

		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>0051763</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Symphony of Orchard Valley</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>2330 W Galena Blvd</u> <u>Aurora</u> <u>60506</u>																									
Number City Zip Code																									
County: <u>Kane</u>																									
Telephone Number: <u>(630) 896-4686</u> Fax # <u>(630) 896-7868</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067												
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	(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067																								
Date of Initial License for Current Owners: <u>01/01/2012</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></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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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																									
Email Address: _____																									

Facility Name & ID Number Symphony of Orchard Valley# 0051763

Report Period Beginning:

1/1/2020Ending: 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>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</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>203</u>	TOTALS	<u>203</u>	<u>74,298</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>33,310</u>	<u>3,974</u>	<u>8,162</u>	<u>45,446</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>33,310</u>	<u>3,974</u>	<u>8,162</u>	<u>45,446</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.17%

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?

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

01/01/2012

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

YES ☒

Date

12/31/2011NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified203

and days of care provided

3,898

Medicare Intermediary

Wisconsin Physician Services (WPS)

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐

Tax Year:

12/31/2020

Fiscal Year:

12/31/2020

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

Facility Name & ID Number		Symphony of Orchard Valley				#	0051763		Report Period Beginning:		1/1/2020		Ending:		Page 3		12/31/2020	
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	9	10							
1	Dietary	345,804	24,631	22,998	393,433		393,433	917	394,350			1						
2	Food Purchase		249,351		249,351		249,351		249,351			2						
3	Housekeeping	-	531,578	-	531,578		531,578		531,578			3						
4	Laundry	-	26,046	3,897	29,943		29,943		29,943			4						
5	Heat and Other Utilities			240,118	240,118		240,118	1,703	241,821			5						
6	Maintenance	73,418	-	127,510	200,928		200,928	3,277	204,205			6						
7	Other (specify):* Mgmt alloc of benef	-	-	-				243	243			7						
8	TOTAL General Services	419,222	831,606	394,523	1,645,351		1,645,351	6,140	1,651,491			8						
	B. Health Care and Programs																	
9	Medical Director	-	-	24,000	24,000		24,000		24,000			9						
10	Nursing and Medical Records	4,416,238	205,874	162,121	4,784,233		4,784,233	142,159	4,926,392			10						
10a	Therapy	-	-	-								10a						
11	Activities	101,362	-	-	101,362		101,362		101,362			11						
12	Social Services	61,398	-	-	61,398		61,398		61,398			12						
13	CNA Training	-	-	-								13						
14	Program Transportation	-	-	-								14						
15	Other (specify):* Mgmt alloc of benef	-	-	-				41,063	41,063			15						
16	TOTAL Health Care and Programs	4,578,998	205,874	186,121	4,970,993		4,970,993	183,222	5,154,215			16						
	C. General Administration																	
17	Administrative	132,550	-	552,148	684,698		684,698	(552,148)	132,550			17						
18	Directors Fees			-								18						
19	Professional Services			356,320	356,320		356,320	18,761	375,081			19						
20	Dues, Fees, Subscriptions & Promotions			52,746	52,746		52,746	(9,241)	43,505			20						
21	Clerical & General Office Expenses	227,145	15,122	83,259	325,526		325,526	139,163	464,689			21						
22	Employee Benefits & Payroll Taxes			897,025	897,025		897,025		897,025			22						
23	Inservice Training & Education			-								23						
24	Travel and Seminar			101	101		101	360	461			24						
25	Other Admin. Staff Transportation		-	5,467	5,467		5,467	6,569	12,036			25						
26	Insurance-Prop.Liab.Malpractice			671,021	671,021		671,021	1,218	672,239			26						
27	Other (specify):* Mgmt alloc of benef			-				28,619	28,619			27						
28	TOTAL General Administration	359,695	15,122	2,618,087	2,992,904		2,992,904	(366,699)	2,626,205			28						
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,357,915	1,052,602	3,198,731	9,609,248		9,609,248	(177,337)	9,431,911			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			113,552	113,552		113,552	42,110	155,662			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			10,734	10,734		10,734	13,773	24,507			32
33	Real Estate Taxes			145,551	145,551		145,551	4,472	150,023			33
34	Rent-Facility & Grounds			1,129,199	1,129,199		1,129,199	5,885	1,135,084			34
35	Rent-Equipment & Vehicles			98,366	98,366		98,366	8,695	107,061			35
36	Other (specify):*			-								36
37	TOTAL Ownership			1,497,402	1,497,402		1,497,402	74,935	1,572,337			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	14,995	14,995		14,995		14,995			38
39	Ancillary Service Centers	-	98,694	1,816,337	1,915,031		1,915,031	(300)	1,914,731			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			363,645	363,645		363,645		363,645			42
43	Other (specify):* Non-Allowable Cos	195,118	-	501,513	696,631		696,631	(696,631)				43
44	TOTAL Special Cost Centers	195,118	98,694	2,696,490	2,990,302		2,990,302	(696,931)	2,293,371			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,553,033	1,151,296	7,392,623	14,096,952		14,096,952	(799,333)	13,297,619			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.)

