

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0053256 Facility Name: Symphony Evanston Healthcare Address: 820 Foster Street Evanston 60201 County: Cook Telephone Number: (847) 792-7700 Fax #: (847) 492-7672 HFS ID Number: Date of Initial License for Current Owners: 11/1/2014 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda Telephone Number: (847) 282-6300

Email Address:

Facility Name & ID Number Symphony Evanston Healthcare

0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,587</u>	<u>15,384</u>	<u>15,096</u>	<u>36,067</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>5,587</u>	<u>15,384</u>	<u>15,096</u>	<u>36,067</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.37%

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

None (Do not include bed-hold 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 ☒

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 10,052

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16
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	559,633	39,076	19,489	618,198		618,198		618,198			1
2	Food Purchase		299,152		299,152		299,152	(6,433)	292,719			2
3	Housekeeping	188,604	46,985		235,589		235,589		235,589			3
4	Laundry	64,634	47,893		112,527		112,527		112,527			4
5	Heat and Other Utilities			222,514	222,514		222,514	(20,566)	201,948			5
6	Maintenance	220,968		235,377	456,345		456,345	13,283	469,628			6
7	Other (specify):*							2,680	2,680			7
8	TOTAL General Services	1,033,839	433,106	477,380	1,944,325		1,944,325	(11,036)	1,933,289			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	4,068,179	180,460	54,396	4,303,035		4,303,035	103,097	4,406,132			10
10a	Therapy	36,047		3,290	39,337		39,337		39,337			10a
11	Activities	141,037	83,365		224,402		224,402		224,402			11
12	Social Services	114,992			114,992		114,992		114,992			12
13	CNA Training											13
14	Program Transportation			28,313	28,313		28,313	(3,757)	24,556			14
15	Other (specify):*							16,005	16,005			15
16	TOTAL Health Care and Programs	4,360,255	263,825	98,999	4,723,079		4,723,079	115,345	4,838,424			16
	C. General Administration											
17	Administrative	241,247		715,386	956,633		956,633	(686,017)	270,616			17
18	Directors Fees											18
19	Professional Services			168,043	168,043		168,043	24,664	192,707			19
20	Dues, Fees, Subscriptions & Promotions			86,318	86,318		86,318	(17,523)	68,795			20
21	Clerical & General Office Expenses	269,182	5,900	864,591	1,139,673		1,139,673	(510,986)	628,687			21
22	Employee Benefits & Payroll Taxes			1,013,546	1,013,546		1,013,546		1,013,546			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,474	1,474		1,474	959	2,433			24
25	Other Admin. Staff Transportation			41,830	41,830		41,830	2,376	44,206			25
26	Insurance-Prop.Liab.Malpractice			321,390	321,390		321,390	2,778	324,168			26
27	Other (specify):*							36,992	36,992			27
28	TOTAL General Administration	510,429	5,900	3,212,578	3,728,907		3,728,907	(1,146,757)	2,582,150			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,904,523	702,831	3,788,957	10,396,311		10,396,311	(1,042,448)	9,353,863			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			229,809	229,809		229,809	195,330	425,139			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,022	42,022		42,022	463,187	505,209			32
33	Real Estate Taxes			228,695	228,695		228,695	(5,346)	223,349			33
34	Rent-Facility & Grounds			1,083,913	1,083,913		1,083,913	(1,079,148)	4,765			34
35	Rent-Equipment & Vehicles			56,714	56,714		56,714	(5,080)	51,634			35
36	Other (specify):*											36
37	TOTAL Ownership			1,641,153	1,641,153		1,641,153	(431,057)	1,210,096			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		631,411	1,623,777	2,255,188		2,255,188	(6,650)	2,248,538			39
40	Barber and Beauty Shops			12,918	12,918		12,918		12,918			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			244,653	244,653		244,653		244,653			42
43	Other (specify):*	87,445		69,683	157,128		157,128	(157,128)	(0)			43
44	TOTAL Special Cost Centers	87,445	631,411	1,951,031	2,669,887		2,669,887	(163,778)	2,506,109			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,991,968	1,334,242	7,381,141	14,707,351		14,707,351	(1,637,283)	13,070,068			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,172)	02		4
5	Telephone, TV & Radio in Resident Rooms	(22,201)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	193,862	30		9
10	Interest and Other Investment Income	(66)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,261)	02		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	(14,748)	21		18
19	Entertainment				19
20	Contributions	(15,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(514,786)	21		24
25	Fund Raising, Advertising and Promotional	(7,665)	20		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	(2,462,324)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,850,311)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,213,028		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,213,028		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,637,283)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration	\$ (130,442)	21	1
2	Community Relations	(19,420)	43	2
3	Marketing	(69,658)	43	3
4	Guest Relations	(68,050)	43	4
5	Bank Charges	(40,823)	21	5
6	Additional R&M	4,611	06	6
7	Non-Allowable Auto Lease	(9,314)	35	7
8	Rental Income	(391)	35	8
9	PAC Dues	(6,124)	20	9
10	Collections	(27,107)	21	10
11	PPA - Restatement Fee	(60)	21	11
12	Bldg Co - Amortization	(965,583)	36	12
13	Bldg Co - Closing Expenses	(569,299)	21	13
14	Capitalized R&M	(9,688)	06	14
15	Rent for Sale/Leaseback Arrangement	(352,013)	34	15
16	R/E Tax	(193,843)	33	16
17	Non-Allowable Legal Fees	(5,121)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,462,324)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(6,433)											(6,433)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(22,201)		1,635									(20,566)	5
6	Maintenance	(5,077)		18,360									13,283	6
7	Other (specify):*			2,680									2,680	7
8	TOTAL General Services	(33,711)		22,675									(11,036)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			103,097									103,097	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(3,757)							(3,757)	14
15	Other (specify):*			16,005									16,005	15
16	TOTAL Health Care and Programs			119,102		(3,757)							115,345	16
	C. General Administration													
17	Administrative			(686,017)									(686,017)	17
18	Directors Fees													18
19	Professional Services	(5,121)		29,785									24,664	19
20	Fees, Subscriptions & Promotions	(29,739)		12,216									(17,523)	20
21	Clerical & General Office Expenses	(1,297,265)	569,299	216,979									(510,986)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			959									959	24
25	Other Admin. Staff Transportation			2,376									2,376	25
26	Insurance-Prop.Liab.Malpractice			2,778									2,778	26
27	Other (specify):*			36,992									36,992	27
28	TOTAL General Administration	(1,332,124)	569,299	(383,932)									(1,146,757)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,365,835)	569,299	(242,155)		(3,757)							(1,042,448)	29

