

		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>0053256</u></p> <p>Facility Name: <u>Symphony Evanston Healthcare</u></p> <p>Address: <u>820 Foster Street</u> <u>Evanston</u> <u>60201</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 792-7700</u> Fax # <u>(847) 492-7672</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/1/2014</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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" 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 type="checkbox"/> "Sub-S" Corp.			<input checked="" 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">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="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td> </tr> <tr> <td>(Telephone) <u>(847) 517-7070</u> Fax # (847)<u>517-7067</u></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) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # (847) <u>517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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Facility Name & ID Number Symphony Evanston Healthcare

0053256 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>158</u>	Skilled (SNF)	<u>158</u>	<u>57,828</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>158</u>	TOTALS	<u>158</u>	<u>57,828</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	<u>23,005</u>	<u>4,690</u>	<u>8,151</u>	<u>35,846</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>23,005</u>	<u>4,690</u>	<u>8,151</u>	<u>35,846</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.99%

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 11/01/2014

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

YES Date 11/01/2014 NO

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

YES NO If YES, enter number of beds certified 158 and days of care provided 4,811

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 Evanston Healthcare # 0053256 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	496,359	35,865	19,792	552,016		552,016	713	552,729		1
2	Food Purchase		251,634		251,634		251,634		251,634		2
3	Housekeeping	220,260	38,560	-	258,820		258,820		258,820		3
4	Laundry	9,482	18,672	62,679	90,833		90,833		90,833		4
5	Heat and Other Utilities			227,608	227,608		227,608	1,326	228,934		5
6	Maintenance	161,621	-	150,436	312,057		312,057	2,551	314,608		6
7	Other (specify):* Mgmt Alloc of Benefi	-	-	-				189	189		7
8	TOTAL General Services	887,722	344,731	460,515	1,692,968		1,692,968	4,779	1,697,747		8
	B. Health Care and Programs										
9	Medical Director	-	-	24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	3,983,869	210,626	27,162	4,221,657		4,221,657	110,965	4,332,622		10
10a	Therapy	-	-	-							10a
11	Activities	114,596	-	(2,420)	112,176		112,176		112,176		11
12	Social Services	105,512	-	-	105,512		105,512		105,512		12
13	CNA Training	-	-	-							13
14	Program Transportation	-	-	-							14
15	Other (specify):* Mgmt Alloc of Benefi	-	-	-				31,960	31,960		15
16	TOTAL Health Care and Programs	4,203,977	210,626	48,742	4,463,345		4,463,345	142,925	4,606,270		16
	C. General Administration										
17	Administrative	115,654	-	551,337	666,991		666,991	(551,337)	115,654		17
18	Directors Fees			-							18
19	Professional Services			480,579	480,579		480,579	10,873	491,452		19
20	Dues, Fees, Subscriptions & Promotions			69,863	69,863		69,863	(6,703)	63,160		20
21	Clerical & General Office Expenses	197,094	30,384	37,816	265,294		265,294	103,861	369,155		21
22	Employee Benefits & Payroll Taxes			807,318	807,318		807,318		807,318		22
23	Inservice Training & Education			-							23
24	Travel and Seminar			283	283		283	281	564		24
25	Other Admin. Staff Transportation		-	2,239	2,239		2,239	5,113	7,352		25
26	Insurance-Prop.Liab.Malpractice			579,187	579,187		579,187	948	580,135		26
27	Other (specify):* Mgmt Alloc of Benefits			-				22,275	22,275		27
28	TOTAL General Administration	312,748	30,384	2,528,622	2,871,754		2,871,754	(414,689)	2,457,065		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,404,447	585,741	3,037,879	9,028,067		9,028,067	(266,985)	8,761,082		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			83,068	83,068		83,068	291,784	374,852			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			31,690	31,690		31,690	(2,037)	29,653			32
33	Real Estate Taxes			854,675	854,675		854,675	(1,435)	853,240			33
34	Rent-Facility & Grounds			2,071,957	2,071,957		2,071,957	2,380	2,074,337			34
35	Rent-Equipment & Vehicles			108,522	108,522		108,522	1,202	109,724			35
36	Other (specify):*			-								36
37	TOTAL Ownership			3,149,912	3,149,912		3,149,912	291,894	3,441,806			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	30,201	30,201		30,201	(1,501)	28,700			38
39	Ancillary Service Centers	-	132,614	1,229,382	1,361,996		1,361,996	(924)	1,361,072			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			275,124	275,124		275,124		275,124			42
43	Other (specify):* Non-Allowable Co	132,474	-	390,930	523,404		523,404	(523,404)				43
44	TOTAL Special Cost Centers	132,474	132,614	1,925,637	2,190,725		2,190,725	(525,829)	1,664,896			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,536,921	718,355	8,113,428	14,368,704		14,368,704	(500,920)	13,867,784			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 Evanston Healthcare

0053256

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	(27,035)	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	272,437	30		9
10	Interest and Other Investment Income	(2,063)	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	(31,993)	43		18
19	Entertainment	(42)	43		19
20	Contributions	(4,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(264,334)	43		24
25	Fund Raising, Advertising and Promotional	(1,490)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(239,212)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (298,232)		\$	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)	(202,688)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (202,688)	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (500,920)	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 Evanston Healthcare