	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	(28,398)	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	(17,500)	30		9
10	Interest and Other Investment Income	(10,734)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,312)	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	(11,903)	43		18
19	Entertainment	(42)	43		19
20	Contributions	(4,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(801,786)	43		24
25	Fund Raising, Advertising and Promotional				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	109,434	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (766,741)		\$	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)	(32,592)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (32,592)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (799,333)		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		Sch. V Line	
	Amount	Reference	
1	Nonallowable marketing events	\$ (91,905)	43 1
2	Laboratory Costs	(22,298)	43 2
3	X-Ray Costs	(9,860)	43 3
4	Theft and Damage Loss	(1,147)	43 4
5	Trust Overcharges	19	43 5
6	Lobbying Expense	(15,814)	20 6
7	Admissions Salary	(65,254)	43 7
8	Director of Customer Experience	(43,336)	43 8
9	Non-allowable branding expense	(13,292)	19 9
10	Other income	(8,954)	21 10
11	Non-allowable legal	(3,817)	19 11
12	Gain/Loss On Sale	(438,200)	43 12
13	Gain/Loss Deferred Rent	532,465	43 13
14	Closing Costs & Adjustment to PY	290,827	43 14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
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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	109,434	49

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	\$	Symphony of Aurora Propco	100	\$ 24,474	\$ 24,474	1
2	V	32	Amortization		Symphony of Aurora Propco	100	2,827	2,827	2
3	V	30	Depreciation		Symphony of Aurora Propco	100	34,753	34,753	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			\$			\$ 62,054	\$ * 62,054	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	100%	\$ 917	\$ 917	15
16	V	5	Utilities		Maestro Consulting Services	100%	1,703	1,703	16
17	V	6	Maintenance Salaries		Maestro Consulting Services	100%	0		17
18	V	6	Maintenance Expenses		Maestro Consulting Services	100%	3,277	3,277	18
19	V	7	Employee Benefits - Maintenance		Maestro Consulting Services	100%	243	243	19
20	V	10	Clinical Salaries		Maestro Consulting Services	100%	142,753	142,753	20
21	V	10	Contract Nursing		Maestro Consulting Services	100%	137	137	21
22	V	15	Employee Benefits - Clinical		Maestro Consulting Services	100%	41,063	41,063	22
23	V	17	Administrative - Other	552,148	Maestro Consulting Services	100%	0	(552,148)	23
24	V	19	Professional Fees		Maestro Consulting Services	100%	35,869	35,869	24
25	V	20	Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100%	6,573	6,573	25
26	V	21	Clerical & General Salaries		Maestro Consulting Services	100%	99,493	99,493	26
27	V	21	Clerical & General Expenses		Maestro Consulting Services	100%	48,624	48,624	27
28	V	24	Seminars and Education		Maestro Consulting Services	100%	360	360	28
29	V	25	Transportation		Maestro Consulting Services	100%	6,569	6,569	29
30	V	26	Insurance		Maestro Consulting Services	100%	1,218	1,218	30
31	V	27	Employee Benefits - Administrative		Maestro Consulting Services	100%	28,619	28,619	31
32	V	30	Depreciation		Maestro Consulting Services	100%	24,857	24,857	32
33	V	32	Interest Expense		Maestro Consulting Services	100%	33	33	33
34	V	33	Real Estate Tax		Maestro Consulting Services	100%	4,472	4,472	34
35	V	34	Building Rental		Maestro Consulting Services	100%	3,058	3,058	35
36	V	35	Equipment Rental		Maestro Consulting Services	100%	8,812	8,812	36
37	V	35	Auto Lease		Maestro Consulting Services	100%	5,070	5,070	37
38	V								38
39	Total			\$ 552,148			\$ 463,720	\$ * (88,428)	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	\$ 4,875	Integra Healthcare Equipment, LLC	19%	\$ 4,144	\$ (731)	15
16	V	35	Rent-Equipment & Vehicles	34,581	Integra Healthcare Equipment, LLC	19%	29,394	(5,187)	16
17	V	39	Oxygen	1,999	Integra Healthcare Equipment, LLC	19%	1,699	(300)	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			\$ 41,455			\$ 35,237	\$ * (6,218)	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	Worker's Compensation	\$ 115,517	Maple Leaf Insurance	100%	\$ 115,517	\$	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			\$ 115,517			\$ 115,517	\$ * 0	39

