	100%	153	153	28
29	V	25	Transportation		Maestro Consulting Services	100%	2,783	2,783	29
30	V	26	Insurance		Maestro Consulting Services	100%	516	516	30
31	V	27	Employee Benefits - Administrative		Maestro Consulting Services	100%	12,124	12,124	31
32	V	30	Depreciation		Maestro Consulting Services	100%	10,531	10,531	32
33	V	32	Interest Expense		Maestro Consulting Services	100%	14	14	33
34	V	33	Real Estate Tax		Maestro Consulting Services	100%	1,895	1,895	34
35	V	34	Building Rental		Maestro Consulting Services	100%	1,296	1,296	35
36	V	35	Equipment Rental		Maestro Consulting Services	100%	3,733	3,733	36
37	V	35	Auto Lease		Maestro Consulting Services	100%	2,148	2,148	37
38	V								38
39	Total			\$ 351,317			\$ 196,454	\$ * (154,863)	39

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

Facility Name & ID Number SYMPHONY MAPLE CREST

0051839

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	10	Nursing and Medical Records	\$ 15,552	Integra Healthcare Equipment, LLC	19%	\$ 13,219	\$ (2,333)	15
16	V	35	Rent-Equipment & Vehicles	764	Integra Healthcare Equipment, LLC	19%	649	(115)	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			\$ 16,316			\$ 13,868	\$ * (2,448)	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	\$ 62,196	Maple Leaf Insurance	100%	\$ 62,196	\$	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			\$ 62,196			\$ 62,196	\$ * 0	39

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

Facility Name & ID Number SYMPHONY MAPLE CREST

0051839

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	Symphony Healthcare, LLC	99.99	SYMPHONY OF CALIFORNIA GARDENS	CHICAGO	Lifeline Ambulance, L	Chicago	Ambulance	1
2	Symphony HMG, LLC	0.01	MAPLECREST CARE CENTRE	BELVIDERE	7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	2
3			NORTHWOODS CARE CENTRE	BELVIDERE	ConcertoHealth	Chicago	Clinical Services	3
4			SYCAMORE VILLAGE	SWANSEA	Integra Healthcare E	Elmhurst	DME & Med. Suppl	4
5			SYMPHONY ARIA	HILLSIDE	Seasons Hospice	Park Ridge	Hospice *	5
6			SYMPHONY AT 87TH STREET	CHICAGO	Mapleleaf Insurance	Grand Cayman	Liability/Work Con	6
7			SYMPHONY AT MIDWAY	CHICAGO	Symphony M.L., LLC	Lincolnwood	Main Lessor	7
8			SYMPHONY AT THE TILLERS	OSWEGO	JLR Financial Svcs. C	Lincolnwood	Management Co.	8
9			SYMPHONY OF BRONZEVILLE	CHICAGO	Drake Louis Enterpris	Lincolnwood	Management Co. **	9
10			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE	KFT Services, LLC	Lincolnwood	Management Co. **	10
11			SYMPHONY OF CHESTERTON	CHESTERTON, IN	Symphony Financial S	Lincolnwood	Mgmt Co.	11
12			SYMPHONY OF CHICAGO WEST	CHICAGO	Maestro Consulting S	Lincolnwood	Mgmt. Co.	12
13			SYMPHONY OF CRESTWOOD	CRESTWOOD	Lifemed Pharmacy	Bensenville	Pharmacy	13
14			SYMPHONY OF CROWN POINT	CROWN POINT, IN	Integra Respiratory S	Elmhurst	Respiratory Service	14
15			SYMPHONY OF DYER	DYER, IN	Symphony Healthcare	Lincolnwood	Sub Lessor	15
16			SYMPHONY OF EVANSTON	EVANSTON	Symphony HMG, LLC	Lincolnwood	Sub Lessor	16
17			SYMPHONY OF GLENDALE	GLENDALE, WI	Diamond Insurance	Northbrook	Work Comp Ins.	17
18			SYMPHONY OF HANOVER PARK	HANOVER PARK				18
19			SYMPHONY OF JOLIET	JOLIET				19
20			SYMPHONY OF LINCOLN PARK	CHICAGO				20
21			SYMPHONY OF MORGAN PARK	CHICAGO				21
22			SYMPHONY OF ORCHARD VALLEY	AURORA				22
23			SYMPHONY RESIDENCES OF LINCOLN PA	CHICAGO				23
24			WOODCARE V INC	BRIGHTON, MI				24
25			CLIFFSIDE COMPANY LLC	ST. JOSEPH, MI	* No expense paid by home to the related			25
26			SYMPHONY APPLEWOOD	WOODHAVEN, MI	entity, therefore no page 6 or 8.			26
27			SYMPHONY LINDEN	LINDEN, MI	** No expense of this related business			27
28			SYMPHONY TRI-CITIES	BAY CITY, MI	allocated to homes			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 MAPLE CREST# 0051839