ID# 0053256

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (93,702)	43	1
2	Laboratory Costs	(22,890)	43	2
3	X-Ray Costs	(12,921)	43	3
4	Lobbying Expense	(11,419)	20	4
5	Misc. Income	(11,422)	21	5
6	Admissions	(64,359)	43	6
7	Community & Guest Relations	(138)	43	7
8	Non-allowable Legal	(4,172)	19	8
9	Non-allowable Branding	(7,348)	19	9
10	Non-allowable Collection fees	(5,525)	19	10
11	Real Estate Taxes	(4,916)	33	11
12	Chamber of Commerce Dues	(400)	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(239,212)		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 <u>DIETARY</u>	\$	<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	\$ 713	\$ 713	15
16	V	5 <u>UTILITIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	1,326	1,326	16
17	V	6 <u>MAINTENANCE SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%			17
18	V	6 <u>MAINTENANCE EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	2,551	2,551	18
19	V	7 <u>EMPLOYEE BENEFITS - MAINTENANCE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	189	189	19
20	V	10 <u>CLINICAL SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	111,108	111,108	20
21	V	10 <u>CONTRACT NURSING</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	107	107	21
22	V	15 <u>EMPLOYEE BENEFITS - CLINICAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	31,960	31,960	22
23	V	17 <u>ADMINISTRATIVE OTHER-MGMT FE</u>	551,337	<u>MAESTRO CONSULTING SERVICES LLC</u>	100%		(551,337)	23
24	V	19 <u>PROFESSIONAL FEES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	27,918	27,918	24
25	V	20 <u>DUES, FEES, SUBSCRIPTIONS, ETC.</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	5,116	5,116	25
26	V	21 <u>CLERICAL & GENERAL SALARIES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	77,438	77,438	26
27	V	21 <u>CLERICAL & GENERAL EXPENSES</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	37,845	37,845	27
28	V	24 <u>SEMINARS AND EDUCATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	281	281	28
29	V	25 <u>TRANSPORTATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	5,113	5,113	29
30	V	26 <u>INSURANCE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	948	948	30
31	V	27 <u>EMPLOYEE BENEFITS - ADMINISTRATIVE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	22,275	22,275	31
32	V	30 <u>DEPRECIATION</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	19,347	19,347	32
33	V	32 <u>INTEREST EXPENSE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	26	26	33
34	V	33 <u>REAL ESTATE TAX</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	3,481	3,481	34
35	V	34 <u>BUILDING RENTAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	2,380	2,380	35
36	V	35 <u>EQUIPMENT RENTAL</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	6,859	6,859	36
37	V	35 <u>AUTO LEASE</u>		<u>MAESTRO CONSULTING SERVICES LLC</u>	100%	3,946	3,946	37
38	V							38
39	Total		\$ 551,337			\$ 360,927	\$ * (190,410)	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	Medical Supplies	\$ 1,669	Integra Healthcare Equipment LLC	19%	\$ 1,419	\$ (250)	15
16	V	35	Equipment Rental	64,021	Integra Healthcare Equipment LLC	19%	54,418	(9,603)	16
17	V	39	Oxygen Supplies	6,157	Integra Healthcare Equipment LLC	19%	5,233	(924)	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			\$ 71,847			\$ 61,070	\$ * (10,777)	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	\$ 10,005	Lifeline Ambulance LLC	4%	\$ 8,504	\$ (1,501)	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			\$ 10,005			\$ 8,504	\$ * (1,501)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 125,684	Maple Leaf Insurance	100%	\$ 125,684	\$	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			\$ 125,684			\$ 125,684	\$ * 0	39

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

Facility Name & ID Number

Symphony Evanston Healthcare

0053256

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	DRAKE LOUIS ENTERPRISE, LLC	64.29	SYMPHONY OF CALIFORNIA GARDENS L	CHICAGO	MAESTRO CONSUL	LINCOLNWOOD	MANAGEMENT	1
2	FAIRHOME TRUST U/A/D 12/31/12	28.57	MAPLE CREST CARE CENTRE	BELVIDERE	7257 N. LINCOLN AV	LINCOLNWOOD	BUILDING RENTA	2
3	BENOIT HOLDINGS LLC	7.14	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				7
8			SYMPHONY AT THE TILLERS	OSWEGO				8
9			SYMPHONY OF BRONZEVILLE	CHICAGO				9
10			SYMPHONY OF CHESTERTON	CHESTERTON, IN				10
11			SYMPHONY OF CHICAGO WEST	CHICAGO				11
12			SYMPHONY OF CRESTWOOD	CRESTWOOD				12
13			SYMPHONY OF CROWN POINT	CROWN POINT, IN				13
14			SYMPHONY OF DYER	DYER, IN				14
15			SYMPHONY OF EVANSTON	EVANSTON				15
16			SYMPHONY OF GLENDALE	GLENDALE, WI				16
17			SYMPHONY OF HANOVER PARK	HANOVER PARK				17
18			SYMPHONY OF JOLIET	JOLIET				18
19			SYMPHONY OF LINCOLN PARK	CHICAGO				19
20			SYMPHONY OF MORGAN PARK	CHICAGO				20
21			SYMPHONY OF ORCHARD VALLEY	AURORA				21
22			SYMPHONY OF SOUTH SHORE	CHICAGO				22
23			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				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 Evanston Healthcare # 0053256 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 Evanston Healthcare