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

Facility Name & ID Number

Symphony of Orchard Valley

0051763

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	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Symphony HMG, LLC	0.01	Symphony Crestwood, LLC D/B/A Symphony of Crestwood	Crestwood	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3			Symphony Deerbrook, LLC D/B/A Symphony of Joliet	Joliet	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4			Symphony Maple Crest, LLC D/B/A Maple Crest	Belvidere	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5			Symphony Northwoods, LLC D/B/A Northwood	Belvidere	Maestro Consulting Se	Lincolnwood	Mgmt. Co.	5
6			Symphony Evanston Healthcare	Evanston				6
7			Symphony of Dyer	Indiana				7
8			Symphony of Crown Point	Indiana				8
9			Symphony of Chesterton	Indiana				9
10			Woodcare V Inc	Brighton, MI				10
11			Cliffside Company LLC	St. Joseph, MI				11
12			Symphony Applewood	Woodhaven, MI	7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13			Symphony Linden	Linden, MI	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Symphony Tri-Cities	Bay City, MI	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15					Seasons Hospice	Park Ridge	Hospice *	15
16					JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Sycamore Village	Swansea	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Symphony of Aria	Hillside	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Symphony at 87th Street	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Symphony at Midway	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Symphony at Tillers	Oswego	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Symphony at Bronzeville	Chicago	Lifemed Pharmacy	Bensenville	Pharmacy	22
23			Symphony of Buffalo Grove	Buffalo Grove	ConcertoHealth	Chicago	Clinical Services	23
24			Symphony of Chicago West	Chicago				24
25			Symphony of Glendale	Glendale, Wiscosin	* No expense paid by h			25
26			Symphony of Hanover Park	Hanover Park	entity, therefore no pa			26
27			Symphony of Lincoln Park	Chicago	** No expense of this r			27
28			Symphony of Morgan Park	Chicago	allocated to homes			28
29			Symphony of South Shore	Chicago				29
30			Symphony Residences of Lincoln Park	Chicago				30

Facility Name & ID Number Symphony of Orchard Valley # 0051763 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Symphony of Orchard Valley # 0051763 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2			N/A							2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Symphony of Orchard Valley# 0051763

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 ☐

Name of Related Organization

Maestro Consulting Services

Street Address

7257 N. Lincoln Ave,

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 933-2600

Fax Number

()

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	Bed Days Available	1,642,974	27	\$ 20,270	\$ 19,367	74,298	\$ 917	1
2	5	Utilities	Bed Days Available	1,642,974	27	37,663		74,298	1,703	2
3	6	Maintenance Salaries	Bed Days Available	1,642,974	27			74,298		3
4	6	Maintenance Expenses	Bed Days Available	1,642,974	27	72,471		74,298	3,277	4
5	7	Employee Benefits - Maintenance	Bed Days Available	1,642,974	27	5,383		74,298	243	5
6	10	Clinical Salaries	Bed Days Available	1,642,974	27	3,156,734	3,156,734	74,298	142,753	6
7	10	Contract Nursing	Bed Days Available	1,642,974	27	3,034		74,298	137	7
8	15	Employee Benefits - Clinical	Bed Days Available	1,642,974	27	908,028		74,298	41,063	8
9	17	Administrative - Other	Bed Days Available	1,642,974	27			74,298		9
10	19	Professional Fees	Bed Days Available	1,642,974	27	793,188		74,298	35,869	10
11	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	1,642,974	27	145,343		74,298	6,573	11
12	21	Clerical & General Salaries	Bed Days Available	1,642,974	27	2,200,120	2,200,120	74,298	99,493	12
13	21	Clerical & General Expenses	Bed Days Available	1,642,974	27	1,075,235		74,298	48,624	13
14	24	Seminars and Education	Bed Days Available	1,642,974	27	7,970		74,298	360	14
15	25	Transportation	Bed Days Available	1,642,974	27	145,272		74,298	6,569	15
16	26	Insurance	Bed Days Available	1,642,974	27	26,926		74,298	1,218	16
17	27	Employee Benefits - Administrative	Bed Days Available	1,642,974	27	632,860		74,298	28,619	17
18	30	Depreciation	Bed Days Available	1,642,974	27	549,679		74,298	24,857	18
19	32	Interest Expense	Bed Days Available	1,642,974	27	738		74,298	33	19
20	33	Real Estate Tax	Bed Days Available	1,642,974	27	98,893		74,298	4,472	20
21	34	Building Rental	Bed Days Available	1,642,974	27	67,631		74,298	3,058	21
22	35	Equipment Rental	Bed Days Available	1,642,974	27	194,869		74,298	8,812	22
23	35	Auto Lease	Bed Days Available	1,642,974	27	112,113		74,298	5,070	23
24										24
25	TOTALS					\$ 10,254,420	\$ 5,376,221		\$ 463,720	25

Facility Name & ID Number Symphony of Orchard Valley # 0051763 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			\$	\$		\$ 4,144	1
2	35	Rent-Equipment & Vehicles	Direct Allocation						29,394	2
3	39	Oxygen	Direct Allocation						1,699	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					\$	\$		\$ 35,237	25