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 ServicesStreet Address 7257 N. Lincoln Ave,City / State / Zip Code Lincolnwood, IL 60712Phone Number (847) 933-2600Fax 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	31,476	\$ 388	1
2	5	Utilities	Bed Days Available	1,642,974	27	37,663	0	31,476	722	2
3	6	Maintenance Salaries	Bed Days Available	1,642,974	27	0	0	31,476	0	3
4	6	Maintenance Expenses	Bed Days Available	1,642,974	27	72,471	0	31,476	1,388	4
5	7	Employee Benefits - Dietary/Main	Bed Days Available	1,642,974	27	5,383	0	31,476	103	5
6	10	Clinical Salaries	Bed Days Available	1,642,974	27	3,156,734	3,156,734	31,476	60,477	6
7	10	Contract Nursing	Bed Days Available	1,642,974	27	3,034	0	31,476	58	7
8	15	Employee Benefits - Clinical	Bed Days Available	1,642,974	27	908,028	0	31,476	17,396	8
9	17	Administrative - Other	Bed Days Available	1,642,974	27	0	0	31,476	0	9
10	19	Professional Fees	Bed Days Available	1,642,974	27	793,188	0	31,476	15,196	10
11	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	1,642,974	27	145,343	0	31,476	2,784	11
12	21	Clerical & General Salaries	Bed Days Available	1,642,974	27	2,200,120	2,200,120	31,476	42,150	12
13	21	Clerical & General Expenses	Bed Days Available	1,642,974	27	1,075,235	0	31,476	20,599	13
14	24	Seminars and Education	Bed Days Available	1,642,974	27	7,970	0	31,476	153	14
15	25	Transportation	Bed Days Available	1,642,974	27	145,272	0	31,476	2,783	15
16	26	Insurance	Bed Days Available	1,642,974	27	26,926	0	31,476	516	16
17	27	Employee Benefits - Administrative	Bed Days Available	1,642,974	27	632,860	0	31,476	12,124	17
18	30	Depreciation	Bed Days Available	1,642,974	27	549,679	0	31,476	10,531	18
19	32	Interest Expense	Bed Days Available	1,642,974	27	738	0	31,476	14	19
20	33	Real Estate Tax	Bed Days Available	1,642,974	27	98,893	0	31,476	1,895	20
21	34	Building Rental	Bed Days Available	1,642,974	27	67,631	0	31,476	1,296	21
22	35	Equipment Rental	Bed Days Available	1,642,974	27	194,869	0	31,476	3,733	22
23	35	Auto Lease	Bed Days Available	1,642,974	27	112,113	0	31,476	2,148	23
24										24
25	TOTALS					\$ 10,254,420	\$ 5,376,221		\$ 196,454	25

Facility Name & ID Number SYMPHONY MAPLE CREST# 0051839

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Integra Healthcare Equipment, LLC

Street Address

747 Church Road

City / State / Zip Code

Elmhurst, IL 60126

Phone Number

(630) 834-3700

Fax Number

(630) 834-1500

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies	Direct Allocation		\$	\$		\$ 13,219	1
2	35	Equipment Rental	Direct Allocation					649	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				\$	\$		\$ 13,868	25