Summary B

Facility Name & ID Number

0053256

01/01/16

Ending:

12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 731,900	Symphony of Evanston, LLC		\$	(731,900)	1
2	V	36	Amortization		Symphony of Evanston, LLC		965,583	965,583	2
3	V	32	Interest		Symphony of Evanston, LLC		463,253	463,253	3
4	V	33	R/E Taxes - Prior Year		Symphony of Evanston, LLC		184,847	184,847	4
5	V	21	Closing Expenses		Symphony of Evanston, LLC		569,299	569,299	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			\$ 731,900			\$ 2,182,982	\$ * 1,451,082	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.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 1,635	\$	1,635 15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	14,968		14,968 16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	3,392		3,392 17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,680		2,680 18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	103,097		103,097 19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	16,005		16,005 20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	29,369		29,369 21
22	V	17	ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%			
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	29,785		29,785 23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	12,216		12,216 24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	192,953		192,953 25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	24,027		24,027 26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	959		959 27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,376		2,376 28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,778		2,778 29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	36,992		36,992 30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,468		1,468 31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	3,650		3,650 32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	4,765		4,765 33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	2,060		2,060 34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,565		2,565 35
36	V								36
37	V	17	MANAGEMENT FEES	715,386	MAESTRO CONSULTING SERVICES LLC	100.00%			(715,386) 37
38	V								38
39	Total			\$ 715,386			\$ 487,739	\$ *	(227,647) 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	39	DME & Medical Supplies	\$ 65,642	Intergra Healthcare Equipment LLC		\$ 58,992	\$ (6,650)	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			\$ 65,642			\$ 58,992	\$ * (6,650)	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	14	Transportation	\$ 28,480	Lifeline Ambulance LLC		\$ 24,723	\$ (3,757)	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			\$ 28,480			\$ 24,723	\$ * (3,757)	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	\$ 185,832	MAPLE LEAF INSURANCE	100.00%	\$ 185,832	\$	15
16	V	26	Liability Insurance	256,068	MAPLE LEAF INSURANCE	100.00%	256,068		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			\$ 441,900			\$ 441,900	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	39