Facility Name & ID Number Symphony of Orchard Valley # 0051763 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	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	Worker's Compensation	Direct Allocation			\$	\$		\$ 115,517	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					\$	\$		\$ 115,517	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	\$ 339	1	
2	LifeMed	X		Pharmacy Services	38,731	1/1/18	6,197,033	107,340	1/1/2024	0.075	9,108	2	
3												3	
4	Integra	X		Medical Supplies/Rental	50,680	07/1/19	1,162,530	3,987	6/30/2021	0.0438	359	4	
5	White Oak Healthcare Finance		X	Mortgage		12/10/2020	13,512,766	13,512,766	12/9/2023	Libor+6%	24,474	5	
	Working Capital												
6	State of Illinois		X	Advance Payment		5/1/2019	1,909,300	1,909,300	8/1/2021			6	
7	WPS		X	Medicare AAP	30,914	4/3/2020	741,925	741,925	4/3/2023			7	
8	CIBC Bank USA		X	Payroll & Oper Exp	47,778.08	6/23/2020	1,146,674	1,146,674	6/23/2022	0.01		8	
9	TOTAL Facility Related				\$235,546.70		\$ 26,840,565	\$ 17,421,992			\$ 34,280	9	
	B. Non-Facility Related*												
10	Cyber Ins										115	10	
11	Worthy Ins										813	11	
12								Interest Income Offset			(10,734)	12	
13								Allocated from Maestro			33	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (9,773)	14	
15	TOTALS (line 9+line14)						\$ 26,840,565	\$ 17,421,992			\$ 24,507	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.			\$	141,942	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	\$	147,361	2
3. Under or (over) accrual (line 2 minus line 1).			\$	5,419	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	140,132	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.		4,472	
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.			\$	150,023	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	108,269	8	
		2016	116,961	9	
		2017	132,187	10	
		2018	139,158	11	
		2019	147,361	12	
2020 Tax Accrual :					
FY19 Taxes \$147,361 X .9509% = \$140,132					

	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.

FACILITY NAME	<u>Symphony Countryside, LLC D/B/A Countryside Care Centre</u>	COUNTY	<u>Kane</u>
---------------	--	--------	-------------

CONTACT PERSON REGARDING THIS REPORT Ari Krupp

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

A. Square Feet: 59,536

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).
N/A

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: 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	Resident Care	-	2020	\$ 2,127,801	1
2	Allocated from 7257			7235	2
3	TOTALS			\$ 2,135,036	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	203		2020		\$ 11,401,195	\$	30	\$ 33,713	\$ 33,713	\$ 33,713	4
5											5
6											6
7											7
8	Allocated from Maestro 7257			2004	65,119		39	1,861	1,861	31,862	8
	Improvement Type**										
9	Architectural fees, contractor fees, paint, remove wallpaper,			2013	198,047	9,902	20	9,902		79,217	9
10	install flooring, demo, carpentry, drywall, install wallpaper										10
11	First Floor										11
12	Demo/carpentry/drywall, acoustical ceiling, interior electrical			2013	116,913	5,846	20	5,846		46,767	12
13	alarms, painting, wall covering, floor covering, add 3 heads										13
14	contractor fees - First Floor and Dining Room										14
15	Interior painting, replace storefront glass, wall and floor			2013	22,173	1,110	20	1,109	(1)	8,691	15
16	coverings - First Floor										16
17	Repiped water line to 3 compartments			2013	2,630	132	20	132		1,022	17
18	Demo/carpentry/drywall, permit, contractor fees - First Floor			2013	54,915	2,746	20	2,746		21,510	18
19	Interior electrical alarms			2013	16,460	823	20	823		6,447	19
20	Exterior demo/carpentry, interior elec/alarms, plumbing,			2013	50,619	2,531	20	2,531		19,615	20
21	open office, engineering - First Floor & Dining Room										21
22	Carpet removal - Nurses station tie back in all vct			2013	10,856	543	20	543		4,208	22
23	Roofing			2013	10,000	500	20	500		3,875	23
24	Lounge 500 - New Carpet			2013	3,100	443	7	149	(294)	3,100	24
25	Demo/carpentry/drywall, electrical, glass, demo brick &			2013	303,589	15,179	20	15,179		114,629	25
26	rebuild around windows, engineering, besam swing door,										26
27	painting, modified, bitumen, ridge vent, aluminum soffit,										27
28	architecture fees, stucco molding, contractors fees -										28
29	First Floor, Spa Room, Rear Entry Vestibule, Exterior of Building										29
30	Fencing in patio			2013	2,922	195	15	195		1,444	30
31	Electircal work for office			2013	4,391	219	20	219		1,607	31
32	Demo/carpentry/drywall, window wall tape & mud, saw cut			2013	49,040	2,452	20	2,452		17,775	32
33	concrete, excavation, rough in & frame roof & rear vestibule,										33
34	steel posts, besam swing door, contractors fees - Rear Vestibule										34
35	& Second Floor										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 of Orchard Valley