Facility Name & ID Number SYMPHONY MAPLE CREST# 0051839

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 Allocation		\$	\$		\$ 62,196	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				\$	\$		\$ 62,196	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Omnicare		X	Pharmacy Services	67,444	11/27/2017	\$ 2,170,337	\$ -	10/20/2020	0.075	\$ 230	1		
2	LifeMed	X		Pharmacy Services	38,731	1/1/18	6,197,033	66,311	01/01/2024	0.075	5,627	2		
3												3		
4	Integra		X	Medical Supplies/rental	50,680	07/1/19	1,162,530	1,117	6/30/2021	0.043802	101	4		
5	White Oak Healthcare Finance,		X	Mortgage		12/10/2020	5,721,097	5,721,097	12/9/2023			5		
	Working Capital													
6	State of Illinois		X	Advance Payment	9,425	5/1/2019	113,100	113,100	8/1/2021			6		
7	National Government Services		X	Medicare AAP	27,264	4/7/2020	654,346	654,346	4/7/2023			7		
8												8		
9	TOTAL Facility Related				\$193,544.49		\$ 16,018,443	\$ 6,555,971			\$ 5,957	9		
	B. Non-Facility Related*													
10	Cyber Ins										49	10		
11	Worthy Ins										406	11		
12								Interest Income Offset			(32)	12		
13											60,935	13		
14	TOTAL Non-Facility Related						\$	Maestro Allocation			\$ 61,372	14		
15	TOTALS (line 9+line14)						\$ 16,018,443	\$ 6,555,971			\$ 67,329	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

[illegible]

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 Maple Crest, LLC D/B/A Maple Crest Care Cent COUNTY Boone

FACILITY IDPH LICENSE NUMBER 0051839

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-14-100-015</u>	<u>Facility</u>	\$ <u>52,572.12</u>	\$ <u>52,572.12</u>
2. <u>10-27-319-028-0000</u>	<u>Land & Property Mgmt. Co.</u>	\$ <u>85,535.22</u>	\$ <u>1,895.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>138,107.34</u></u>	\$ <u><u>54,467.12</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach 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: 36,000

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 1

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).
N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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 Fr Maestro 7257	-	2004	\$ 3,065	1
	2 Resident Care		2020	1,771,616	2
	3 TOTALS			\$ 1,774,681	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	86		2020		\$ 3,956,321	\$	30	\$ 11,699	\$ 11,699	\$ 11,699	4
5											5
6											6
7											7
8	Allocated from Maestro 7257		2004		27,587			788	788	13,498	8
	Improvement Type**										
9	F&I Smoke Detector above fire alarm control panel in			2013	3,725	186	20	186		1,489	9
10	100 Wing Nurse Station										10
11											11
12	Facility Remodeling			2014	396,750	19,838	20	19,838		132,932	12
13	-Demo/carpentry/drywall throughout facility										13
14	-Railing throughout facility										14
15	-Pulled wires for lights, rough in & installed can lights in										15
16	200 Wing Spa										16
17	-Rough in fire place area, rough in floor box in										17
18	200 Wing Spa										18
19	-Hallway, restrooms, dining room & recreation room -										19
20	remove wallpaper & prep wall										20
21	-Spa wall and floor tile in salon										21
22	-Plumbing work done in salon										22
23	-Electrical throughout facility										23
24	-Interior painting in resident rooms, front offices,										24
25	reception area and therapy room										25
26	-Floor coverings throughout facility										26
27	-Vestibule work										27
28	-Automatic doors throughout Facility										28
29	-Permits										29
30	-Gazebo outside										30
31	-Architectoral services										31
32	-General contractors fees										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 MAPLE CREST

0051839

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	Architecture fee, Electric power for new entrance door	2015	\$ 10,187	\$ 510	20	\$ 509	\$ (1)	\$ 2,973	37
38	Repair broken drain pipe, Kitchen floor	2015	4,995	249	20	250	1	1,413	38
39	Dark bronze glass and aluminum door and frame	2015	19,144	957	20	957		4,865	39
40	-1 dining room, 1 end of 100 Hallway (LTC) and 200 Hallway								40
41									41
42	Installed electrical work: new conduit, trench and back fill from	2016	3,910	196	20	196		898	42
43	the main valve to the back of the building, fire wire to main fire panel								43
44									44
45	Replace A-coil in air handler	2017	7,281	728	10	728		2,980	45
46	R&M - Replaced LED parking lot head and installed new timers.	2017	2,774	277	10	277		970	46
47	R&M - Welded and repaired holes in boiler and water heater pipes	2017	4,013	201	20	201		703	47
48	Installed new insulation, new vent damper and new belts for boiler								48
49	Install New Phone System throughout building	2018	20,535	2,934	7	2,934		5,876	49
50	18 new cat6 cable drops, new phone system complete installation	2019	14,309	2,044	7	2,044		3,163	50
51	15 Ton split system cooling replacement 1st floor N. wing	2019	27,307	3,901	7	3,901		5,106	51
52	A/C in 200 wing and therapy unit. Added refrigerant and	2019	4,085		15	272	272	408	52
53	replace supply hose.								53
54	Downblast vent belt for exhaust in boiler room	2019	4,103	586	7	586		625	54
55									55
56	Plumbing to repair sewer, backfill and patch floor	2020	7,895	4	15	4		4	56
57	Replace hot water heater and install	2020	9,928	515	7	515		515	57
58	Install new mixing valve in hot water heater	2020	4,144	172	7	172		172	58
59	Replacement of circuit breaker panel in boiler room	2020	9,892			330	330	330	59
60	Domestic Water heater replacement	2020	9,928			331	331	331	60
61	Concrete & Asphalt repair	2020	8,100			270	270	270	61
62	Electrical circuit in the garage	2020	3,448			115	115	115	62
63									63
64									64
65									65
66	Tie to book depreciation			611			(611)		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,560,361	\$ 33,909		\$ 47,103	\$ 13,194	\$ 191,336	70