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

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	<u>DRAKE LOUIS ENTERPRISE, LLC</u>	<u>30.00%</u>	<u>CALIFORNIA GARDENS</u>	<u>CHICAGO</u>	<u>MAESTRO CONSULTING SERV</u>	<u>LINCOLNWOOD</u>	<u>MANAGEMENT</u>	1
2	<u>IBEX MANAGEMENT SERVICES, LLC</u>	<u>22.00%</u>	<u>MAPLECREST CARE CENTRE</u>	<u>BELVIDERE</u>	<u>7257 N. LINCOLN AVENUE</u>	<u>LINCOLNWOOD</u>	<u>BUILDING RENTAL</u>	2
3	<u>FAIRHOME TRUST U/A/D 12/31/12</u>	<u>20.00%</u>	<u>MCKINLEY COURT</u>	<u>DECATUR</u>	<u>MAPLELEAF INSURANCE</u>	<u>GRAND CAYMAN</u>	<u>LIABILITY/WORK COMP IN</u>	3
4	<u>WILLOW DELTA TRUST</u>	<u>12.00%</u>	<u>MONROE PAVILION</u>	<u>CHICAGO</u>	<u>INTEGRA HEALTHCARE EQUIP</u>	<u>ELMHURST</u>	<u>DME & MEDICAL SUPPLIES</u>	4
5	<u>MAW TRUST</u>	<u>8.00%</u>	<u>NORTHWOODS CARE CENTRE</u>	<u>BELVIDERE</u>	<u>INTEGRA RESPIRATORY SERV</u>	<u>ELMHURST</u>	<u>RESPIRATORY SERVICES</u>	5
6	<u>BENOIT HOLDINGS LLC</u>	<u>5.00%</u>	<u>SYCAMORE VILLAGE</u>	<u>SWANSEA</u>	<u>LIFELINE AMBULANCE</u>	<u>CHICAGO</u>	<u>AMBULANCE</u>	6
7	<u>SKITTLES HUNTINGTON, LLC</u>	<u>3.00%</u>	<u>SYMPHONY ARIA</u>	<u>HILLSIDE</u>				7
8			<u>SYMPHONY AT 87TH STREET</u>	<u>CHICAGO</u>				8
9			<u>SYMPHONY AT MIDWAY</u>	<u>CHICAGO</u>				9
10			<u>SYMPHONY AT THE TILLERS</u>	<u>OSWEGO</u>				10
11			<u>SYMPHONY OF BRONZEVILLE</u>	<u>CHICAGO</u>				11
12			<u>SYMPHONY OF BUFFALO GROVE</u>	<u>BUFFALO GROVE</u>				12
13			<u>SYMPHONY OF CHESTERTON</u>	<u>CHESTERTON, IN</u>				13
14			<u>SYMPHONY OF CHICAGO WEST</u>	<u>CHICAGO</u>				14
15			<u>SYMPHONY OF CRESTWOOD</u>	<u>CRESTWOOD</u>				15
16			<u>SYMPHONY OF CROWN POINT</u>	<u>CROWN POINT, IN</u>				16
17			<u>SYMPHONY OF DECATUR</u>	<u>DECATUR</u>				17
18			<u>SYMPHONY OF DYER</u>	<u>DYER, IN</u>				18
19			<u>SYMPHONY OF GLENDALE</u>	<u>GLENDALE, WI</u>				19
20			<u>SYMPHONY OF HANOVER PARK</u>	<u>HANOVER PARK</u>				20
21			<u>SYMPHONY OF JOLIET</u>	<u>JOLIET</u>				21
22			<u>SYMPHONY OF LINCOLN</u>	<u>LINCOLN</u>				22
23			<u>SYMPHONY OF LINCOLN PARK</u>	<u>CHICAGO</u>				23
24			<u>SYMPHONY OF MORGAN PARK</u>	<u>CHICAGO</u>				24
25			<u>SYMPHONY OF ORCHARD VALLEY</u>	<u>AURORA</u>				25
26			<u>SYMPHONY OF SOUTH SHORE</u>	<u>CHICAGO</u>				26
27			<u>SYMPHONY RESIDENCES OF LINCOLN PARK</u>	<u>CHICAGO</u>				27
28								28
29								29
30								30

