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| | | 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.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---------------------------------------|---|-------------------------------------|--------------------------------|--------------------------------|--------------------------------------|---------------------------------|---------------------------------|--------------------------------------|--------------------------------------|--|---|--|--|--|--|--|--------------------------------|--|--|--------------------------------------|--|--|---|----------------|--------------|----------------------|----------------------------|---------------|--|----------------|--------------|--|------------------------------|--|---|--|
| <p>I. IDPH License ID Number: <u>0053686</u></p> <p>Facility Name: <u>Symphony of Chicago West</u></p> <p>Address: <u>5130 W Jackson Blvd</u> <u>Chicago</u> <u>60644</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 921-8000</u> Fax # <u>(773) 921-3980</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>7/1/1994</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>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: _____</p> | <input type="checkbox"/> VOLUNTARY, NON-PROFIT | <input checked="" type="checkbox"/> PROPRIETARY | <input type="checkbox"/> GOVERNMENTAL | <input type="checkbox"/> Charitable Corp. | <input type="checkbox"/> Individual | <input type="checkbox"/> State | <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership | <input type="checkbox"/> County | IRS Exemption Code _____ | <input type="checkbox"/> Corporation | <input type="checkbox"/> Other _____ | | <input checked="" type="checkbox"/> "Sub-S" Corp. | | | <input type="checkbox"/> Limited Liability Co. | | | <input type="checkbox"/> Trust | | | <input type="checkbox"/> Other _____ | | <p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="2"></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"></td> <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 colspan="2">(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067</td> </tr> </table> <p>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</p> | 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 # (847)517-7067 | |
| <input type="checkbox"/> VOLUNTARY, NON-PROFIT | <input checked="" type="checkbox"/> PROPRIETARY | <input type="checkbox"/> GOVERNMENTAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Charitable Corp. | <input type="checkbox"/> Individual | <input type="checkbox"/> State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership | <input type="checkbox"/> County | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IRS Exemption Code _____ | <input type="checkbox"/> Corporation | <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input checked="" type="checkbox"/> "Sub-S" Corp. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Limited Liability Co. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Trust | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 # (847)517-7067 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Facility Name & ID Number Symphony of Chicago West

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

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

| | 1 | 2 | 3 | 4 | |
|---|------------------------------------|-----------------------------|------------------------------|--|---|
| | Beds at Beginning of Report Period | Licensure Level of Care | Beds at End of Report Period | Licensed Bed Days During Report Period | |
| 1 | <u>234</u> | Skilled (SNF) | <u>234</u> | <u>85,644</u> | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | | 2 |
| 3 | | Intermediate (ICF) | | | 3 |
| 4 | | Intermediate/DD | | | 4 |
| 5 | | Sheltered Care (SC) | | | 5 |
| 6 | | ICF/DD 16 or Less | | | 6 |
| 7 | <u>234</u> | TOTALS | <u>234</u> | <u>85,644</u> | 7 |

B. Census-For the entire report period.

| | 1 Level of Care | 2 3 4 5 Patient Days by Level of Care and Primary Source of Payment | | | | |
|----|--------------------|--|-------------|---------------|---------------|----|
| | | Medicaid Recipient | Private Pay | Other | Total | |
| 8 | SNF | <u>66,237</u> | <u>893</u> | <u>12,707</u> | <u>79,837</u> | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | | | | | 10 |
| 11 | ICF/DD | | | | | 11 |
| 12 | SC | | | | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | <u>66,237</u> | <u>893</u> | <u>12,707</u> | <u>79,837</u> | 14 |

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

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

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/01/1994

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

YES Date 07/01/1994 NO

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

YES NO If YES, enter number of beds certified 234 and days of care provided 3,181

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

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

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

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

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

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

V. COST CENTER EXPENSES (continued)

| | Capital Expense | Cost Per General Ledger | | | | Reclass-ification 5 | Reclassified Total 6 | Adjust-ments 7 | Adjusted Total 8 | FOR BHF USE ONLY | | |
|----|---|-------------------------|---------------|------------|------------|------------------------|----------------------------|-------------------|------------------------|------------------|----|----|
| | | Salary/Wage 1 | Supplies 2 | Other 3 | Total 4 | | | | | 9 | 10 | |
| | D. Ownership | | | | | | | | | | | |
| 30 | Depreciation | | | 117,214 | 117,214 | | 117,214 | 103,347 | 220,561 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | - | | | | | | | | 31 |
| 32 | Interest | | | 26,603 | 26,603 | | 26,603 | (17,533) | 9,070 | | | 32 |
| 33 | Real Estate Taxes | | | 675,557 | 675,557 | | 675,557 | 5,155 | 680,712 | | | 33 |
| 34 | Rent-Facility & Grounds | | | 2,779,813 | 2,779,813 | | 2,779,813 | 3,525 | 2,783,338 | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 131,330 | 131,330 | | 131,330 | 4,781 | 136,111 | | | 35 |
| 36 | Other (specify):* | | | - | | | | | | | | 36 |
| 37 | TOTAL Ownership | | | 3,730,517 | 3,730,517 | | 3,730,517 | 99,275 | 3,829,792 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | - | - | 27,265 | 27,265 | | 27,265 | (2,159) | 25,106 | | | 38 |
| 39 | Ancillary Service Centers | - | 205,419 | 1,263,952 | 1,469,371 | | 1,469,371 | (2,777) | 1,466,594 | | | 39 |
| 40 | Barber and Beauty Shops | - | - | - | | | | | | | | 40 |
| 41 | Coffee and Gift Shops | - | - | - | | | | | | | | 41 |
| 42 | Provider Participation Fee | | | 593,768 | 593,768 | | 593,768 | | 593,768 | | | 42 |
| 43 | Other (specify):* Non-Allowable Co | 220,925 | - | 818,413 | 1,039,338 | | 1,039,338 | (1,039,338) | | | | 43 |
| 44 | TOTAL Special Cost Centers | 220,925 | 205,419 | 2,703,398 | 3,129,742 | | 3,129,742 | (1,044,274) | 2,085,468 | | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 6,625,668 | 1,024,542 | 11,514,698 | 19,164,908 | | 19,164,908 | (1,419,580) | 17,745,328 | | | 45 |