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

Facility Name & ID Number SYMPHONY MAPLE CREST

0051839

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		\$ 4,560,361	\$ 33,909		\$ 47,103	\$ 13,194	\$ 191,336	1
2									2
3	Allocated from Maestro Consulting Services	2003	224		39	11	11	192	3
4	Allocated from Maestro Consulting Services	2004	4,556		39	227	227	3,808	4
5	Allocated from Maestro Consulting Services	2005	270		39	14	14	214	5
6	Allocated from Maestro Consulting Services	2006	366		39	18	18	263	6
7	Allocated from Maestro Consulting Services	2008	386		39	19	19	237	7
8	Allocated from Maestro Consulting Services	2009	6,215		20	311	311	3,608	8
9	Allocated from Maestro Consulting Services	2010	955		20	48	48	502	9
10	Allocated from Maestro Consulting Services	2011	52		20	3	3	26	10
11	Allocated from Maestro Consulting Services	2012	57		20	3	3	25	11
12	Allocated from Maestro Consulting Services	2014	718		20	36	36	237	12
13	Allocated from Maestro Consulting Services	2015	203		20	10	10	54	13
14	Allocated from Maestro Consulting Services	2016	886		20	44	44	300	14
15	Allocated from Maestro Consulting Services	2017	119		20	6	6	23	15
16	Allocated from Maestro Consulting Services	2020	191		20	5	5	5	16
17									17
18	Allocated from Maestro 7257	2004	548		10	27	27	452	18
19	Allocated from Maestro 7257	2005	2,515		10	90	90	2,115	19
20	Allocated from Maestro 7257	2015	435		15	30	30	155	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)		\$ 4,579,057	\$ 33,909		\$ 48,005	\$ 14,096	\$ 203,552	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	\$229,229	\$21,105	\$21,104	\$(1)	5	\$198,918	71
72	Current Year Purchases	68,842	1,911	2,352	441	5	2,352	72
73	Fully Depreciated Assets	14,060					14,060	73
74	Allocated from Maestro	80,677		8,841	8,841		38,741	74
75	TOTALS	\$392,808	\$23,016	\$32,297	\$9,281		\$254,071	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			\$170	\$-	\$-			\$170	76
77					-	-				77
78					-	-				78
79					-	-				79
80	TOTALS			\$170	\$	\$			\$170	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,746,716	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$56,925	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$80,302	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$23,377	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$457,793	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: Eclipse Kensington Master Landlord, LLC
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:	1972	86	12/31/2011	\$ 697,168	10	10	3
4	Additions							4
5	Allocated from Symphony Propco				3,083			5
6	Allocated from Maestro				1,296			6
7	TOTAL		86		\$ 701,547			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 10 .
- 0
0

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: \$ 46,251 Description: See 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	Facility	2016 Van	\$ 480	\$ 5,194	17
18					18
19					19
20	Allocated from Maestro			2,148	20
21	TOTAL		\$ 480	\$ 7,342	21

10. Effective dates of current rental agreement:

Beginning 12/31/2011
Ending 12/31/2021

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2021	\$ 540,007
13.	12/31/2022	\$ 550,807
14.	12/31/2023	\$ 561,824

* 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 MAPLE CREST
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2020