0051763

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	Painting/Carpentry - Entry & Second Floor	2013	\$ 13,180	\$ 1,882	7	\$ 1,416	\$ (466)	\$ 13,180	37
38	Demo/Carpentry/Drywall, exterior demo, emergency	2013	53,564	2,679	20	2,679		18,975	38
39	power, electrical, gen cont fees-Entryway & Second Floor								39
40	Painting/Carpentry - Office & Back Entrance	2013	1,980	283	7	259	(25)	1,980	40
41	Roof Garden	2013	8,595	573	15	573		4,057	41
42									42
43	Facility Remodeling	2014	85,002	5,741	5-20	5,741		38,097	43
44	- Custom Hollow Metal Doors & Frames: Entrance								44
45	- Exterior Demo & Carpentry								45
46	- General Contracting								46
47	- Architecture Fees								47
48	- Install & Wire 2 Light Poles & Replace Ballards								48
49	- Interior Painting of Door Jambs & 3 Hallways								49
50	- Supplied & Installed Metal Flashing, Flat Roof, and								50
51	Cement Roof on 2nd Floor								51
52	- Sealcoating Parking Lot								52
53	- Bipart Slide Door								53
54	- Repair and Install Grease Interceptor: Kitchen								54
55	- Enclose Top of W/Drywall in Closet: Resident Rooms								55
56	- Remove Vent and Install Piece of Sheet Metal in closets								56
57	- Tape and Install FRP								57
58	- Provide Door Coordinators on 8 doors								58
59									59
60	Code-Compliant Door Restrictor on 2-Stop Hydraulic Elevator	2015	3,300	165	20	165		963	60
61	New Overhang Roof, Replaced 12 Pieces of Metal Decking	2015	21,248	1,062	20	1,062		5,840	61
62	-Applied Patch to Wall Flashing								62
63									63
64	Window Treatments, Design Fee for Dialysis Unit	2015	4,409	220	20	220		1,137	64
65	Demo, Flooring, Electrical, plumbing, permits	2015	53,972	2,698	20	2,699	1	13,941	65
66	Signs & Banners Aluminum, Rebranded Facility	2015	20,164	1,008	20	1,008		5,095	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,577,382	\$ 58,930		\$ 93,719	\$ 34,789	\$ 498,744	70

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

Facility Name & ID Number Symphony of Orchard Valley

0051763

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	
1	Totals from Page 12A, Carried Forward		\$ 12,577,382	\$ 58,930		\$ 93,719	\$ 34,789	\$ 498,744	1
2	Relocate sink waste, vent H&C water supply	2016	15,315	766	20	766		3,830	2
3	in 1 dialysis station								3
4	Install new stand alone wall mounted cooling	2016	20,741	1,037	20	1,037		5,099	4
5	system in mechanical room.								5
6	Design and IFPH Certification for dialysis unit	2016	12,694	635	20	635		2,910	6
7	Strip and refinish floors 2nd floor dining room	2016	6,434	919	7	919		3,906	7
8	Lounge, corridors, 1st floor patient rooms(9)								8
9	Therapy Room (2)								9
10	Roof Repairs-33,750 Square feet	2016	3,015	603	5	603		2,563	10
11									11
12	Galvanized Steel Insulate Mechanical Room	2017	2,531	182	14	182		712	12
13	Remodify Ductwork - Rooftop	2017	8,100	576	14	576		2,307	13
14	Remodify Ductwork - Rooftop	2017	8,100	576	14	576		2,259	14
15	A/C Heat Pump	2017	6,099	1,225	5	1,225		3,981	15
16	Install power unit ATS 3 phase-Electrical Room 1st floor	2018	5,516	394	14	394		1,197	16
17	Elevator-Door Edge Lobby	2018	3,250	232	14	232		643	17
18	Repair damaged asphalt in 22 areas in parking lot	2018	8,900	636	14	636		1,456	18
19	Phone System Upgrade - Full building 1st floor main	2018	45,831	6,547	7	6,547		13,112	19
20	Broken cast iron piping and combi oven	2018	6,019	301	20	301		903	20
21	New front sliding glass door	2019	10,347	690	15	690		985	21
22	Repair major holes parking lot 38 different areas	2019	7,200	480	15	480		713	22
23	Repair tiles in kitchen	2019	2,500	167	15	167		242	23
24	Remove and replace existing water heater basement	2019	23,600	1,573	15	1,573		2,019	24
25	Install ATA adapters for 216 single phone line extenstions	2019	37,287	5,327	7	5,327		8,974	25
26	for resident rooms. Cables, wall mounts, POE Switches								26
27	Southeast 1st floor ductwork	2020	18,750		15	625	625	625	27
28	Elevator-install 2 stainless steel surface mount hall buttons	2020	3,246		15	108	108	108	28
29	Flooring purchas, ceiling, lighting, 701-712,714-716 hallway	2020	148,500		15	4,950	4,950	4,950	29
30	Rooftop replacement	2020	18,990		15	633	633	633	30
31	Roottop blower AC replacement	2020	2,729		15	91	91	91	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,076	\$ 81,796		\$ 122,992	\$ 41,196	\$ 562,962	34