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

| | | 1 | 2 | 3 | |
|----|---|----------------|----------------|-----------------|----|
| | NON-ALLOWABLE EXPENSES | Amount | Refer- ence | BHF USE ONLY | |
| 1 | Day Care | \$ | | \$ | 1 |
| 2 | Other Care for Outpatients | | | | 2 |
| 3 | Governmental Sponsored Special Programs | | | | 3 |
| 4 | Non-Patient Meals | | | | 4 |
| 5 | Telephone, TV & Radio in Resident Rooms | (23,055) | 43 | | 5 |
| 6 | Rented Facility Space | | | | 6 |
| 7 | Sale of Supplies to Non-Patients | | | | 7 |
| 8 | Laundry for Non-Patients | | | | 8 |
| 9 | Non-Straightline Depreciation | 74,694 | 30 | | 9 |
| 10 | Interest and Other Investment Income | (17,571) | 32 | | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds | | | | 11 |
| 12 | Non-Working Officer's or Owner's Salary | | | | 12 |
| 13 | Sales Tax | | | | 13 |
| 14 | Non-Care Related Interest | | | | 14 |
| 15 | Non-Care Related Owner's Transactions | | | | 15 |
| 16 | Personal Expenses (Including Transportation) | | | | 16 |
| 17 | Non-Care Related Fees | | | | 17 |
| 18 | Fines and Penalties | (45,669) | 43 | | 18 |
| 19 | Entertainment | | | | 19 |
| 20 | Contributions | (4,500) | 43 | | 20 |
| 21 | Owner or Key-Man Insurance | | | | 21 |
| 22 | Special Legal Fees & Legal Retainers | | | | 22 |
| 23 | Malpractice Insurance for Individuals | | | | 23 |
| 24 | Bad Debt | (699,954) | 43 | | 24 |
| 25 | Fund Raising, Advertising and Promotional | | | | 25 |
| 26 | Income Taxes and Illinois Personal Property Replacement Tax | (3,497) | 43 | | 26 |
| 27 | CNA Training for Non-Employees | | | | 27 |
| 28 | Yellow Page Advertising | | | | 28 |
| 29 | Other-Attach Schedule See PG5A | (303,327) | Var. | | 29 |
| 30 | SUBTOTAL (A): (Sum of lines 1-29) | \$ (1,022,879) | | \$ | 30 |

| BHF USE ONLY | | | | | | | |
|--------------|--|----|--|----|--|----|--|
| 48 | | 49 | | 50 | | 51 | |
| | | | | | | | |

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

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

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

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

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

Symphony of Chicago West

ID# 0053686

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

VII. RELATED PARTIES

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

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

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

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

| 1 Schedule V | 2 Line | 3 Cost Per General Ledger | | 5 Cost to Related Organization | | 6 Percent of Ownership | 7 Operating Cost of Related Organization | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|--------------|--------|---------------------------|----------|--------------------------------|--|------------------------|--|--|----|
| | | Item | 4 Amount | Name of Related Organization | | | | | |
| 1 | V | N/A | \$ | | | | \$ | \$ | 1 |
| 2 | V | | | | | | | | 2 |
| 3 | V | | | | | | | | 3 |
| 4 | V | | | | | | | | 4 |
| 5 | V | | | | | | | | 5 |
| 6 | V | | | | | | | | 6 |
| 7 | V | | | | | | | | 7 |
| 8 | V | | | | | | | | 8 |
| 9 | V | | | | | | | | 9 |
| 10 | V | | | | | | | | 10 |
| 11 | V | | | | | | | | 11 |
| 12 | V | | | | | | | | 12 |
| 13 | V | | | | | | | | 13 |
| 14 | Total | | \$ | | | | \$ | \$ * 0 | 14 |