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

Ending: 12/31/16

(847) 933-2601

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	39	DME & Medical Supplies	Direct Allocation			\$	\$		\$ 58,992	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					\$	\$		\$ 58,992	25

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	14	Transportation	Direct Allocation			\$	\$		\$ 24,723	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					\$	\$		\$ 24,723	25

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 185,832	1
2	26	Liability Insurance	Direct Allocation						256,068	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					\$	\$		\$ 441,900	25

Facility Name & ID Number Symphony Evanston Healthcare # 0053256 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

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

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	Private Bank		X	Mortgage			\$					\$ 368,253	1
2	Harborview Mezz		X	Note Payable								95,000	2
3													3
4													4
5					-								5
	Working Capital												
6	Private Bank		X	Note Payable				980,000				42,022	6
7	Private Bank		X	NP - Telephone System				46,680					7
8					-								8
9	TOTAL Facility Related						\$	1,026,680			\$ 505,274	9	
	B. Non-Facility Related*												
10	Interest Income		X									(66)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$ (66)	14	
15	TOTALS (line 9+line14)						\$	1,026,680			\$ 505,208	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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 - SUPPLEMENTAL SCHEDULE

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							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

FACILITY NAME	<u>Symphony Evanston Healthcare</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

IL478-2471

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Symphony Evanston Healthcare

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0053256

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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? 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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 84,834 **B. General Construction Type:** **Exterior** Frame **Number of Stories** 1

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

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

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

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

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2014	\$ 1,500,000	1
2	Allocated from Maestro 7257 Lincoln		2004	5,039	2
3	TOTALS			\$ 1,505,039	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	158		2014	1975	\$ 5,920,641	\$	40	\$ 148,016	\$ 148,016	\$ 320,701	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.

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

See Page 12A, Line 70 for total

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	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	75,573	1,316		2,744	1,428	31,038	68
69	Financial Statement Depreciation		229,809			(229,809)		69
70	TOTAL (lines 4 thru 69)	\$ 5,996,214	\$ 231,125		\$ 150,760	\$ (80,365)	\$ 351,739	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:

01/01/16

Ending:

12/31/16

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		\$ 5,996,214	\$ 231,125		\$ 150,760	\$ (80,365)	\$ 351,739	1
2	Interior Design Services	2014	4,000		20	200	200	400	2
3	Interior Design Services	2014	19,500		20	975	975	1,950	3
4	Field Work, Drawings	2015	9,180		20	421	421	842	4
5	Field Work, Drawings, Project Submission	2015	12,180		20	558	558	1,117	5
6	Demo-Remove Exisiting Finishes, Floor, Light Ceiling Fixtures, Flo	2015	10,775		20	449	449	898	6
7	Tile Avila Blanco, Grout Tec Sanded, Mortar Wall White	2015	15,628		20	586	586	1,172	7
8	Van Gogh Wood Plan Adhesive	2015	12,954		20	486	486	972	8
9	Van Gogh Wood Plan Adhesive	2015	11,663		20	389	389	778	9
10	Flooring Kardean Van Gogh Wood Plank	2015	19,308		20	644	644	1,287	10
11	Interior Design	2015	4,000		20	183	183	367	11
12	Garage Door, Fire Doors	2015	3,599		20	45	45	90	12
13	Power Wash, Panel & Vents Painting, Repair Fence Posts	2015	8,500		20	106	106	213	13
14	Paint Stucco Surface	2015	9,400		20	118	118	235	14
15	Light Fixtures, Ceiling Mount, Wallscones	2015	32,995		20	583	583	1,165	15
16	Orchids & Flowers Draper	2015	2,678		20	45	45	89	16
17	Flooring Tile, Plumbing, Adhesive	2015	103,136		20	3,868	3,868	7,735	17
18	Floor, Painting, Wall Vinyl, Carpentry, Electrical, Plumb-4&5Th Fl	2015	131,033		20	4,368	4,368	8,736	18
19	Flooring, Doors, Carpentry, Plumbing, Electircal, Fireplace-1St Fl	2015	91,737		20	3,058	3,058	6,116	19
20	Lighting, Grout For Rooms, Schluter-Rooms 10-16	2015	4,120		20	137	137	275	20
21	Flooring, Electrical, Plumbing, Carpentry, Painting, Wall Vinyl ...	2015	123,763		20	4,125	4,125	8,251	21
22	Flooring, Painting, Drop Ceiling, Carpentry, Electical-4&5Th Fl	2015	131,022		20	3,821	3,821	7,643	22
23	Speakers, Lighting, Wall Vinyl	2015	6,893		20	172	172	345	23
24	Flooring, Carpentry, Painting, Plumbing, Electircal, Fireplace-1St Fl	2015	91,737		20	2,293	2,293	4,587	24
25	Flooring, Carpentry, Painting, Plumbing, Electircal, Fireplace-1St Fl	2015	92,013		20	2,300	2,300	4,601	25
26	Floor, Painting, Wall Vinyl, Plumbing, Electrical-4&5Th Fl	2015	131,049		20	2,730	2,730	5,460	26
27	Flooring, Electical, Plumbing Fixtures, Wood Work, Wall Vinyl	2015	61,881		20	1,805	1,805	3,610	27
28	Flooring, Electical, Plumbing Fixtures, Painging, Wall Vinyl	2015	55,693		20	1,392	1,392	2,785	28
29	Lights, Glass Mirror, Switches, Flooring, Plumbing-4&5Th Fl	2015	14,824		20	309	309	618	29
30	Electical, Wood Work, Drop Ceiling, Doors, Plumbing-4&5Th Fl	2015	40,395		20	842	842	1,683	30
31	Demo, Flooring, Lighting, Plumbing, Painting, Permits-1St Fl	2015	34,782		20	580	580	1,159	31
32	Ventilator For 4Th And 5Th Floor	2015	4,397		20	92	92	183	32
33	Two Exhaust Grills 4Th & 5Th Floor	2015	3,653		20	61	61	122	33
34	TOTAL (lines 1 thru 33)		\$ 7,294,700	\$ 231,125		\$ 188,500	\$ (42,625)	\$ 427,219	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:

01/01/16

Ending:

12/31/16

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 12B, Carried Forward		\$ 7,294,700	\$ 231,125		\$ 188,500	\$ (42,625)	\$ 427,219	1
2	Ac Split System	2015	2,500		20	42	42	83	2
3	Custome Build Work Desk, Counters,	2015	5,300		20	88	88	177	3
4	Support Column Cover & Base Cabinet, Food Serving Station	2015	2,900		20	48	48	97	4
5	Interior Stainless Steel Passenger Elevators	2015	3,200		20	53	53	107	5
6	Relaminated Patient Room	2015	9,800		20	204	204	408	6
7	Replace Nurse Call Master	2015	7,704		20	642	642	1,284	7
8	Troubleshoot Air Handling	2015	5,454		20	454	454	909	8
9	Compressor - Repaired Leak And Charge	2015	2,984		20	199	199	398	9
10	Night Ir Turret Pow Camera	2015	29,345		20	1,956	1,956	3,913	10
11	Replace Compressor, Added Suction Filter & Valve	2015	12,460		20	623	623	1,246	11
12	Installed Air Conditioning	2015	10,960		20	548	548	1,096	12
13	Ceiling, Overbed, And Bathroom Light Fixtures	2015	57,800		20	2,890	2,890	5,780	13
14	4Th & 5Th Floor Nurse Call System	2015	4,820		20	241	241	482	14
15	Lighting, Plumbing, Electrical Work In Bathrooms	2016	25,391		20	1,270	1,270	1,270	15
16	& Resident Rooms	2016			20				16
17	Satum Ceiling Fixture	2016	10,614		20	531	531	531	17
18	Flooring - Van Gogh Field Woodplank	2016	6,070		20	304	304	304	18
19	Flooring Installation - 1St, 2Nd & 3Rd Floor	2016	57,240		20	2,862	2,862	2,862	19
20	Flooring Installation - 1St, 2Nd & 3Rd Floor Architect Fees	2016	10,780		20	539	539	539	20
21	Carpet Installation On 2Nd And 3Rd Floors	2016	6,332		20	317	317	317	21
22	Bathroom Tiles, Plumbing Fixtures, Electrical Work, New Doors,	2016	30,253		20	1,513	1,513	1,513	22
23	Plumbing - Repair Hi-Lo Tmv And Balance Return System	2016	7,012		20	351	351	351	23
24	Domestic Water Booster System	2016	4,615		20	231	231	231	24
25	Insinkerator Disposal	2016	2,666		20	133	133	133	25
26	Sliding Door	2016	4,265		20	427	427	427	26
27	Ejector Pump Replacement	2016	2,796		20	140	140	140	27
28	Elevator Repair	2016	6,872		20	344	344		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,624,832	\$ 231,125		\$ 205,448	\$ (25,677)	\$ 451,816	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,624,832	\$ 231,125		\$ 205,448	\$ (25,677)	\$ 451,816	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
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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)		\$ 7,624,832	\$ 231,125		\$ 205,448	\$ (25,677)	\$ 451,816	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,624,832	\$ 231,125		\$ 205,448	\$ (25,677)	\$ 451,816	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,624,832	\$ 231,125		\$ 205,448	\$ (25,677)	\$ 451,816	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		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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Ave. - Maestro	2004	45,350	1,163	35	1,296	133	17,006	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting Services	2003	369		20	18	18	242	9
10	Allocated from Maestro Consulting Services	2004	7,489		20	406	406	4,766	10
11	Allocated from Maestro Consulting Services	2005	444		20	22	22	263	11
12	Allocated from Maestro Consulting Services	2006	602		20	30	30	312	12
13	Allocated from Maestro Consulting Services	2008	635		20	32	32	262	13
14	Allocated from Maestro Consulting Services	2009	10,217		20	479	479	3,887	14
15	Allocated from Maestro Consulting Services	2010	1,570		20	79	79	511	15
16	Allocated from Maestro Consulting Services	2011	85		20	4	4	25	16
17	Allocated from Maestro Consulting Services	2012	94		20	5	5	22	17
18	Allocated from Maestro Consulting Services	2014	1,181		20	59	59	154	18
19	Allocated from Maestro Consulting Services	2015	332		20	17	17	22	19
20	Allocated from Maestro Consulting Services	2016	1,455	56	20	56		56	20
21									21
22	Allocated from 7257 N. Lincoln Ave. - Maestro	2015	715	68	20	48	(20)	64	22
23	Allocated from 7257 N. Lincoln Ave. - Maestro	2005	4,134	29	20	148	119	2,883	23
24	Allocated from 7257 N. Lincoln Ave. - Maestro	2004	901		20	45	45	563	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)		\$ 75,573	\$ 1,316		\$ 2,744	\$ 1,428	\$ 31,038	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 75,573	\$ 1,316		\$ 2,744	\$ 1,428	\$ 31,038	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 75,573	\$ 1,316		\$ 2,744	\$ 1,428	\$ 31,038	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	\$2,070,937	\$	\$210,424	\$210,424	10	\$452,034	71
72	Current Year Purchases	91,656	152	9,160	9,008	10	9,186	72
73	Fully Depreciated Assets	19,098		107	107	10	36,199	73
74								74
75	TOTALS	\$2,181,691	\$152	\$219,691	\$219,539		\$497,418	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 Consulti	2016	\$279	\$	\$	\$	5	\$279	76
77										77
78										78
79										79
80	TOTALS			\$279	\$	\$	\$		\$279	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,311,841	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$231,277	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$425,139	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$193,862	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$949,513	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$113,054	92
93			93
94			94
95		\$113,054	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: MHI Evanston (sale/leaseback arrangement)
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:		158		\$ 352,013			3
4	Additions				(352,013)			4
5	Allocated from Maestro Consulting Services				4,765			5
6								6
7	TOTAL		158		\$ 4,765			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 34,916