0053256

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 Evanston Healthcare

0053256

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	57,828	\$ 713	1
2	5	UTILITIES	Bed Days Available	1,642,974	27	37,663		57,828	1,326	2
3	6	MAINTENANCE SALARIES	Bed Days Available	1,642,974	27			57,828		3
4	6	MAINTENANCE EXPENSES	Bed Days Available	1,642,974	27	72,471		57,828	2,551	4
5	7	EMPLOYEE BENEFITS - MAIN	Bed Days Available	1,642,974	27	5,383		57,828	189	5
6	10	CLINICAL SALARIES	Bed Days Available	1,642,974	27	3,156,734	3,156,734	57,828	111,108	6
7	10	CONTRACT NURSING	Bed Days Available	1,642,974	27	3,034		57,828	107	7
8	15	EMPLOYEE BENEFITS - CLIN	Bed Days Available	1,642,974	27	908,028		57,828	31,960	8
9	17	ADMINISTRATIVE OTHER M	Bed Days Available	1,642,974	27			57,828		9
10	19	PROFESSIONAL FEES	Bed Days Available	1,642,974	27	793,188		57,828	27,918	10
11	20	DUES, FEES, SUBSCRIPTIONS	Bed Days Available	1,642,974	27	145,343		57,828	5,116	11
12	21	CLERICAL & GENERAL SALA	Bed Days Available	1,642,974	27	2,200,120	2,200,120	57,828	77,438	12
13	21	CLERICAL & GENERAL EXPE	Bed Days Available	1,642,974	27	1,075,235		57,828	37,845	13
14	24	SEMINARS AND EDUCATION	Bed Days Available	1,642,974	27	7,970		57,828	281	14
15	25	TRANSPORTATION	Bed Days Available	1,642,974	27	145,272		57,828	5,113	15
16	26	INSURANCE	Bed Days Available	1,642,974	27	26,926		57,828	948	16
17	27	EMPLOYEE BENEFITS - ADM	Bed Days Available	1,642,974	27	632,860		57,828	22,275	17
18	30	DEPRECIATION	Bed Days Available	1,642,974	27	549,679		57,828	19,347	18
19	32	INTEREST EXPENSE	Bed Days Available	1,642,974	27	738		57,828	26	19
20	33	REAL ESTATE TAX	Bed Days Available	1,642,974	27	98,893		57,828	3,481	20
21	34	BUILDING RENTAL	Bed Days Available	1,642,974	27	67,631		57,828	2,380	21
22	35	EQUIPMENT RENTAL	Bed Days Available	1,642,974	27	194,869		57,828	6,859	22
23	35	AUTO LEASE	Bed Days Available	1,642,974	27	112,113		57,828	3,946	23
24										24
25	TOTALS					\$ 10,254,420	\$ 5,376,221		\$ 360,927	25

Facility Name & ID Number Symphony Evanston Healthcare

0053256

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	Medical Supplies	Direct Allocation		\$	\$		\$ 1,419	1
2	35	Equipment Rental	Direct Allocation					54,418	2
3	39	Oxygen Supplies	Direct Allocation					5,233	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				\$	\$		\$ 61,070	25

Facility Name & ID Number Symphony Evanston Healthcare

0053256

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	38	Transportation	Direct Allocation		\$	\$		\$ 8,504	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				\$	\$		\$ 8,504	25

Facility Name & ID Number Symphony Evanston Healthcare

0053256

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Maple Leaf Insurance
 Street Address PO Box 69, 720 West Bay Rd
 City / State / Zip Code Grand Cayman, KY1-1102
 Phone Number (
 Fax Number (

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct		\$	\$		\$ 125,684	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				\$	\$		\$ 125,684	25

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 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
					Original	Balance				
Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
A. Directly Facility Related										
Long-Term										
1		X	Pharmacy Services	67,444	11/27/2017	\$ 2,170,337	\$ -	10/20/2020	0.075	\$ 550
2	X		Pharmacy Services	38,731	1/1/2018	6,197,033	206,364	1/1/2024	0.075	17,511
3		X	Operational	159,503	12/31/2018	12,216,125	482,433	12/31/2023	0.002	11,178
4	X		Medical Supplies/rental	50,680	7/1/2019	1,162,530	16,428	6/30/2021	0.043802	1,479
5										
Working Capital										
6		X	Line of Credit	\$30,395.22	7/1/2019	7,000,000	231,290	12/31/2033	0.05	
7		X	Advance Payment	\$8,212.00	5/1/2019	267,300	267,300	8/1/2021		
8			See SCH 9A	\$88,975.30		2,135,407	2,135,407			
9			TOTAL Facility Related	\$443,940.59		\$ 31,148,732	\$ 3,339,223			\$ 30,718
B. Non-Facility Related*										
10										90
11										882
12								Interest Income Offset		(2,063)
13								Allocated from Maestro		26
14			TOTAL Non-Facility Related			\$	\$			\$ (1,065)
15			TOTALS (line 9+line14)			\$ 31,148,732	\$ 3,339,223			\$ 29,653

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.)

Facility Name: Symphony Evanston Healthcare
 IDPH License ID Number: 0053256
 Fiscal Year End: 12/31/2020

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	National Government Services		X	Medicare AAP	\$40,772.42	4/7/2020	978,538	978,538	4/7/2023	0.0000										
7	CIBC Bank USA		X	PPP	\$48,202.88	6/23/2020	1,156,869	1,156,869	6/23/2022	0.0100										
8																				
9	TOTAL Facility Related				\$88,975.30		\$ 2,135,407	\$ 2,135,407		\$ -										
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related				\$0.00		\$ -	\$ -		\$ -										

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.		\$	<u>304,672</u>	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	\$	<u>165,414</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(139,258)</u>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>989,017</u>	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.		<u>3,481</u>	
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.		\$	<u>853,240</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<u>225,704</u>	8	
	2016	<u>277,809</u>	9	
	2017	<u>292,900</u>	10	
	2018	<u>300,752</u>	11	
	2019	<u>535,315</u>	12	
Accrual Calculation :				
Real estate taxes paid (\$535,315 X 1.1565%) + second installment of 2019 taxes \$369,901= \$989,017				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Symphony Evanston Healthcare COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053256

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>11-18-109-057-0000</u>	<u>Long Term Care Property</u>	\$ <u>535,314.52</u>	\$ <u>535,314.52</u>
2. <u>10-27-319-028-0000</u>	<u>Maestro - Home Office Allocation</u>	\$ <u>85,535.22</u>	\$ <u>3,481.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>620,849.74</u></u>	\$ <u><u>538,795.52</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 Evanston Healthcare

0053256 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 84,834 B. General Construction Type: Exterior Frame Number of Stories

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Allocated From Maestro-7257 Lin</u>	<u>-</u>	<u>2004</u>	<u>\$ 5,632</u>	1
2					2
3	TOTALS			\$ 5,632	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											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											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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 Evanston Healthcare# 0053256