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

VII. RELATED PARTIES (continued)

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

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

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|---------------------------------------|------------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | |
| 15 | V | 1 Dietary | \$ | Maestro Consulting Services | 100% | \$ 1,057 | \$ 1,057 | 15 |
| 16 | V | 5 Utilities | | Maestro Consulting Services | 100% | 1,963 | 1,963 | 16 |
| 17 | V | 6 Maintenance Salaries | | Maestro Consulting Services | 100% | 0 | | 17 |
| 18 | V | 6 Maintenance Expenses | | Maestro Consulting Services | 100% | 3,778 | 3,778 | 18 |
| 19 | V | 7 Employee Benefits - Maintenance | | Maestro Consulting Services | 100% | 281 | 281 | 19 |
| 20 | V | 10 Clinical Salaries | | Maestro Consulting Services | 100% | 164,552 | 164,552 | 20 |
| 21 | V | 10 Contract Nursing | | Maestro Consulting Services | 100% | 158 | 158 | 21 |
| 22 | V | 15 Employee Benefits - Clinical | | Maestro Consulting Services | 100% | 47,333 | 47,333 | 22 |
| 23 | V | 17 Administrative - Other | 880,191 | Maestro Consulting Services | 100% | 0 | (880,191) | 23 |
| 24 | V | 19 Professional Fees | | Maestro Consulting Services | 100% | 41,347 | 41,347 | 24 |
| 25 | V | 20 Dues, Fees, Subscriptions, Etc. | | Maestro Consulting Services | 100% | 7,576 | 7,576 | 25 |
| 26 | V | 21 Clerical & General Salaries | | Maestro Consulting Services | 100% | 114,687 | 114,687 | 26 |
| 27 | V | 21 Clerical & General Expenses | | Maestro Consulting Services | 100% | 56,049 | 56,049 | 27 |
| 28 | V | 24 Seminars and Education | | Maestro Consulting Services | 100% | 415 | 415 | 28 |
| 29 | V | 25 Transportation | | Maestro Consulting Services | 100% | 7,573 | 7,573 | 29 |
| 30 | V | 26 Insurance | | Maestro Consulting Services | 100% | 1,404 | 1,404 | 30 |
| 31 | V | 27 Employee Benefits - Administrative | | Maestro Consulting Services | 100% | 32,989 | 32,989 | 31 |
| 32 | V | 30 Depreciation | | Maestro Consulting Services | 100% | 28,653 | 28,653 | 32 |
| 33 | V | 32 Interest Expense | | Maestro Consulting Services | 100% | 38 | 38 | 33 |
| 34 | V | 33 Real Estate Tax | | Maestro Consulting Services | 100% | 5,155 | 5,155 | 34 |
| 35 | V | 34 Building Rental | | Maestro Consulting Services | 100% | 3,525 | 3,525 | 35 |
| 36 | V | 35 Equipment Rental | | Maestro Consulting Services | 100% | 10,158 | 10,158 | 36 |
| 37 | V | 35 Auto Lease | | Maestro Consulting Services | 100% | 5,844 | 5,844 | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ 880,191 | | | \$ 534,535 | \$ * (345,656) | 39 |

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

| 1 | | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|------|---------------------------|-----------|--------------------------------|----------------------|--|--|----|
| Schedule V | | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | |
| 15 | V | 38 | Transportation | \$ 14,394 | Lifeline Ambulance, LLC | 4% | \$ 12,235 | \$ (2,159) | 15 |
| 16 | V | | | | | | | | 16 |
| 17 | V | | | | | | | | 17 |
| 18 | V | | | | | | | | 18 |
| 19 | V | | | | | | | | 19 |
| 20 | V | | | | | | | | 20 |
| 21 | V | | | | | | | | 21 |
| 22 | V | | | | | | | | 22 |
| 23 | V | | | | | | | | 23 |
| 24 | V | | | | | | | | 24 |
| 25 | V | | | | | | | | 25 |
| 26 | V | | | | | | | | 26 |
| 27 | V | | | | | | | | 27 |
| 28 | V | | | | | | | | 28 |
| 29 | V | | | | | | | | 29 |
| 30 | V | | | | | | | | 30 |
| 31 | V | | | | | | | | 31 |
| 32 | V | | | | | | | | 32 |
| 33 | V | | | | | | | | 33 |
| 34 | V | | | | | | | | 34 |
| 35 | V | | | | | | | | 35 |
| 36 | V | | | | | | | | 36 |
| 37 | V | | | | | | | | 37 |
| 38 | V | | | | | | | | 38 |
| 39 | Total | | | \$ 14,394 | | | \$ 12,235 | \$ * (2,159) | 39 |

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

VII. RELATED PARTIES (continued)

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

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

| 1 | | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|------|---------------------------|------------|--------------------------------|----------------------|--|--|----|
| Schedule V | | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | |
| 15 | V | 10 | Dialysis | \$ 227,634 | Concerto Dialysis LLC | 20% | \$ 193,489 | \$ (34,145) | 15 |
| 16 | V | | | | | | | | 16 |
| 17 | V | | | | | | | | 17 |
| 18 | V | | | | | | | | 18 |
| 19 | V | | | | | | | | 19 |
| 20 | V | | | | | | | | 20 |
| 21 | V | | | | | | | | 21 |
| 22 | V | | | | | | | | 22 |
| 23 | V | | | | | | | | 23 |
| 24 | V | | | | | | | | 24 |
| 25 | V | | | | | | | | 25 |
| 26 | V | | | | | | | | 26 |
| 27 | V | | | | | | | | 27 |
| 28 | V | | | | | | | | 28 |
| 29 | V | | | | | | | | 29 |
| 30 | V | | | | | | | | 30 |
| 31 | V | | | | | | | | 31 |
| 32 | V | | | | | | | | 32 |
| 33 | V | | | | | | | | 33 |
| 34 | V | | | | | | | | 34 |
| 35 | V | | | | | | | | 35 |
| 36 | V | | | | | | | | 36 |
| 37 | V | | | | | | | | 37 |
| 38 | V | | | | | | | | 38 |
| 39 | Total | | | \$ 227,634 | | | \$ 193,489 | \$ * (34,145) | 39 |

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

Facility Name & ID Number

Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Symphony of Chicago West

#

0053686

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

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

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization MAESTRO CONSULTING SERVICES LLC
 Street Address 7257 N. LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