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

Facility Name & ID Number Symphony of Orchard Valley

0051763

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 13,003,076	\$ 81,796		\$ 122,992	\$ 41,196	\$ 562,962	1
2	Allocated from Maestro Consulting Services	2003	530		20	27	27	454	2
3	Allocated from Maestro Consulting Services	2004	10,754		20	536	536	8,989	3
4	Allocated from Maestro Consulting Services	2005	638		20	32	32	506	4
5	Allocated from Maestro Consulting Services	2006	865		20	43	43	621	5
6	Allocated from Maestro Consulting Services	2008	911		20	46	46	558	6
7	Allocated from Maestro Consulting Services	2009	14,669		20	732	732	8,516	7
8	Allocated from Maestro Consulting Services	2010	2,254		20	113	113	1,185	8
9	Allocated from Maestro Consulting Services	2011	122		20	6	6	60	9
10	Allocated from Maestro Consulting Services	2012	136		20	7	7	59	10
11	Allocated from Maestro Consulting Services	2014	1,696		20	85	85	560	11
12	Allocated from Maestro Consulting Services	2015	477		20	24	24	127	12
13	Allocated from Maestro Consulting Services	2016	2,090		20	104	104	708	13
14	Allocated from Maestro Consulting Services	2017	279		20	14	14	56	14
15	Allocated from Maestro Consulting Services	2020	452		20	11	11	11	15
16									16
17									17
18									18
19									19
20									20
21	Allocated from Maestro 7257	2015	1,026		20	68	68	365	21
22	Allocated from Maestro 7257	2005	5,937		10	213	213	4,991	22
23	Allocated from Maestro 7257	2004	1,294		10	65	65	1,068	23
24									24
25									25
26									26
27	Book depreciation tied to financial statements			23,122			(23,122)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,047,206	\$ 104,918		\$ 125,118	\$ 20,200	\$ 591,796	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	\$7,590	\$1,302	\$1,302	\$	5	\$1,613	71
72	Current Year Purchases	162,637	5,673	6,713	1,040	5	6,713	72
73	Fully Depreciated Assets	829,277					832,391	73
74	Allocated from Maestro	190,436		20,870	20,870		91,447	74
75	TOTALS	\$1,189,940	\$6,975	\$28,885	\$21,910		\$932,164	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	Patient Transportation	2008 Ford Van	2013	\$16,587	\$1,659	\$1,659	\$	10	\$12,856	76
77					-	-				77
78	Alloc. from Maestro Consult.			401	-	-			401	78
79					-	-				79
80	TOTALS			\$16,988	\$1,659	\$1,659	\$		\$13,257	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)	\$16,389,170	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$113,552	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$155,662	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$42,110	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,537,217	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$117,265	92
93			93
94			94
95		\$117,265	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	203	12/31/2011	\$ 1,129,199	10	10	3
4	Additions							4
5	Allocated from Maestro				3,058			5
6	Allocation from Propco Real Estate				2,827			6
7	TOTAL		203		\$ 1,135,084			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 .

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: \$ 101,991 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			\$	\$	17
18					18
19					19
20	Alloc. from Mgmt. Co.			5,070	20
21	TOTAL		\$	\$ 5,070	21

10. Effective dates of current rental agreement:

Beginning12/31/2011

Ending12/31/2021

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2021	\$ 1,233,664
13.	12/31/2022	\$ 1,258,337
14.	12/31/2023	\$ 1,283,504

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

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

Facility Name: Symphony of Orchard Valley
IDPH License ID Number: 0051763
Fiscal Year End: 12/31/2020

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	33,876
Nursing Equipment	1,774
Building Equipment	5,502
Office Equipment	57,214
Allocated from Maestro	8,812
Allocated from Integra	(5,187)
Total - Line 16	101,991

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

HFS 3745 (N-4-99)

IL478-2471

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	7,469	\$ 537,791	\$	7,469	\$ 537,791	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,132	153,528		2,132	153,528	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		14,942	1,075,848		14,942	1,075,848	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				96,695		96,695	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)					1,699		1,699	12
13	Other (specify): <u>See Schedule 16A</u>	39(3)			570	41,069		570	41,069	13
14	TOTAL			\$	25,114	\$ 1,808,236	\$ 98,394	25,114	\$ 1,906,630	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.

XIV. SPECIAL SERVICES
Line 13 Other

Account	Description	Amount
500103-MAID	Inhalation Therapy Costs-Medicaid	6,099
500103-MEDA	Inhalation Therapy Costs-Medicare A	7,139
500103-MNGD	Inhalation Therapy Costs-Managed Care	4,369
500103-PRVT	Inhalation Therapy Costs-Private	2,128
500113-MAID	I.V. Therapy Costs-Medicaid	6,422
500113-MEDA	I.V. Therapy Costs-Medicare A	9,099
500113-MNGD	I.V. Therapy Costs-Managed Care	5,480
500120-MEDA	Other Ancillary Costs-Medicare A	333
Cost		41,069

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,500	\$ 3,500	1
2	Cash-Patient Deposits	55,093	55,093	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,736,905)	2,668,260	2,668,260	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	15,638	15,638	6
7	Other Prepaid Expenses	31,121	31,121	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): Escrow Deposits	-	25,783	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,773,612	\$ 2,799,395	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	2,135,036	13
14	Buildings, at Historical Cost	-	11,466,314	14
15	Leasehold Improvements, at Historical Cost	-	1,580,892	15
16	Equipment, at Historical Cost	978,965	1,206,928	16
17	Accumulated Depreciation (book methods)	(871,581)	(1,537,217)	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 Org Costs	-	35,009	22
23	Other(specify): See Schedule 17A	5,284,120	5,056,742	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,391,504	\$ 19,943,704	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,165,116	\$ 22,743,099	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,730,418	\$ 1,730,418	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	54,645	54,645	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	402,029	402,029	30
31	Accrued Taxes Payable (excluding real estate taxes)	286,649	286,649	31
32	Accrued Real Estate Taxes(Sch.IX-B)	145,551	140,132	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	5,120,119	5,120,119	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,739,411	\$ 7,733,992	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,909,226	17,421,992	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)	\$ 3,909,226	\$ 17,421,992	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,648,637	\$ 25,155,984	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,483,521)	\$ (2,412,885)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,165,116	\$ 22,743,099	48

*(See instructions.)