Report Period Beginning:

1/1/2020

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Interior Design Services	2014	\$ 4,000	\$	20	\$ 200	\$ 200	\$ 1,200	37
38	Interior Design Services	2014	19,500		20	975	975	5,850	38
39	Field Work, Drawings	2015	9,180		20	459	459	2,563	39
40	Field Work, Drawings, Project Submission	2015	12,180		20	609	609	3,400	40
41	Demo-Remove Existing Finishes, Floor, Light Ceiling Fixtures, Flo	2015	10,775		20	539	539	2,784	41
42	Tile Avila Blanco, Grout Tec Sanded, Mortar Wall White	2015	15,628		20	781	781	3,712	42
43	Van Gogh Wood Plan Adhesive	2015	12,954		20	648	648	3,077	43
44	Van Gogh Wood Plan Adhesive	2015	11,663		20	583	583	2,527	44
45	Flooring Kardean Van Gogh Wood Plank	2015	19,308		20	965	965	4,183	45
46	Interior Design	2015	4,000		20	200	200	1,116	46
47	Garage Door, Fire Doors	2015	3,599		20	180	180	405	47
48	Power Wash, Panel & Vents Painting, Repair Fence Posts	2015	8,500		20	425	425	956	48
49	Paint Stucco Surface	2015	9,400		20	470	470	1,059	49
50	Light Fixtures, Ceiling Mount, Wallscones	2015	32,995		20	1,650	1,650	4,564	50
51	Orchids & Flowers Draper	2015	2,678		20	134	134	357	51
52	Flooring Tile, Plumbing, Adhesive	2015	103,136		20	5,157	5,157	24,496	52
53	Floor, Painting, Wall Vinyl, Carpentry, Electrical, Plumb-4&5Th Fl	2015	131,033		20	6,552	6,552	28,391	53
54	Flooring, Doors, Carpentry, Plumbing, Electircal, Fireplace-1St Fl	2015	91,737		20	4,587	4,587	19,877	54
55	Lighting, Grout For Rooms, Schluter-Rooms 10-16	2015	4,120		20	206	206	893	55
56	Flooring, Electrical, Plumbing, Carpentry, Painting, Wall Vinyl ...	2015	123,763		20	6,188	6,188	26,815	56
57	Flooring, Painting, Drop Ceiling, Carpentry, Electical-4&5Th Fl	2015	131,022		20	6,551	6,551	25,658	57
58	Speakers, Lighting, Wall Vinyl	2015	6,893		20	345	345	1,206	58
59	Flooring, Carpentry, Painting, Plumbing, Electircal, Fireplace-1St Fl	2015	91,737		20	4,587	4,587	16,053	59
60	Flooring, Carpentry, Painting, Plumbing, Electircal, Fireplace-1St Fl	2015	92,013		20	4,601	4,601	16,102	60
61	Floor, Painting, Wall Vinyl, Plumbing, Electrical-4&5Th Fl	2015	131,049		20	6,552	6,552	20,203	61
62	Flooring, Electrical, Plumbing Fixtures, Wood Work, Wall Vinyl	2015	61,881		20	3,094	3,094	12,118	62
63	Flooring, Electrical, Plumbing Fixtures, Painging, Wall Vinyl	2015	55,693		20	2,785	2,785	9,746	63
64	Lights, Glass Mirror, Switches, Flooring, Plumbing-4&5Th Fl	2015	14,824		20	741	741	2,285	64
65	Electical, Wood Work, Drop Ceiling, Doors, Plumbing-4&5Th Fl	2015	40,395		20	2,020	2,020	6,227	65
66	Demo, Flooring, Lighting, Plumbing, Painting, Permits-1St Fl	2015	34,782		20	1,739	1,739	4,638	66
67	Ventilator For 4Th And 5Th Floor	2015	4,397		20	220	220	678	67
68	Two Exhaust Grills 4Th & 5Th Floor	2015	3,653		20	183	183	487	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,298,486	\$		\$ 64,924	\$ 64,924	\$ 253,624	70

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

Facility Name & ID Number Symphony Evanston Healthcare# 0053256

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 12A, Carried Forward		\$ 1,298,486	\$		\$ 64,924	\$ 64,924	\$ 253,624	1
2	Ac Split System	2015	2,500		20	125	125	333	2
3	Custome Build Work Desk, Counters,	2015	5,300		20	265	265	706	3
4	Support Column Cover & Base Cabinet, Food Serving Station	2015	2,900		20	145	145	386	4
5	Interior Stainless Steel Passenger Elevators	2015	3,200		20	160	160	427	5
6	Relaminated Patient Room	2015	9,800		20	490	490	1,511	6
7	Replace Nurse Call Master	2015	7,704		20	385	385	3,595	7
8	Troubleshoot Air Handling	2015	5,454		20	273	273	2,545	8
9	Compressor - Repaired Leak And Charge	2015	2,984		20	149	149	1,144	9
10	Night Ir Turret Pow Camera	2015	29,345		20	1,467	1,467	11,248	10
11	Replace Compressor, Added Suction Filter & Valve	2015	12,460		20	623	623	3,738	11
12	Installed Air Conditioning	2015	10,960		20	548	548	3,288	12
13	Ceiling, Overbed, And Bathroom Light Fixtures	2015	57,800		20	2,890	2,890	17,340	13
14	4Th & 5Th Floor Nurse Call System	2015	4,820		20	241	241	1,446	14
15	Lighting, Plumbing, Electrical Work In Bathrooms	2016	25,391		20	1,270	1,270	6,348	15
16	& Resident Rooms	2016			20				16
17	Satum Ceiling Fixture	2016	10,614		20	531	531	2,654	17
18	Flooring - Van Gogh Field Woodplank	2016	6,070		20	304	304	1,518	18
19	Flooring Installation - 1St, 2Nd & 3Rd Floor	2016	57,240		20	2,862	2,862	14,310	19
20	Flooring Installation - 1St, 2Nd & 3Rd Floor Architect Fees	2016	10,780		20	539	539	2,695	20
21	Carpet Installation On 2Nd And 3Rd Floors	2016	6,332		20	317	317	1,584	21
22	Bathroom Tiles, Plumbing Fixtures, Electrical Work, New Doors, F	2016	30,253		20	1,513	1,513	7,564	22
23	Plumbing - Repair Hi-Lo Tmv And Balance Return System	2016	7,012		20	351	351	1,753	23
24	Domestic Water Booster System	2016	4,615		20	231	231	1,155	24
25	Insinkerator Disposal	2016	2,666		20	133	133	666	25
26	Sliding Door	2016	4,265		20	213	213	1,921	26
27	Ejector Pump Replacement	2016	2,796		20	140	140	700	27
28	Elevator Repair	2016	6,872		20	344	344	1,374	28
29	Flooring/Tiling/Plumbing- Resident Rooms And Bathrooms	2017	68,070		20	3,403	3,403	13,613	29
30	7 Door Holders- Surface Mount Chrome- Throughout Facility	2017	2,785		20	139	139	557	30
31	Flooring- 2Nd And 3Rd Floor Rooms	2017	32,925		20	1,646	1,646	6,585	31
32	Carpeting 3Rd Floor Rooms	2017	10,885		20	544	544	2,177	32
33	Finish & Supply Conduit- Elevator For Wanderguard Wiring	2017	8,500		20	425	425	1,700	33
34	TOTAL (lines 1 thru 33)		\$ 1,751,783	\$		\$ 87,589	\$ 87,589	\$ 370,203	34