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	13,083
Nursing Equipment	5,260
Building Equipment	(505)
Office Equipment	24,794
Integra Allocation	(115)
Maestro Allocation	3,733
Total - Line 16	46,251

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)

		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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,618	\$ 332,472	\$	4,618	\$ 332,472	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		887	63,834		887	63,834	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,095	366,856		5,095	366,856	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				100,134		100,134	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2&7)					2,533		2,533	12
13	Other (specify): <u>See Sch 16A</u>	39(3)			109	7,883		109	7,883	13
14	TOTAL			\$	10,709	\$ 771,045	\$ 102,667	10,709	\$ 873,712	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 MAPLE CREST
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2020

Schedule 16A

Other Ancillary Services

Rental Description	Amount
I.V. Therapy Costs-Medicare A	5,686
I.V. Therapy Costs-Managed Care	824
Other Ancillary Costs-Medicare A	1,373
Total - Line 13	7,883

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$ 2,000	1
2	Cash-Patient Deposits	14,875	14,875	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 280,371)	956,660	956,660	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	8,654	8,654	6
7	Other Prepaid Expenses	76,068	76,068	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify):	-	-	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,058,257	\$ 1,058,257	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	1,774,681	13
14	Buildings, at Historical Cost	-	3,983,908	14
15	Leasehold Improvements, at Historical Cost	7,895	595,149	15
16	Equipment, at Historical Cost	333,565	392,978	16
17	Accumulated Depreciation (book methods)	(224,152)	(457,793)	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 (spec. Organiz. Costs)	-	14,822	22
23	Other(specify): See Schedule 17A	8,691,058	8,553,247	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,808,366	\$ 14,856,992	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,866,623	\$ 15,915,249	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 524,685	\$ 524,685	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	14,875	14,875	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	240,729	240,729	30
31	Accrued Taxes Payable (excluding real estate taxes)	135,661	135,661	31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,514	55,700	32
33	Accrued Interest Payable	-	-	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,872,519	1,872,519	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,841,983	\$ 2,844,169	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	834,874	6,555,971	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)	\$ 834,874	\$ 6,555,971	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,676,857	\$ 9,400,140	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,189,766	\$ 6,515,109	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,866,623	\$ 15,915,249	48

*(See instructions.)

Facility Name: SYMPHONY MAPLE CREST
IDPH License ID Number:0051839
Fiscal Year End: 12/31/2020

Schedule 17A

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

Description	Operating	After Consolidation
Due To/From - Crestwood LLC	588,500	588,500
Due To/From - Decatur	236,000	236,000
Due To/From - Deerbrook LLC	181,000	181,000
Due To/From - Evanston Healthcare LLC	(64,308)	(64,308)
Due To/From - Jackson Square LLC	720	720
Due To/From - Maple Ridge LLC	95,000	95,000
Due To/From - McKinley LLC	(47,994)	(47,994)
Due To/From - Sycamore LLC	24,400	24,400
Due To/From - Tillers	12,429	12,429
Due To/From - California Gardens Nursing and Reha	276	276
Due To/From - Orchard Valley	24,580	24,580
Due To/From - Chesterton LLC	198,000	198,000
Due To/From - Glendale	115,775	115,775
Due To/From - Symphony Healthcare	7,230,785	7,092,974
Due To/From - Symphony Financial Services	6,694	6,694
Due To/From - Symdiana Healthcare	283,500	283,500
Due To/From - Maestro	49,150	49,150
Total - Line 23	8,934,507	8,796,696

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

Description	Operating	After Consolidation
Cash	5,638	5,638
CSA I/C Related/Party Due To/From Accts	(79,144)	(79,144)
Due To/From - Northwoods LLC	(220,699)	(220,699)
Due To/From - Symcare Healthcare	731,250	731,250
Due To/From - Nucare Services	9,608	9,608
Resident Receivable Balance	296,116	296,116
Accrued Payables	5,967	5,967
Accrued Payables - Professional Fees	32,410	32,410
Accrued Payables - Health Insurance	2,492	2,492
Accrued Payable - Dental Insurance	(846)	(846)
Accrued Payables - Vision Insurance	(92)	(92)
Accrued Payables - Life Insurance	16,633	16,633
Accrued Payables - Short Term Disability	(15,139)	(15,139)
Fringe Benefits - Flow Through	577	577
Accrued Payables - WC/GL Insurance	42,732	42,732
Accrued Payables - OIG Audit	21,786	21,786
Accrued Payables - Bed Taxes Add'l	5,384	5,384
Accrued Payables - Management Fees	516,044	516,044
Accrued Payables - Sales Tax	328	328
Sales Tax Payable - Manual	214	214
Deferred Income	299,342	299,342
Total - Line 36	1,670,601	1,670,601