Facility Name: Symphony of Orchard Valley
IDPH License ID Number: 0051763
Fiscal Year End: 12/31/2020

Schedule 17A

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

Description	After	
	Operating	Consolidation
Fixed Assets - Construction in Process	117,265	117,265
Due To/From - Aria LLC	1,727	1,727
Due To/From - Crestwood LLC	830,395	830,395
Due To/From - Decatur	231,000	231,000
Due To/From - Deerbrook LLC	97,403	97,403
Due To/From - Maple Ridge LLC	112,600	112,600
Due To/From - McKinley LLC	105,000	105,000
Due To/From - Northwoods LLC	100,000	100,000
Due To/From - Sycamore LLC	105,000	105,000
Due To/From - Symphony of Cal Gardens	49	49
Due To/From - Symphony ML	1,146,674	1,146,674
Due To/From - Symphony Healthcare	1,528,203	1,300,825
Due To/From - Symdiana Healthcare	127,000	127,000
Due To/From - Maestro	776,107	776,107
Total - Line 23	5,278,423	5,051,045

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

Description	After	
	Operating	Consolidation
Cash	24,950	24,950
Due To/From - Evanston Healthcare LLC	31,773	31,773
Due To/From - Jackson Square LLC	395	395
Due To/From - Maple Crest LLC	24,580	24,580
Due To/From - South Shore	240	240
Due To/From - Tillers	13,697	13,697
Due To/From - California Gardens Nursin	121,192	121,192
Due To/From - Symphony Financial Servi	575,135	575,135
Due To/From - Symcare Healthcare	1,764,047	1,764,047
Due To/From - Nucare Services	20,238	20,238
Resident Receivable Balance	504,435	504,435
Accrued Payables	64,278	64,278
Accrued Payables - Professional Fees	32,410	32,410
Accrued Payables - Health Insurance	39,705	39,705
Accrued Payable - Dental Insurance	(2,511)	(2,511)
Accrued Payables - Vision Insurance	(312)	(312)
Accrued Payables - Life Insurance	55,326	55,326
Accrued Payables - Short Term Disability	(51,442)	(51,442)
Fringe Benefits - Flow Through	403	403
Accrued Payables - WC/GL Insurance	227,249	227,249
Accrued Payables - OIG Audit	309,569	309,569
Accrued Payables - Bed Taxes Add'l	17,579	17,579
Accrued Payables - Management Fees	929,346	929,346
Accrued Payables - Sales Tax	854	854
Sales Tax Payable - Manual	528	528
Deferred Income	416,455	416,455
Total - Line 36	5,120,119	5,120,119

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,875,904)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	85,165	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,790,739)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(692,782)	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)	\$ (692,782)	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)	\$ (3,483,521)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Orchard Valley# 0051763Report Period Beginning: 1/1/2020Ending: 12/31/2020**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,885,184	1
2	Discounts and Allowances for all Levels	(2,249,109)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,636,075	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	3,251,074	6
7	Oxygen	13,098	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,264,172	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,148,093	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	144,079	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	51,310	19
20	Radiology and X-Ray	10,407	20
21	Other Medical Services	(471)	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,353,418	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	12,695	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,695	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income See SCH 19A	137,810	28
28a		-	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 137,810	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,404,170	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,645,351	31
32	Health Care	4,970,993	32
33	General Administration	2,992,904	33
	B. Capital Expense		
34	Ownership	1,497,402	34
	C. Ancillary Expense		
35	Special Cost Centers	2,626,657	35
36	Provider Participation Fee	363,645	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,096,952	40
41	Income before Income Taxes (line 30 minus line 40)**	(692,782)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (692,782)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,668,186	44
45	Private Pay - Net Inpatient Revenue	1,310,489	45
46	Medicare - Net Inpatient Revenue	1,466,438	46
47	Other-(specify) MAIP	(927,331)	47
48	Other-(specify) Managed Care/Veteran/Hospice	118,293	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,636,075	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.

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Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Preferred Insurance Provider Incentive - Revenue-	128,908
Other Income-Other	8,954
Total - Line 28	137,862

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	1,952	2,144	\$ 111,520	\$ 52.02	1
2	Assistant Director of Nursing	1,749	1,869	79,285	42.41	2
3	Registered Nurses	35,665	39,267	1,408,326	35.86	3
4	Licensed Practical Nurses	21,254	25,344	735,928	29.04	4
5	CNAs & Orderlies	85,471	103,708	1,862,576	17.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,736	2,011	40,580	20.18	9
10	Activity Assistants	3,507	3,828	60,782	15.88	10
11	Social Service Workers	2,101	2,238	61,398	27.44	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,136	59,401	27.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,779	6,202	90,696	14.62	15
16	Dishwashers	12,638	14,653	195,707	13.36	16
17	Maintenance Workers	2,201	2,588	73,418	28.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,880	2,080	132,550	63.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,865	1,954	40,156	20.55	23
24	Clerical	9,822	10,173	128,659	12.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,680	4,595	94,162	20.49	31
32	Other Health Care MDS Coordinator	3,304	3,606	124,441	34.51	32
33	Other(specify) SCH 20A	7,328	8,094	253,448	31.31	33
34	TOTAL (lines 1 - 33)	203,924	236,491	\$ 5,553,033 *	\$ 23.48	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 22,998	1(3)	35
36	Medical Director	Monthly	24,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	137	10(7)	38
39	Pharmacist Consultant	Monthly	15,528	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	8,101	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)		\$ 70,764		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	282	\$ 15,501	10(3)	50
51	Licensed Practical Nurses	336	16,784	10(3)	51
52	Certified Nurse Assistants/Aides	1,597	49,499	10(3)	52
53	TOTAL (lines 50 - 52)	2,215	\$ 81,784		53