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	Facility	2015 Ford Challenger	\$ 1,179	\$ 14,153	17
18	Allocated from Maestro Consulting Services			2,565	18
19					19
20					20
21	TOTAL		\$ 1,179	\$ 16,718	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 621,218	\$		\$ 621,218	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			216,942			216,942	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			785,437			785,437	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				418,528		418,528	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					180	212,883		213,063	13
14	TOTAL			\$		\$ 1,623,777	\$ 631,411		\$ 2,255,188	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.

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	\$ 1,500	\$ 3,101	1
2	Cash-Patient Deposits	32,364	32,364	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,238,526	3,999,587	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	47,548	47,548	7
8	Accounts Receivable (owners or related parties)	1,177,078	2,699,348	8
9	Other(specify): <u>See Attached Schedule</u>	189,220	204,220	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,686,236	\$ 6,986,168	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	25,391	25,391	15
16	Equipment, at Historical Cost	37,991	37,991	16
17	Accumulated Depreciation (book methods)	(2,818)	(2,818)	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>	113,054	113,054	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 173,618	\$ 173,618	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,859,854	\$ 7,159,786	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,408,833	\$ 6,408,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60	60	28
29	Short-Term Notes Payable	980,000	980,000	29
30	Accrued Salaries Payable	126,996	126,996	30
31	Accrued Taxes Payable (excluding real estate taxes)	81,735	81,735	31
32	Accrued Real Estate Taxes(Sch.IX-B)	228,695	228,695	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>	68,325	982,825	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,894,644	\$ 8,809,144	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	46,680	46,680	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)	\$ 46,680	\$ 46,680	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,941,324	\$ 8,855,824	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,081,470)	\$ (1,696,038)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,859,854	\$ 7,159,786	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (764,241)	1
2	Restatements (describe):		2
3	Operating Expenses Adjustment	102,016	3
4	Rounding	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (662,221)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(285,081)	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	(2,134,168)	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)	\$ (2,419,249)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,081,470)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony Evanston Healthcare

0053256

Report Period Beginning: 01/01/16

Ending:

12/31/16

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	\$ 13,694,154	1
2	Discounts and Allowances for all Levels	(185,315)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,508,839	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	860,171	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 860,171	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		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	3,352	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	212	19
20	Radiology and X-Ray	113	20
21	Other Medical Services	33,426	21
22	Laundry	16,091	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 53,194	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,422,270	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,944,325	31
32	Health Care	4,723,079	32
33	General Administration	3,728,907	33
	B. Capital Expense		
34	Ownership	1,641,153	34
	C. Ancillary Expense		
35	Special Cost Centers	2,425,234	35
36	Provider Participation Fee	244,653	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,707,351	40
41	Income before Income Taxes (line 30 minus line 40)**	(285,081)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (285,081)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,181,360	44
45	Private Pay - Net Inpatient Revenue	4,798,081	45
46	Medicare - Net Inpatient Revenue	5,894,917	46
47	Other-(specify) <u>Hospice</u>	787,543	47
48	Other-(specify) <u>Managed Care</u>	846,938	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,508,839	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