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

| 1 | 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 | Dietary | Bed Days Available | 1,642,974 | 27 | \$ 20,270 | \$ 19,367 | 85,644 | \$ 1,057 | 1 |
| 2 | 5 | Utilities | Bed Days Available | 1,642,974 | 27 | 37,663 | | 85,644 | 1,963 | 2 |
| 3 | 6 | Maintenance Salaries | Bed Days Available | 1,642,974 | 27 | | | 85,644 | | 3 |
| 4 | 6 | Maintenance Expenses | Bed Days Available | 1,642,974 | 27 | 72,471 | | 85,644 | 3,778 | 4 |
| 5 | 7 | Employee Benefits - Maintenance | Bed Days Available | 1,642,974 | 27 | 5,383 | | 85,644 | 281 | 5 |
| 6 | 10 | Clinical Salaries | Bed Days Available | 1,642,974 | 27 | 3,156,734 | 3,156,734 | 85,644 | 164,552 | 6 |
| 7 | 10 | Contract Nursing | Bed Days Available | 1,642,974 | 27 | 3,034 | | 85,644 | 158 | 7 |
| 8 | 15 | Employee Benefits - Clinical | Bed Days Available | 1,642,974 | 27 | 908,028 | | 85,644 | 47,333 | 8 |
| 9 | 17 | Administrative - Other | Bed Days Available | 1,642,974 | 27 | | | 85,644 | | 9 |
| 10 | 19 | Professional Fees | Bed Days Available | 1,642,974 | 27 | 793,188 | | 85,644 | 41,347 | 10 |
| 11 | 20 | Dues, Fees, Subscriptions, Etc. | Bed Days Available | 1,642,974 | 27 | 145,343 | | 85,644 | 7,576 | 11 |
| 12 | 21 | Clerical & General Salaries | Bed Days Available | 1,642,974 | 27 | 2,200,120 | 2,200,120 | 85,644 | 114,687 | 12 |
| 13 | 21 | Clerical & General Expenses | Bed Days Available | 1,642,974 | 27 | 1,075,235 | | 85,644 | 56,049 | 13 |
| 14 | 24 | Seminars and Education | Bed Days Available | 1,642,974 | 27 | 7,970 | | 85,644 | 415 | 14 |
| 15 | 25 | Transportation | Bed Days Available | 1,642,974 | 27 | 145,272 | | 85,644 | 7,573 | 15 |
| 16 | 26 | Insurance | Bed Days Available | 1,642,974 | 27 | 26,926 | | 85,644 | 1,404 | 16 |
| 17 | 27 | Employee Benefits - Administrati | Bed Days Available | 1,642,974 | 27 | 632,860 | | 85,644 | 32,989 | 17 |
| 18 | 30 | Depreciation | Bed Days Available | 1,642,974 | 27 | 549,679 | | 85,644 | 28,653 | 18 |
| 19 | 32 | Interest Expense | Bed Days Available | 1,642,974 | 27 | 738 | | 85,644 | 38 | 19 |
| 20 | 33 | Real Estate Tax | Bed Days Available | 1,642,974 | 27 | 98,893 | | 85,644 | 5,155 | 20 |
| 21 | 34 | Building Rental | Bed Days Available | 1,642,974 | 27 | 67,631 | | 85,644 | 3,525 | 21 |
| 22 | 35 | Equipment Rental | Bed Days Available | 1,642,974 | 27 | 194,869 | | 85,644 | 10,158 | 22 |
| 23 | 35 | Auto Lease | Bed Days Available | 1,642,974 | 27 | 112,113 | | 85,644 | 5,844 | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ 10,254,420 | \$ 5,376,221 | | \$ 534,535 | 25 |

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

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 & Medical Records | Direct Allocation | | \$ | \$ | | \$ 4,209 | 1 |
| 2 | 35 | Equipment Rental | Direct Allocation | | | | | 63,588 | 2 |
| 3 | 39 | Oxygen | Direct Allocation | | | | | 15,739 | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | TOTALS | | | | \$ | \$ | | \$ 83,536 | 25 |

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lifeline Ambulance, LLC
 Street Address 2424 S. Wabash Avenue
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|---------------------------|--------|--|-------------------|--|-------------------------------------|---|----------------|---------------------------------|----|
| Schedule V Line Reference | Item | Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | Total Units | Number of Subunits Being Allocated Among | Total Indirect Cost Being Allocated | Amount of Salary Cost Contained in Column 6 | Facility Units | Allocation (col.8/col.4)x col.6 | |
| 1 | 38 | Transportation | Direct Allocation | | \$ | \$ | | \$ 12,235 | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | TOTALS | | | | \$ | \$ | | \$ 12,235 | 25 |

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Concerto Dialysis LLC
 Street Address 4600 W. Touhy Ave. Suite 100
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (547) 233-1200
 Fax Number ()

| 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|--------------------------------------|-----------|---|-------------------|---|--|--|------------------------|---|----|
| 1 | 10 | Dialysis | Direct Allocation | | \$ | \$ | | \$ 193,489 | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | TOTALS | | | | \$ | \$ | | \$ 193,489 | 25 |

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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. | | \$ | 561,989 | 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 | \$ | 609,629 | 2 |
| 3. Under or (over) accrual (line 2 minus line 1). | | \$ | 47,640 | 3 |
| 4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.) | | \$ | 627,917 | 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. | | 5,155 | |
| 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. | | \$ | 680,712 | 7 |
| Real Estate Tax History: | | | | |
| Real Estate Tax Bill for Calendar Year: | 2015 | 414,808 | 8 | |
| | 2016 | 453,387 | 9 | |
| | 2017 | 526,810 | 10 | |
| | 2018 | 559,194 | 11 | |
| | 2019 | 609,629 | 12 | |
| Accrual Calculation : | | | | |
| Real estate taxes paid \$609,629 X 1.03% = \$627,917. | | | | |
| 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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 OF CHICAGO WEST COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053686