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Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions	5,744	6,246	195,118	\$ 31.56
Human Resources Director	1,584	1,848	58,330	\$ 31.24
Total - Line 33 Other (specify):	7,328	8,094	253,448	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Brittany Herwig	Administrator	0%	\$ 132,550
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 132,550
B. Administrative - Other			
Description			Amount
Management Fees (Eliminated in Col. 7)			\$ 552,148
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 552,148
C. Professional Services			
Vendor/Payee	Type		Amount
See Schedule 21C			\$ 356,320
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 356,320
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 115,517
Unemployment Compensation Insurance			24,880
FICA Taxes			395,854
Employee Health Insurance			337,832
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Retirement			9,940
Employee Benefits - Other			9,919
Employees' Physical Exams			3,083
TOTAL (agree to Schedule V, line 22, col.8)			\$ 897,025
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			4,542
Health Care Worker Background Check (Indicate # of checks performed)	92		1,102
Patient Background Checks	141		1,697
Miscellaneous Licenses & Fees			8,574
Health Care Council of Illinois			31,627
Miscellaneous Dues & Subscriptions			3,214
Lobbying Expense			(15,814)
Allocated from Maestro			6,573
Less: Public Relations Expense			()
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 43,505
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			101
Allocated from Maestro			360
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 461

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Symphony of Orchard Valley
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Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ABILITY CHOICE	Secure Exchange Managed Services	(90)
Allscripts LLC	Referral System	3,787
Alteryx, Inc.	Data Analytics	2,917
apploi-applicant tracing system	apploi-applicant tracking system	76
CATS- APPLICANT TRACKING SYSTE	Applicant Tracking System	404
CDW	IT Support	1,617
Comcast Cable	Internet and cable	29,377
Creative Technology Solutions	IT Support	3,206
Darktrace Limited	Cyber Security	2,110
Data Robot-Cloud Professional	Data Storage	2,145
EMMI Solutions	Data Analytics	(346)
Enquire Solutions LLC	Marketing solution	1,067
ENTERPRISE IMMUNE SYSTEM	Immune System tracker	203
enVista, LLC	IT Support	774
FORMATION HEALTHCARE	Monthly Subscription Fee	1,114
Health Data Systems Inc	Programming	3,057
Intellicomp Technologies Inc.	IT Support	21,427
IntelliLogix	IT Support	464
KRONOS SUPPORT SERVICES	Payroll service	5,967
Managed Care Group LLC	IT Support	6,821
Microsoft Corp	Computer service	5,741
Navigator Group Purchasing, In	Data Analytics	291
Nexuscomm, LLC	Phone/fax service	4,300
PatientPing, Inc.	Care Collaboration	8,097
Pay access	Payroll	146
PointClickCare Technologies Inc.	Cloud based software and services	51,278
PRIME CARE TECHNOLOGIES	PBJ Reporting Module Access Fee	2,520
Reputation.com, Inc.	Online Reputation Management	978
Reside Admissions LLC	Admission Process Consulting	2,524
Scott Norton	HR Services	215
Sprout Social Inc.	Social Media Management	2,326
Striv Technologies LLC dba Striv360	IT Support	2,400
Team TSI Corporation	Collection	4,793
Telemedicine Solutions, LLC	Wound Rounds Care	15,012
Third Eye Health Inc.	Data Analytics	4,882
Wencel	Branding	7,024
RSM and Marcum		36,576
McCabe, Kirshner P.C.	Legal Counsel	15,117
MKB	Legal Counsel	59,669
Stone, Pogrund & Korey LLC	Collection, guardianship etc	20,614
Achieve Accreditation	Accreditation	9,024
ADP, LLC	Payroll service	1,613
Advanced Care Medical Specialist	Infectious Disease Consult	789
Corporation Service Company	Annual Filing	867
MTS Consulting, LLC	Tax Consulting	2,190
National Datacare Corporation	trust service charge	4,745
Personnel Planners, Inc	Qtrly Unemployment Claims	1,170
Petty Cash - Symphony of Orchard Valley	Misc.	122
SB2	Legal Fees -appeal Medicaid/Medicare cl	5,200
Total (agree to Schedule V, line 19, column 3)		356,320
Allocated from Management Company Professional Services		35,869
Less: Non-Allowable Legal Fees		(9,017)
Less: Non-Allowable Branding & Marketing		(8,091)
Total (agree to Schedule V, line 19, column 8)		375,081

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. HC Council of IL - \$31,627
- (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.

\$ 252

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.

\$ 363,645

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 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.