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	1,973	2,127	\$ 115,002	\$ 54.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,595	56,022	1,989,919	35.52	3
4	Licensed Practical Nurses	14,477	15,259	427,871	28.04	4
5	CNAs & Orderlies	94,107	101,951	1,535,387	15.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,982	2,091	36,047	17.24	8
9	Activity Director	1,267	1,352	39,094	28.92	9
10	Activity Assistants	6,837	7,159	101,943	14.24	10
11	Social Service Workers	3,437	3,634	98,542	27.12	11
12	Dietician					12
13	Food Service Supervisor	7,073	8,209	186,253	22.69	13
14	Head Cook	5,465	5,918	108,060	18.26	14
15	Cook Helpers/Assistants	21,521	23,233	265,320	11.42	15
16	Dishwashers					16
17	Maintenance Workers	10,279	11,138	220,968	19.84	17
18	Housekeepers	14,485	15,384	188,604	12.26	18
19	Laundry	4,643	5,302	64,634	12.19	19
20	Administrator	2,025	2,103	241,247	114.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,967	2,092	42,231	20.19	23
24	Clerical	6,672	7,070	226,951	32.10	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					31
32	Other Health Care(specify)					32
33	Other(specify)	4,110	4,264	103,895	24.37	33
34	TOTAL (lines 1 - 33)	254,914	274,309	\$ 5,991,968 *	\$ 21.84	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 19,489	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	4,785	10-03	38
39	Pharmacist Consultant	Monthly	19,611	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	3,290	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Cardiologist	Monthly	30,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 90,175		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Symphony Evanston Healthcare

0053256

Report Period Beginning:

01/01/16

Ending:

12/31/16

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Moshe Polstein

Administrator

0

\$ 241,247

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

(List each licensed administrator separately.)

\$ 241,247

B. Administrative - Other

Description

Amount

Management Fees - Maestro

\$ 715,386

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

(Attach a copy of any management service agreement)

\$ 715,386

C. Professional Services

Vendor/Payee

Type

Amount

Marcum LLP

Accounting

\$ 57,930

Achieve Accreditation

Accreditation Consulting

11,056

Language Line Services

Translation Services

179

Personnel Planners

Unemployment Consulting

1,500

Pension Financial Services

Financial Planner

483

See Attached

Legal Fees

35,770

Ability Network

Data Processing

5,368

Creative Technology Solutions

Data Processing

14,551

E-health Data Solutions

Data Processing

1,278

Formation HC Group

Clinical Consulting

536

Health Data Systems

Data Processing

6,107

See Supplemental Schedule

33,285

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

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

\$ 168,043

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 185,832

Unemployment Compensation Insurance

33,616

FICA Taxes

436,865

Employee Health Insurance

329,443

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Pension Plan

10,800

Employee Physical Exams

6,731

Other Employee Benefits

10,260

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

\$ 1,013,547

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

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

6,033

Health Care Worker Background Check

(Indicate # of checks performed 242)

2,420

Patient Background Checks

557

5,570

Dues & Subscriptions

27,428

Licenses & Permits

13,139

Allocated from Maestro Consulting

12,216

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

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

\$ 68,795

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

1,474

Allocated from Maestro

959

Entertainment Expense

()

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

\$ 2,433

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Symphony Evanston Healthcare</u>	STATE OF ILLINOIS # <u>0053256</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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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. ICLTC - \$18,556

(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 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,375 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. 11/01/2016

(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. \$ 244,653
 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 benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,172

(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 14
 d. Have vehicle usage logs been maintained? N/A
 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? No
 Firm Name: N/A

(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