CONTACT PERSON REGARDING THIS REPORT Ari Krupp

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

| (A) | (B) | (C) | (D) <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>16-16-209-002-0000</u> | <u>Nursing Home</u> | \$ <u>609,628.92</u> | \$ <u>609,628.92</u> |
| 2. <u>10-27-319-028-0000</u> | <u>Home Office Allocation</u> | \$ <u>85,535.22</u> | \$ <u>5,155.00</u> |
| 3. _____ | _____ | \$ _____ | \$ _____ |
| 4. _____ | _____ | \$ _____ | \$ _____ |
| 5. _____ | _____ | \$ _____ | \$ _____ |
| 6. _____ | _____ | \$ _____ | \$ _____ |
| 7. _____ | _____ | \$ _____ | \$ _____ |
| 8. _____ | _____ | \$ _____ | \$ _____ |
| 9. _____ | _____ | \$ _____ | \$ _____ |
| 10. _____ | _____ | \$ _____ | \$ _____ |
| TOTALS | | \$ <u><u>695,164.14</u></u> | \$ <u><u>614,783.92</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.**

Facility Name & ID Number Symphony of Chicago West

0053686 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medical Clinic - Costs are not included on Schedule V

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

| | 1 | 2 | 3 | 4 | |
|----------|--|-------------|---------------|-----------------|---|
| A. Land. | Use | Square Feet | Year Acquired | Cost | |
| 1 | | - | | \$ - | 1 |
| 2 | <u>Allocated from Maestro 7257 Lincoln</u> | | <u>2004</u> | <u>8340</u> | 2 |
| 3 | TOTALS | | | \$ 8,340 | 3 |

XI. OWNERSHIP COSTS (continued)

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

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

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

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

| 1 | 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 | | \$ | \$ | | \$ | \$ | \$ | 37 | | |
| 38 | | | | | | | | 38 | | |
| 39 | | | | | | | | 39 | | |
| 40 | | | | | | | | 40 | | |
| 41 | | | | | | | | 41 | | |
| 42 | | | | | | | | 42 | | |
| 43 | | | | | | | | 43 | | |
| 44 | | | | | | | | 44 | | |
| 45 | | | | | | | | 45 | | |
| 46 | | | | | | | | 46 | | |
| 47 | | | | | | | | 47 | | |
| 48 | | | | | | | | 48 | | |
| 49 | | | | | | | | 49 | | |
| 50 | | | | | | | | 50 | | |
| 51 | | | | | | | | 51 | | |
| 52 | | | | | | | | 52 | | |
| 53 | | | | | | | | 53 | | |
| 54 | | | | | | | | 54 | | |
| 55 | | | | | | | | 55 | | |
| 56 | | | | | | | | 56 | | |
| 57 | | | | | | | | 57 | | |
| 58 | | | | | | | | 58 | | |
| 59 | | | | | | | | 59 | | |
| 60 | | | | | | | | 60 | | |
| 61 | | | | | | | | 61 | | |
| 62 | | | | | | | | 62 | | |
| 63 | | | | | | | | 63 | | |
| 64 | | | | | | | | 64 | | |
| 65 | | | | | | | | 65 | | |
| 66 | | | | | | | | 66 | | |
| 67 | | | | | | | | 67 | | |
| 68 | | | | | | | | 68 | | |
| 69 | | | | | | | | 69 | | |
| 70 | TOTAL (lines 4 thru 69) | \$ | 2,389,709 | \$ | 34,414 | \$ | 34,414 | \$ | 2,298,853 | 70 |

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

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**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 | | \$ 2,389,709 | \$ | | \$ 34,414 | \$ 34,414 | \$ 2,298,853 | 1 |
| 2 | Skylight Glass Replacement | 2014 | 7,380 | | 20 | 369 | 369 | 4,551 | 2 |
| 3 | Parking Lot Paving | 2014 | 13,250 | | 20 | 663 | 663 | 5,667 | 3 |
| 4 | Fire Alarm System | 2014 | 9,655 | | 20 | 483 | 483 | 8,068 | 4 |
| 5 | Electrical Outlets | 2014 | 5,300 | | 20 | 265 | 265 | 3,092 | 5 |
| 6 | Plumbing-Replace P-Trap In Boiler Room, Replace Corridor Pipe | 2014 | 20,945 | | 20 | 1,047 | 1,047 | 12,219 | 6 |
| 7 | Replace Door Operators On 3 Elevators | 2014 | 36,600 | | 20 | 1,830 | 1,830 | 11,285 | 7 |
| 8 | Repaired Elevators | 2015 | 7,578 | | 20 | 379 | 379 | 2,274 | 8 |
| 9 | Demolition Of Existing Walk-In Freezer/Cooler/Electrical | 2015 | 7,240 | | 20 | 362 | 362 | 2,172 | 9 |
| 10 | Electrical Services For Walk-In Freezer/Cooler | 2015 | 3,200 | | 20 | 160 | 160 | 960 | 10 |
| 11 | New Door Frame And New Glass Doors At Main Entrance | 2015 | 11,580 | | 20 | 579 | 579 | 3,474 | 11 |
| 12 | New Walk-In Cooler/Freezer | 2015 | 18,318 | | 20 | 916 | 916 | 5,496 | 12 |
| 13 | Wired Call System | 2015 | 86,995 | | 20 | 4,350 | 4,350 | 26,099 | 13 |
| 14 | Furnish/Install New Pump And Pump Motor Valve And Tank | 2016 | 10,450 | | 20 | 523 | 523 | 2,614 | 14 |
| 15 | Plumbing - 1St/2Nd Floor Drain And Piping | 2016 | 2,750 | | 20 | 138 | 138 | 689 | 15 |
| 16 | Roof Work - Repair Leaks Rooms 416/430, Lower Roof Leaks - Ea | 2016 | 3,800 | | 20 | 190 | 190 | 950 | 16 |
| 17 | Wired Nurse Call System | 2016 | 7,248 | | 20 | 362 | 362 | 1,811 | 17 |
| 18 | 3 Elevators - Furnish And Apply Car Top Hand Rails | 2016 | 3,732 | | 20 | 187 | 187 | 935 | 18 |
| 19 | Electrical Work - Replace/Rewire Disconnect, Supply New Fuse Disc | 2016 | 4,620 | | 20 | 231 | 231 | 1,155 | 19 |
| 20 | Plumbing - Camera And Rod Kitchen Waste Lines | 2016 | 3,630 | | 20 | 182 | 182 | 910 | 20 |
| 21 | New Door Sill \$3,200 | 2017 | 3,200 | | 20 | 160 | 160 | 640 | 21 |
| 22 | Fire Sprinkler \$3,810 | 2017 | 3,810 | | 20 | 191 | 191 | 762 | 22 |
| 23 | Telephone System/Install/Main | 2017 | 26,860 | | 20 | 1,343 | 1,343 | 5,372 | 23 |
| 24 | Plumbing To Repair Rodding Of Grease Line | 2017 | 2,720 | | 20 | 136 | 136 | 544 | 24 |
| 25 | Install New Slop Sink | 2017 | 2,670 | | 20 | 134 | 134 | 534 | 25 |
| 26 | Plumbing Repiping And Replace 4 Gate Valves | 2017 | 5,265 | | 20 | 263 | 263 | 1,053 | 26 |
| 27 | Repaired Trane Rtu | 2017 | 5,283 | | 20 | 264 | 264 | 1,057 | 27 |
| 28 | Replace flooring, doors, millwork-Clinical Bldg | 2018 | 87,200 | 6,188 | 20 | 6,188 | | 18,564 | 28 |
| 29 | Replace tile flooring, 4" wall base, insulate, drywall & paint, | 2018 | 116,073 | 6,502 | 20 | 6,502 | | 19,506 | 29 |
| 30 | electrical, light fixtures - 1st & 2nd Floor | | | | | | | | 30 |
| 31 | Camera System install-Throughout Facility | 2018 | 33,986 | 2,926 | 20 | 2,926 | | 8,778 | 31 |
| 32 | R&M-Replace phone jacks, face-plates, gang boxes, patch cords-CI | 2018 | 2,969 | | 20 | 148 | 148 | 444 | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 2,944,016 | \$ 15,616 | | \$ 65,882 | \$ 50,266 | \$ 2,450,526 | 34 |