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

Facility Name & ID Number Symphony Evanston Healthcare# 0053256

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		\$ 1,751,783	\$		\$ 87,589	\$ 87,589	\$ 370,203	1
2	Replaced Ducts Split System- Mechanical System	2017	13,494		20	675	675	2,699	2
3	Paving Of Parking Lot	2017	7,899		20	395	395	1,580	3
4	New Shunt Trip Breakers And Low Voltage Control Wires- Elevat	2017	13,780		20	689	689	2,756	4
5	Boiler Replacement	2017	46,900		20	2,345	2,345	9,380	5
6	Replace Motor And Coupling On Circulation Pump	2017	2,742		20	137	137	548	6
7	Code Alert System	2017	44,474		20	2,224	2,224	8,895	7
8	Chiller- Tubes, Circuits, Refrigerant	2017	28,960		20	1,448	1,448	5,792	8
9	Carpeting /Flooring In 2Nd And 3Rd Floor Resident Rooms And L	2017	34,128		20	1,706	1,706	6,825	9
10	16 Led Recessed Lighting Fixtures- Throughout Facility	2017	2,977		20	149	149	596	10
11	Door Rim Device, trim and door strike	2018	4,165	255	20	255		765	11
12	Architectural Services-Evacuation plan	2018	3,260	180	20	180		540	12
13	3 New key switches to lock lower level 3 elevators	2018	3,435	163	20	163		415	13
14					20				14
15	Architectural Services-2nd and 3rd floor modifications	2018	5,880	394	20	394		1,182	15
16	3 Shut breakers for elevator	2018	6,890	500	20	500		1,500	16
17	Exposition Carpet-Hallways	2018	34,127	4,373	20	4,373		13,119	17
18	Concrete repair and stone installation around transformer	2018	3,800	190	20	190		570	18
19	2nd fl elevator lobby, 2nd fl sitting room, 2nd floor	2018	113,054	11,974	20	11,974		35,922	19
20	dining room, 3rd floor elevator lobby, 3rd floor activity room,								20
21	3rd floor dining room, private dining-floor labor, millwork,								21
22	install lighting, wallpaper, drapery.								22
23	Door-40" surface vertical rod panic device	2019	6,851	343	20	343	(0)	662	23
24	Sprinkler system modifications-update sprinkler heads	2019	7,580	379	20	379		710	24
25	Chiller B circuit locked, switch kit circuit board	2019	14,400	720	20	720		1,249	25
26	Repairs to chiller-replace gaskets, pulled vacuum, replaced dryer c	2019	11,116	556	20	556	(0)	753	26
27	Work on elevator-new solid state starter.	2019	2,900	145	20	145		690	27
28	Chiller-installed gauges to 1st stage, add refrigerant	2019	2,998	150	20	150	(0)	225	28
29	Heat repair-air handler for hallway cold air, water reducing valve	2020	2,657	162	15	162		162	29
30	Ejector pit clean plumbing	2020	6,120	150	15	150		150	30
31	Ejector pumps leak and hot water-metropolitan pump fee	2020	3,113	27	15	27		27	31
32	2 door replacement alarm, keypad	2020	3,260		15			-	32
33	Reconcile book depreciation to financials			1,087			(1,087)		33
34	TOTAL (lines 1 thru 33)		\$ 2,182,743	\$ 21,748		\$ 118,017	\$ 96,269	\$ 467,914	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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,182,743	\$ 21,748		\$ 118,017	\$ 96,269	\$ 467,914	1
2	Buildings:								2
3	<u>Allocated From Maestro- 7257 Lincoln</u>	2004	50,684		35	1,448	1,448	24,799	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated From Maestro</u>	2003	412		20	21	21	353	9
10	<u>Allocated From Maestro</u>	2004	8,370		20	417	417	6,996	10
11	<u>Allocated From Maestro</u>	2005	496		20	25	25	393	11
12	<u>Allocated From Maestro</u>	2006	673		20	34	34	483	12
13	<u>Allocated From Maestro</u>	2008	709		20	35	35	435	13
14	<u>Allocated From Maestro</u>	2009	11,419		20	571	571	6,628	14
15	<u>Allocated From Maestro</u>	2010	1,755		20	88	88	922	15
16	<u>Allocated From Maestro</u>	2011	95		20	5	5	47	16
17	<u>Allocated From Maestro</u>	2012	106		20	5	5	46	17
18	<u>Allocated From Maestro</u>	2014	1,320		20	66	66	436	18
19	<u>Allocated From Maestro</u>	2015	371		20	19	19	99	19
20	<u>Allocated From Maestro</u>	2016	1,627		20	81	81	551	20
21	<u>Allocated From Maestro</u>	2017	217		20	11	11	44	21
22	<u>Allocated from Maestro</u>	2020	351		20	9	9	9	22
23	<u>Allocated From Maestro- 7257 Lincoln</u>	2015	799		20	53	53	284	23
24	<u>Allocated From Maestro- 7257 Lincoln</u>	2005	4,621		20	166	166	3,885	24
25	<u>Allocated From Maestro- 7257 Lincoln</u>	2004	1,007		20	50	50	831	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,267,775	\$ 21,748		\$ 121,121	\$ 99,373	\$ 515,155	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,188,962	\$ 53,957	\$ 230,125	\$ 176,168	10	\$ 1,319,352	71
72	Current Year Purchases	42,864	5,577	5,577		10	5,577	72
73	Fully Depreciated Assets	17,443				10	17,443	73
74	Allocated from Maestro	148,221		16,243	16,243		71,175	74
75	TOTALS	\$ 2,397,490	\$ 59,534	\$ 251,945	\$ 192,411		\$ 1,413,547	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	\$ 312	\$ -	\$ -	\$ -	5	\$ 312	76
77	Facility	2015 Ford Chamption Challenge	2019	12,500	1,786	1,786		7	1,967	77
78					-	-				78
79					-	-				79
80	TOTALS			\$ 12,812	\$ 1,786	\$ 1,786	\$ -		\$ 2,279	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,683,709	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,068	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 374,852	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 291,784	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,930,981	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Invesque