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,644,274	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,644,274	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,545,492	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)	\$ 1,545,492	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)	\$ 6,189,766	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SYMPHONY MAPLE CREST

0051839

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	\$ 7,442,786	1
2	Discounts and Allowances for all Levels	(1,278,760)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,164,026	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	1,470,844	6
7	Oxygen	-	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,470,844	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	586,687	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	137,439	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	21,505	19
20	Radiology and X-Ray	6,325	20
21	Other Medical Services	4,286	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 756,242	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	32	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	6,350	28
28a		-	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,350	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,397,494	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	869,036	31
32	Health Care	2,562,799	32
33	General Administration	1,585,375	33
	B. Capital Expense		
34	Ownership	861,846	34
	C. Ancillary Expense		
35	Special Cost Centers	788,312	35
36	Provider Participation Fee	184,634	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,852,002	40
41	Income before Income Taxes (line 30 minus line 40)**	1,545,492	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,545,492	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,749,663	44
45	Private Pay - Net Inpatient Revenue	1,347,875	45
46	Medicare - Net Inpatient Revenue	1,687,809	46
47	Other-(specify) <u>MAIP</u>	195,408	47
48	Other-(specify) <u>Managed Care/Veteran/Hospice</u>	183,271	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,164,026	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.

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	2,053	2,181	\$ 101,546	\$ 46.55	1
2	Assistant Director of Nursing	2,069	2,213	86,596	39.12	2
3	Registered Nurses	13,635	14,946	499,576	33.43	3
4	Licensed Practical Nurses	17,536	20,611	550,778	26.72	4
5	CNAs & Orderlies	53,491	58,765	912,783	15.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,907	5,233	80,562	15.39	10
11	Social Service Workers	1,984	2,184	43,604	19.97	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,160	73,746	34.14	13
14	Head Cook	4,187	4,560	58,827	12.90	14
15	Cook Helpers/Assistants	9,853	10,480	116,670	11.13	15
16	Dishwashers					16
17	Maintenance Workers	2,150	2,454	50,269	20.48	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,016	2,160	35,318	16.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,498	5,813	126,256	21.72	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	2,797	3,186	52,185	16.38	31
32	Other Health Care MDS	2,324	2,500	97,158	38.86	32
33	Other(specify) Admission	6,634	6,954	99,247	14.27	33
34	TOTAL (lines 1 - 33)	133,206	146,401	\$ 2,985,121 *	\$ 20.39	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,298	1(3)	35
36	Medical Director	Monthly	21,484	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	58	10(7)	38
39	Pharmacist Consultant	Monthly	8,273	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	1,094	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 39,207		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 & ID Number		SYMPHONY MAPLE CREST		STATE OF ILLINOIS		# 0051839		Report Period Beginning:		1/1/2020		Page 21		Ending: 12/31/2020									
XIX. SUPPORT SCHEDULES																							
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions															
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount									
Renee Woods		Administrator		0		\$ 35,318		Workers' Compensation Insurance		\$ 62,196		IDPH License Fee		\$ 1,420									
								Unemployment Compensation Insurance		9,659		Advertising: Employee Recruitment		4,647									
								FICA Taxes		216,240		Health Care Worker Background Check											
								Employee Health Insurance		139,767		(Indicate # of checks performed 150)		1,796									
								Employee Meals				Patient Background Checks		118 1,413									
								Illinois Municipal Retirement Fund (IMRF)*				Miscellaneous Licenses & Fees		1,609									
												Health Care Council of Illinois		13,399									
TOTAL (agree to Schedule V, line 17, col. 1)								Employee Benefits - Other				9,172				Miscellaneous Dues & Subscriptions				2,041			
(List each licensed administrator separately.)				\$ 35,318				Employees' Physical Exams				12,701				Lobbying offset and Chamber of commerce				(6,699)			
B. Administrative - Other								Employee 401k				7,210				Allocated from Maestro				2,784			
Description				Amount												Less: Public Relations Expense ()							
Management Fees (Eliminated in Col. 7)				\$ 351,317												Non-allowable advertising ()							
																Yellow page advertising ()							
								TOTAL (agree to Schedule V, line 22, col.8)				\$ 456,945				TOTAL (agree to Sch. V, line 20, col. 8)				\$ 22,410			
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 351,317				E. Schedule of Non-Cash Compensation Paid to Owners or Employees								G. Schedule of Travel and Seminar**							
(Attach a copy of any management service agreement)								Description				Line #		Amount		Description				Amount			
C. Professional Services								N/A								Out-of-State Travel				\$			
Vendor/Payee		Type		Amount																			
See Schedule 21C		Various		\$ 237,473																			
TOTAL (agree to Schedule V, line 19, column 3)				\$ 237,473				TOTAL				\$		Seminar Expense				256					
(For legal fee disclosure, see page 39 of instructions)														Allocated from Maestro				153					
														Entertainment Expense ()									
														(agree to Sch. V, line 24, col. 8)									
														TOTAL				\$ 409					