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

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

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

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

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

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

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

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

| 1 | 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 12D, Carried Forward | | \$ 3,733,456 | \$ 35,686 | | \$ 114,825 | \$ 79,139 | \$ 2,838,768 | 1 |
| 2 | Fuel tank test vent isolation | 2020 | 3,820 | 219 | 11 | 219 | | 219 | 2 |
| 3 | Fuel tank vent replacement | 2020 | 9,480 | 544 | 11 | 544 | | 544 | 3 |
| 4 | Replace storm piping | 2020 | 8,568 | 143 | 11 | 143 | | 143 | 4 |
| 5 | Install new boiler shut off valves & fittings | 2020 | 4,843 | 13 | 11 | 13 | | 13 | 5 |
| 6 | Replace 100 gallon water heater basement | 2020 | 8,990 | 737 | 5 | 737 | | 737 | 6 |
| 7 | Elevator door, wiring, install, elevator kit | 2020 | 31,518 | 2,549 | 5 | 2,549 | | 2,549 | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | Reconcile to book depreciation | | | 21,668 | | | (21,668) | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | | | | | | | | | 25 |
| 26 | | | | | | | | | 26 |
| 27 | | | | | | | | | 27 |
| 28 | | | | | | | | | 28 |
| 29 | | | | | | | | | 29 |
| 30 | | | | | | | | | 30 |
| 31 | | | | | | | | | 31 |
| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 3,800,675 | \$ 61,558 | | \$ 119,029 | \$ 57,471 | \$ 2,842,972 | 34 |

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

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 | 10 |
|----|--|------------------|--------------|---------------------------|---------------|----------------------------|-------------|--------------------------|----|
| | Improvement Type** | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation | |
| 1 | Totals from Page 12E, Carried Forward | | \$ 3,800,675 | \$ 61,558 | | \$ 119,029 | \$ 57,471 | \$ 2,842,972 | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | Leasehold Improvements: | | | | | | | | 4 |
| 5 | Allocated from Maestro Consulting | 2003 | 611 | | 20 | 31 | 31 | 523 | 5 |
| 6 | Allocated from Maestro Consulting | 2004 | 12,396 | | 20 | 618 | 618 | 10,361 | 6 |
| 7 | Allocated from Maestro Consulting | 2005 | 735 | | 20 | 37 | 37 | 583 | 7 |
| 8 | Allocated from Maestro Consulting | 2006 | 997 | | 20 | 50 | 50 | 716 | 8 |
| 9 | Allocated from Maestro Consulting | 2008 | 1,050 | | 20 | 52 | 52 | 644 | 9 |
| 10 | Allocated from Maestro Consulting | 2009 | 16,911 | | 20 | 846 | 846 | 9,817 | 10 |
| 11 | Allocated from Maestro Consulting | 2010 | 2,599 | | 20 | 130 | 130 | 1,365 | 11 |
| 12 | Allocated from Maestro Consulting | 2011 | 140 | | 20 | 7 | 7 | 70 | 12 |
| 13 | Allocated from Maestro Consulting | 2012 | 156 | | 20 | 8 | 8 | 68 | 13 |
| 14 | Allocated from Maestro Consulting | 2014 | 1,955 | | 20 | 98 | 98 | 646 | 14 |
| 15 | Allocated from Maestro Consulting | 2015 | 550 | | 20 | 27 | 27 | 147 | 15 |
| 16 | Allocated from Maestro Consulting | 2016 | 2,409 | | 20 | 120 | 120 | 816 | 16 |
| 17 | Allocated from Maestro Consulting | 2017 | 322 | | 20 | 16 | 16 | 65 | 17 |
| 18 | Allocated from Maestro Consulting | 2020 | 520 | | 20 | 13 | 13 | 13 | 18 |
| 19 | | | | | | | | | 19 |
| 20 | Allocated from 7257 N. Lincoln | 2004 | 1,492 | | 20 | 75 | 75 | 1,231 | 20 |
| 21 | Allocated from 7257 N. Lincoln | 2005 | 6,843 | | 20 | 245 | 245 | 5,753 | 21 |
| 22 | Allocated from 7257 N. Lincoln | 2015 | 1,183 | | 20 | 79 | 79 | 421 | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | | | | | | | | | 25 |
| 26 | | | | | | | | | 26 |
| 27 | | | | | | | | | 27 |
| 28 | | | | | | | | | 28 |
| 29 | | | | | | | | | 29 |
| 30 | | | | | | | | | 30 |
| 31 | | | | | | | | | 31 |
| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 3,851,544 | \$ 61,558 | | \$ 121,481 | \$ 59,923 | \$ 2,876,211 | 34 |