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>158</u>	<u>11/1/2015</u>	\$ <u>2,071,957</u>	<u>15</u>	<u>15</u>	3
4	Additions							4
5								5
6	Allocated Fr				<u>2,380</u>			6
7	TOTAL		<u>158</u>		\$ <u>2,074,337</u>			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>1,922,210</u>
13.	<u>12/31/2022</u>	\$ <u>1,960,655</u>
14.	<u>12/31/2023</u>	\$ <u>1,999,868</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: \$ 105,778 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Maestro</u>		\$ _____	\$ <u>3,946</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>3,946</u>	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 Evanston Healthcare
IDPH License ID Number: 0053256
Fiscal Year End: 12/31/2020

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	59,577
Nursing Equipment	7,694
Building Equipment	864
Office Equipment	40,387
Allocated from Maestro	6,859
Allocated from Integra	(9,603)
Total - Line 16	<u>105,778</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? <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 Drop-outs	2 Completed	3 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	\$	5,245	\$ 377,630	\$	5,245	\$ 377,630		5,245	\$ 377,630				1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,437	175,461		2,437	175,461		2,437	175,461				2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39(3)	hrs		8,361	601,150		8,361	601,150		8,361	601,150				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						126,457			126,457				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)							5,233			5,233				12
13	Other (specify): <u>See Sch 16A</u>	39(3)			1,041	74,952		1,041	74,952		1,041	74,952				13
14	TOTAL			\$	17,084	\$ 1,229,193	\$	17,084	\$ 1,360,883	\$	17,084	\$ 1,360,883				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 Evanston Healthcare
IDPH License ID Number: 0053256
Fiscal Year End: 12/31/2020

Schedule 16A

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

Line 13 Other

Rental Description	Amount
Inhalation Therapy Costs-Private	3,686
Inhalation Therapy Costs-Medicare A	17,220
Inhalation Therapy Costs-Medicaid	21,911
I.V. Therapy Costs-Medicare A	11,294
I.V. Therapy Costs-Managed Care	11,509
I.V. Therapy Costs-Medicaid	700
Inhalation Therapy Costs-Managed Care	8,632
Total - Line 13	74,952

Facility Name & ID Number **Symphony Evanston Healthcare**

0053256

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	\$ (28,580)	\$ (28,580)	1
2	Cash-Patient Deposits	44,386	44,386	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,657,900</u>)	2,365,699	2,365,699	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	5,462	5,462	6
7	Other Prepaid Expenses	20,731	20,731	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify):	-	-	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,407,698	\$ 2,407,698	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	5,632	13
14	Buildings, at Historical Cost	-	50,684	14
15	Leasehold Improvements, at Historical Cost	370,117	2,217,091	15
16	Equipment, at Historical Cost	353,321	2,410,302	16
17	Accumulated Depreciation (book methods)	(266,864)	(1,930,981)	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 17A</u>	2,941,782	2,941,782	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,398,356	\$ 5,694,510	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,806,054	\$ 8,102,208	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,282,523	\$ 1,282,523	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	44,386	44,386	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	299,444	299,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	301,464	301,464	31
32	Accrued Real Estate Taxes(Sch.IX-B)	989,017	989,017	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 17A</u>	8,301,212	8,301,212	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,218,046	\$ 11,218,046	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,339,223	3,339,223	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
Other Long-Term Liabilities(specify):				
43		-	-	43
44		-	-	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,339,223	\$ 3,339,223	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,557,269	\$ 14,557,269	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,751,215)	\$ (6,455,061)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,806,054	\$ 8,102,208	48

*(See instructions.)