* Attach copy of IMRF notifications

**See instructions.

Facility Name: SYMPHONY MAPLE CREST
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ABILITY CHOICE	Secure Exchange Managed Services	(38)
Allscripts LLC	Referral System	1,713
Alteryx, Inc.	Data Analytics	1,349
apploi-applicant tracing system	apploi-applicant tracking system	76
CATS- APPLICANT TRACKING SYSTEM	Applicant Tracking System	404
CDW	IT Support	685
Comcast Cable	Internet and cable	29,600
Creative Technology Solutions	IT Support	3,001
Darktrace Limited	Cyber Security	1,203
Data Robot-Cloud Professional	Data Storage	863
EMMI Solutions	Data Analytics	(146)
Enquire Solutions LLC	Marketing solution	452
ENTERPRISE IMMUNE SYSTEM	Immune System tracker	86
enVista, LLC	IT Support	328
FORMATION HEALTHCARE	Monthly Subscription Fee	472
Health Data Systems Inc	Programming	1,829
Intellicomp Technologies Inc.	IT Support	21,684
IntelliLogix	IT Support	197
KRONOS SUPPORT SERVICES	Payroll service	4,163
Managed Care Group LLC	IT Support	6,882
Microsoft Corp	Computer service	2,432
Navigator Group Purchasing, In	Data Analytics	123
Nexuscomm, LLC	Phone/fax service	5,150
Pay access	Payroll	62
PointClickCare Technologies Inc.	Cloud based software and services	20,618
PRIME CARE TECHNOLOGIES	PBJ Reporting Module Access Fee	2,520
Reputation.com, Inc.	Online Reputation Management	414
Reside Admissions LLC	Admission Process Consulting	1,924
Scott Norton	HR Services	215
Sprout Social Inc.	Social Media Management	986
Striv Technologies LLC dba Striv360	IT Support	2,400
Team TSI Corporation	Collection	2,030
Telemedicine Solutions, LLC	Wound Rounds Care	6,193
Third Eye Health Inc.	Data Analytics	4,892
Wencel	Branding	4,414
RSM	Accounting	38,026
McCabe, Kirshner P.C.	Legal Counsel	4,400
MKB	Legal Counsel	36,208
Stone, Pogrund & Korey LLC	Collection, guardianship etc	1,719
ADP, LLC	Payroll service	683
Advanced Care Medical Specialist	Infectious Disease Consult	334
Amex-Credit Card Fees	Misc.	(108)
Boone County Government	Lease rental	17,188
Corporation Service Company	Annual Filing	846
Language Line Services	Language lesson	15
MTS Consulting, LLC	Tax Consulting	1,002
National Datacare Corporation	trust service charge	3,688
Personnel Planners, Inc	Qtrly Unemployment Claims	1,080
SB2	Legal Fees -appeal Medicaid/Medicare cla	2,203
Transworld Systems Inc		1,012
Total (agree to Schedule V, line 19, column 3)		237,473
Allocated from Management Company Legal Fees		
Allocated from Management Company Professional Services		15,196
Less: Non-Allowable Legal Fees		(1,719)
Less: Non-Allowable Branding/Appeals		(7,069)
Total (agree to Schedule V, line 19, column 8)		243,881

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 - \$13,399
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(2)
- (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? No
If YES, give effective date of lease. N/A
- (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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 184,634
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? 5
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? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.