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

Facility Name & ID Number Symphony of Chicago West

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

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

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

D. Vehicle Costs. (See instructions.)*

| | 1 Use | Model, Make and Year 2 | Year Acquired 3 | 4 Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7 Adjustments | Life in Years 8 | Accumulated Depreciation 9 | |
|----|----------|---------------------------|--------------------|-----------|--------------------------------|---------------------------------|------------------|--------------------|-------------------------------|----|
| 76 | | Allocated from Maestro | 2017 | \$ 462 | \$ - | \$ - | \$ - | 5 | \$ 462 | 76 |
| 77 | | | | | - | - | | | | 77 |
| 78 | | | | | - | - | | | | 78 |
| 79 | | | | | - | - | | | | 79 |
| 80 | TOTALS | | | \$ 462 | \$ - | \$ - | \$ - | | \$ 462 | 80 |

E. Summary of Care-Related Assets

| | 1 Reference | 2 Amount | | |
|----|----------------------------|--|--------------|----|
| 81 | Total Historical Cost | (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable) | \$ 6,396,182 | 81 |
| 82 | Current Book Depreciation | (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) | \$ 117,214 | 82 |
| 83 | Straight Line Depreciation | (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) | \$ 220,561 | 83 |
| 84 | Adjustments | (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable) | \$ 103,347 | 84 |
| 85 | Accumulated Depreciation | (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable) | \$ 5,170,239 | 85 |

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

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

G. Construction-in-Progress

| | Description | Cost | |
|----|-------------|------------|----|
| 92 | CIP | \$ 245,945 | 92 |
| 93 | | | 93 |
| 94 | | | 94 |
| 95 | | \$ 245,945 | 95 |

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Invesque

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

| | | 1 Year Constructed | 2 Number of Beds | 3 Original Lease Date | 4 Rental Amount | 5 Total Years of Lease | 6 Total Years Renewal Option* | |
|---|---|--------------------------|------------------------|-----------------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building: | | <u>234</u> | <u>11/1/2015</u> | \$ <u>2,779,813</u> | <u>15</u> | <u>15</u> | 3 |
| 4 | Additions | | | | | | | 4 |
| 5 | <u>Allocated from Maestro Consulting Services</u> | | | | <u>3,525</u> | | | 5 |
| 6 | | | | | | | | 6 |
| 7 | TOTAL | | 234 | | \$ 2,783,338 | | | 7 |

10. Effective dates of current rental agreement:

Beginning 11/1/2015

Ending 10/31/2030

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

Fiscal Year Ending Annual Rent

| | | |
|-----|-------------------|---------------------|
| 12. | <u>12/31/2021</u> | \$ <u>2,676,918</u> |
| 13. | <u>12/31/2022</u> | \$ <u>2,737,148</u> |
| 14. | <u>12/31/2023</u> | \$ <u>2,798,734</u> |

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 130,267

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

| | | |
|--|---|--|
| <p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p> | <p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p> | <p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p> |
|--|---|--|

B. EXPENSES

ALLOCATION OF COSTS (d)

| | | Facility | | | Total |
|----|--|-----------|-----------|----------|-------|
| | | 1 | 2 | 3 | |
| | | Drop-outs | Completed | Contract | |
| 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) | \$ | \$ | | |

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 | |

- (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.)

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

Schedule 16A

XIV. Special Services (Direct Cost)

Line 13 Other (specify)

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

Facility Name & ID Number **Symphony of Chicago West**

0053686

Report Period Beginning: **1/1/2020**

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2020**

(last day of reporting year)

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

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

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

*(See instructions.)