Facility Name: Symphony Evanston Healthcare
 IDPH License ID Number: 0053256
 Fiscal Year End: 12/31/2020

Schedule 17A

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
CSA I/C Related/Party Due To/From Accts	279,509	279,509
Due To/From - Decatur	25,000	25,000
Due To/From - Deerbrook LLC	342,762	342,762
Due To/From - Ivy LLC	3,310	3,310
Due To/From - Lincoln Park LLC	1,589	1,589
Due To/From - Maple Ridge LLC	143,000	143,000
Due To/From - Northwoods LLC	74,000	74,000
Due To/From - South Shore	190	190
Due To/From - Sycamore LLC	20,000	20,000
Due To/From - California Gardens Nursing an	418	418
Due To/From - Monroe Corp	20,000	20,000
Due To/From - Orchard Valley	31,773	31,773
Due To/From - Crown Point LLC	1,731	1,731
Due To/From - Symphony ML	975,000	975,000
Due To/From - Symdiana Healthcare	666,000	666,000
Due To/From - Tillers	357,500	357,500
Total - Line 23	2,941,782	2,941,782

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Due To/From - Hanover Park	1,529	1,529
Due To/From - Jackson Square LLC	307	307
Due To/From - Maple Crest LLC	(64,308)	(64,308)
Due To/From - McKinley LLC	30,000	30,000
Due To/From - Symphony of Cal Gardens	256	256
Due To/From - Chesterton LLC	34,228	34,228
Due To/From - Symphony Healthcare	690,000	690,000
Due To/From - Symphony Financial Services	330,950	330,950
Due To/From - Sycamore Healthcare	347,163	347,163
Due To/From - Symcare ML	1,303,845	1,303,845
Due To/From - Symcare HMG	900,000	900,000
Due To/From - Maestro	198,226	198,226
Accrued Payables	52,482	52,482
Accrued Payables - Professional Fees	26,716	26,716
Accrued Payables - Health Insurance	77,420	77,420
Accrued Payable - Dental Insurance	(2,630)	(2,630)
Accrued Payables - Vision Insurance	(337)	(337)
Accrued Payables - Life Insurance	30,001	30,001
Accrued Payables - Short Term Disability	(26,993)	(26,993)
Accrued Payables - 401K Deductions	6,568	6,568
Accrued Payables - 401K Loan Repayments	664	664
Accrued Payables - Garnishments	(2,231)	(2,231)
Employee Purchases	457	457
Fringe Benefits - Flow Through	211	211
Accrued Payables - WC/GL Insurance	302,969	302,969
Accrued Payables - Bed Taxes	(10,367)	(10,367)
Accrued Payables - Bed Taxes Add'l	13,366	13,366
Accrued Payables - Management Fees	329,056	329,056
Accrued Payables - Interest	(5,695)	(5,695)
Accrued Payables - Rent	(49,379)	(49,379)
Accrued Payables - Sales Tax	1,678	1,678
Sales Tax Payable - Manual	(4,843)	(4,843)
Deferred Rent	955,896	955,896
Due To/From - Evanston Realty	2,567,640	2,567,640
Deferred Income	266,367	266,367
Total - Line 36	8,301,212	8,301,212

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,425,273)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,425,273)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,325,942)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,325,942)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (8,751,215)	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	\$ 10,405,939	1
2	Discounts and Allowances for all Levels	(2,042,370)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,363,569	3
B. Ancillary Revenue			
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	2,379,316	6
7	Oxygen	25,072	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,404,388	8
C. Other Operating Revenue			
9	Payments for Education	-	9
10	Other Government Grants	1,026,518	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	(5,897)	12
13	Barber and Beauty Care	49	13
14	Non-Patient Meals	(281)	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	188,466	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	38,666	19
20	Radiology and X-Ray	11,869	20
21	Other Medical Services	97,360	21
22	Laundry	2,183	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,358,933	23
D. Non-Operating Revenue			
24	Contributions	-	24
25	Interest and Other Investment Income***	2,063	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,063	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule 19A	(86,191)	28
28a		-	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (86,191)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,042,762	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,692,968	31
32	Health Care	4,463,345	32
33	General Administration	2,871,754	33
B. Capital Expense			
34	Ownership	3,149,912	34
C. Ancillary Expense			
35	Special Cost Centers	1,915,601	35
36	Provider Participation Fee	275,124	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,368,704	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,325,942)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,325,942)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,503,389	44
45	Private Pay - Net Inpatient Revenue	1,737,468	45
46	Medicare - Net Inpatient Revenue	1,706,974	46
47	Other-(specify) Hospice	176,334	47
48	Other-(specify) Managed Care	239,404	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,363,569	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 Evanston Healthcare
IDPH License ID Number: 0053256
Fiscal Year End: 12/31/2020

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Other revenue	11,422
Other Services - Revenue-Managed Care	(97,613)
Total - Line 28	(86,191)

Facility Name & ID Number **Symphony Evanston Healthcare**

0053256

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	1,797	1,667	\$ 92,912	\$ 55.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,750	30,700	1,262,370	41.12	3
4	Licensed Practical Nurses	34,331	30,273	1,046,241	34.56	4
5	CNAs & Orderlies	83,989	74,270	1,341,318	18.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,371	3,825	114,596	29.96	10
11	Social Service Workers	4,103	3,896	105,512	27.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,939	1,880	52,906	28.14	14
15	Cook Helpers/Assistants	10,732	9,451	164,928	17.45	15
16	Dishwashers	20,366	18,397	278,525	15.14	16
17	Maintenance Workers	7,381	6,378	161,621	25.34	17
18	Housekeepers	16,030	14,548	220,260	15.14	18
19	Laundry	651	614	9,482	15.44	19
20	Administrator	2,108	1,952	115,654	59.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,894	9,191	136,851	14.89	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	3,919	3,603	73,870	20.50	31
32	Other Health Care See Sch 20A	6,308	5,800	227,401	39.21	32
33	Other(specify) Admission Coord	5,127	4,831	132,474	27.42	33
34	TOTAL (lines 1 - 33)	248,796	221,277	\$ 5,536,921 *	\$ 25.02	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	\$ 19,792	1(3) 35
36	Medical Director	Monthly	24,000	9(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly	107	10(7) 38
39	Pharmacist Consultant	Monthly	12,131	10(3) 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	Monthly	189	39(3) 42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly	(2,420)	11(3) 44
45	Social Service Consultant			45
46	Other(specify) Psychiatric Consultant	Monthly	2,880	10(3) 46
47	Dental Consultant	Monthly	5,316	10(3) 47
48	Orthopedic Consultant	Monthly	22	10(3) 48
49	TOTAL (lines 35 - 48)		\$ 62,017	49

C. CONTRACT NURSES

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

Facility Name: Symphony Evanston Healthcare
IDPH License ID Number: 0053256
Fiscal Year End: 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS Coordinator	4,200	3,840	167,158	44
Human Resource Director	2,108	1,960	60,243	31
Total - Line 33 Other (spec	6,308	5,800	227,401	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Moshe Pretter	Administrator	0.00%	\$ 49,381	Workers' Compensation Insurance	\$ 125,683	IDPH License Fee	\$ 3,980	
Amanda Lanser	Administrator	0.00%	27,752	Unemployment Compensation Insurance	34,474	Advertising: Employee Recruitment	4,447	
Emily Bailey	Administrator	0.00%	38,521	FICA Taxes	404,722	Health Care Worker Background Check		
				Employee Health Insurance	208,343	(Indicate # of checks performed 154)	1,846	
				Employee Meals		Patient Background Checks 143	1,710	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,922	
				Pension Contribution		Licenses & Permits	29,119	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 115,654	Employee Benefits - Other	8,299	Health Care Council of Illinois	22,839	
(List each licensed administrator separately.)				401K	16,958	Chamber of commerce	(400)	
				Employees' Physical Exams	2,138	Allocated from Maestro	5,116	
B. Administrative - Other				Uniform Supplies-Human Resources & Benefits	6,701	Less: Public Relations Expense	(11,419)	
Description			Amount			Non-allowable advertising	()	
Management Fees- Maestro			\$ 551,337			Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 807,318	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 63,160	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 551,337	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
See Sch 21C			\$ 480,579				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	283
							Allocated from Maestro	281
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 480,579	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 564
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Symphony Evanston Healthcare**
 IDPH License ID Number: **0053256**
 Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ABILITY CHOICE	Secure Exchange Managed Services	(70)
Allscripts LLC	Referral System	3,776
Alteryx, Inc.	Data Analytics	2,327
applioi-applicant tracing system	applioi-applicant tracking system	76
CATS- APPLICANT TRACKING SYSTEM	Applicant Tracking System	404
CDW	IT Support	1,258
Comcast Cable	Internet and cable	25,348
Cortex Health, Inc.	Patient Follow-up	2,270
Creative Technology Solutions	IT Support	3,127
Darktrace Limited	Cyber Security	1,735
Data Robot-Cloud Professional	Data Storage	1,359
EMMI Solutions	Data Analytics	(269)
Enquire Solutions LLC	Marketing solution	830
ENTERPRISE IMMUNE SYSTEM	Immune System tracker	158
enVista, LLC	IT Support	603
FORMATION HEALTHCARE	Monthly Subscription Fee	867
Health Data Systems Inc	Programming	3,480
Intellcomp Technologies Inc.	IT Support	23,787
IntelliLogix	IT Support	370
JoLanda Williams	IT Support	40
KRONOS SUPPORT SERVICES	Payroll service	6,494
Managed Care Group LLC	IT Support	6,830
Microsoft Corp	Computer service	4,468
Navigator Group Purchasing, In	Data Analytics	227
Nexuscomm, LLC	Phone/fax service	7,043
Pay access	Payroll	113
PointClickCare Technologies Inc.	Cloud based software and services	28,646
PRIME CARE TECHNOLOGIES	PBJ Reporting Module Access Fee	2,520
Reputation.com, Inc.	Online Reputation Management	762
Reside Admissions LLC	Admission Process Consulting	3,965
Scott Norton	HR Services	215
Sprout Social Inc.	Social Media Management	1,811
Striv Technologies LLC dba Striv360	IT Support	2,594
Team TSI Corporation	Collection	3,730
Telemedicine Solutions, LLC	Wound Rounds Care	8,154
Third Eye Health Inc.	Data Analytics	5,178
Wencel	Branding	6,518
RSM and Marcum		37,056
MKB	Legal Counsel	47,215
Stone, Pogrund & Korey LLC	Collection, guardianship etc	14,849
Huston May & Fayeze,LLC	Legal	6,996
McCabe, Kirshner P.C.	Legal Counsel	954
Abbey Road Tax Consultants, LLC	Real Estate appeal-Accounting	180,000
Achieve Accreditation	Accreditation	10,546
ADP, LLC	Payroll service	1,255
Advanced Care Medical Specialist	Infectious Disease Consult	614
Corporation Service Company	Annual Filing	1,875
Duane Morris LLP	Guardianship	5,525
Gabriel Environment Services	Site Assessment Services	3,206
Language Line Services	Language lesson	395
MTS Consulting, LLC	Tax Consulting	1,202
National Datacare Corporation	trust service charge	2,450
Personnel Planners, Inc	Qtrly Unemployment Claims	1,650
SB2	Legal Fees -appeal Medicaid/Medicare cl	4,047
Total (agree to Schedule V, line 19, column 3)		480,579
Allocated from Maestro Professional Fees		27,918
Less: Non-Allowable Legal Fees		(9,697)
Less: Non-Allowable Branding/Marketing		(7,348)
Total (agree to Schedule V, line 19, column 8)		491,452

Facility Name & ID Number Symphony Evanston Healthcare# 0053256Report Period Beginning: 1/1/2020Ending: 12/31/2020**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (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 \$22,839
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 710 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? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 275,124
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ - Has any meal income been offset against related costs? N/A 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? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.