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

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

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

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

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

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

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

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

| I. Revenue | | Amount | |
|--|---|---------------|-----|
| A. Inpatient Care | | | |
| 1 | Gross Revenue -- All Levels of Care | \$ 16,913,865 | 1 |
| 2 | Discounts and Allowances for all Levels | (2,336,186) | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 14,577,679 | 3 |
| B. Ancillary Revenue | | | |
| 4 | Day Care | - | 4 |
| 5 | Other Care for Outpatients | - | 5 |
| 6 | Therapy | 2,394,275 | 6 |
| 7 | Oxygen | 23,834 | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ 2,418,109 | 8 |
| C. Other Operating Revenue | | | |
| 9 | Payments for Education | - | 9 |
| 10 | Other Government Grants | 1,460,580 | 10 |
| 11 | CNA Training Reimbursements | - | 11 |
| 12 | Gift and Coffee Shop | - | 12 |
| 13 | Barber and Beauty Care | - | 13 |
| 14 | Non-Patient Meals | - | 14 |
| 15 | Telephone, Television and Radio | - | 15 |
| 16 | Rental of Facility Space | - | 16 |
| 17 | Sale of Drugs | 338,237 | 17 |
| 18 | Sale of Supplies to Non-Patients | - | 18 |
| 19 | Laboratory | 30,195 | 19 |
| 20 | Radiology and X-Ray | 8,688 | 20 |
| 21 | Other Medical Services | 24,584 | 21 |
| 22 | Laundry | - | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ 1,862,284 | 23 |
| D. Non-Operating Revenue | | | |
| 24 | Contributions | - | 24 |
| 25 | Interest and Other Investment Income*** | 17,571 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 17,571 | 26 |
| E. Other Revenue (specify):**** | | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | <u>See Supplemental Schedule</u> | 223,851 | 28 |
| 28a | | - | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ 223,851 | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 19,099,494 | 30 |

2

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

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.
^Entity is a cash basis taxpayer.

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

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

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

Facility Name & ID Number **Symphony of Chicago West**

0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

| | 1 | 2** | 3 | 4 | | |
|----|--|----------------------------|--|---------------------|----------|----|
| | # of Hrs. Actually Worked | # of Hrs. Paid and Accrued | Reporting Period Total Salaries, Wages | Average Hourly Wage | | |
| 1 | Director of Nursing | 1,840 | 2,031 | \$ 115,536 | \$ 56.90 | 1 |
| 2 | Assistant Director of Nursing | 1,128 | 1,185 | 48,492 | 40.94 | 2 |
| 3 | Registered Nurses | 13,407 | 14,972 | 525,828 | 35.12 | 3 |
| 4 | Licensed Practical Nurses | 55,460 | 66,629 | 1,986,304 | 29.81 | 4 |
| 5 | CNAs & Orderlies | 106,739 | 122,160 | 2,112,026 | 17.29 | 5 |
| 6 | CNA Trainees | | | | | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | | | | | 8 |
| 9 | Activity Director | | | | | 9 |
| 10 | Activity Assistants | 4,690 | 5,338 | 133,649 | 25.04 | 10 |
| 11 | Social Service Workers | 6,328 | 6,797 | 160,109 | 23.56 | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | 1,656 | 1,816 | 53,961 | 29.72 | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 4,876 | 5,374 | 101,370 | 18.86 | 15 |
| 16 | Dishwashers | 16,789 | 18,441 | 276,166 | 14.98 | 16 |
| 17 | Maintenance Workers | 4,201 | 4,443 | 107,867 | 24.28 | 17 |
| 18 | Housekeepers | 1,842 | 2,114 | 34,244 | 16.20 | 18 |
| 19 | Laundry | | | | | 19 |
| 20 | Administrator | 1,920 | 2,160 | 127,019 | 58.81 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | | | | | 22 |
| 23 | Office Manager | 1,848 | 2,092 | 59,534 | 28.45 | 23 |
| 24 | Clerical | 10,475 | 12,160 | 200,365 | 16.48 | 24 |
| 25 | Vocational Instruction | | | | | 25 |
| 26 | Academic Instruction | | | | | 26 |
| 27 | Medical Director | | | | | 27 |
| 28 | Qualified MR Prof. (QMRP) | | | | | 28 |
| 29 | Resident Services Coordinator | | | | | 29 |
| 30 | Habilitation Aides (DD Homes) | | | | | 30 |
| 31 | Medical Records | 3,763 | 4,158 | 89,078 | 21.42 | 31 |
| 32 | Other Health Care See Sch 20A | 7,532 | 8,650 | 273,195 | 31.58 | 32 |
| 33 | Other(specify) Admission & Com | 5,906 | 6,412 | 220,925 | 34.45 | 33 |
| 34 | TOTAL (lines 1 - 33) | 250,400 | 286,932 | \$ 6,625,668 * | \$ 23.09 | 34 |

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

** See instructions.

B. CONSULTANT SERVICES

| | 1 | 2 | 3 | | |
|----|--|--|------------------------------------|--------|----|
| | Number of Hrs. Paid & Accrued | Total Consultant Cost for Reporting Period | Schedule V Line & Column Reference | | |
| 35 | Dietary Consultant | Monthly | \$ 39,271 | 1(3) | 35 |
| 36 | Medical Director | Monthly | 24,000 | 9(3) | 36 |
| 37 | Medical Records Consultant | | | | 37 |
| 38 | Nurse Consultant | Monthly | 158 | 10(7) | 38 |
| 39 | Pharmacist Consultant | Monthly | 29,980 | 10(3) | 39 |
| 40 | Physical Therapy Consultant | | | | 40 |
| 41 | Occupational Therapy Consultant | | | | 41 |
| 42 | Respiratory Therapy Consultant | Monthly | 4,534 | 39 (3) | 42 |
| 43 | Speech Therapy Consultant | | | | 43 |
| 44 | Activity Consultant | | | | 44 |
| 45 | Social Service Consultant | | | | 45 |
| 46 | Other(specify) Psychiatric Consult | Monthly | 11,860 | 10 (3) | 46 |
| 47 | Dental Consultant | Monthly | 4,425 | 39 (3) | 47 |
| 48 | | | | | 48 |
| 49 | TOTAL (lines 35 - 48) | | \$ 114,228 | | 49 |

C. CONTRACT NURSES

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

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

Schedule 20A

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

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

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

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

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

Facility Name & ID Number Symphony of Chicago West# 0053686

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council of Illinois \$30,684
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 11/1/2015
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Jackson Square Nursing and Rehab IDPH #0039834
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 593,768
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.