FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0051763

Facility Name: Countryside Care Centre

Address: 2330 W Galena Blvd (Number) Aurora (City) 60506 (Zip Code)

County: Kane

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2012

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	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	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,189	10,189	8
9	SNF/PED					9
10	ICF	47,024	5,199	7,040	59,263	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,024	5,199	17,229	69,452	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.73%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 127 and days of care provided 8,482

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	380,752	50,073	22,274	453,099		453,099		453,099			1
2	Food Purchase		392,883		392,883		392,883		392,883			2
3	Housekeeping	247,984	67,157		315,141		315,141		315,141			3
4	Laundry	88,059	32,941	13,703	134,703		134,703		134,703			4
5	Heat and Other Utilities			235,120	235,120		235,120	778	235,898			5
6	Maintenance	58,350	2,708	165,877	226,935		226,935	4,607	231,542			6
7	Other (specify):*											7
8	TOTAL General Services	775,145	545,762	436,974	1,757,881		1,757,881	5,385	1,763,266			8
	B. Health Care and Programs											
9	Medical Director			14,550	14,550		14,550		14,550			9
10	Nursing and Medical Records	4,014,726	282,615	15,153	4,312,494		4,312,494	(2,117)	4,310,377			10
10a	Therapy	71,580			71,580		71,580		71,580			10a
11	Activities	129,516		10,203	139,719		139,719		139,719			11
12	Social Services	70,739		1,136	71,875		71,875		71,875			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,286,561	282,615	41,042	4,610,218		4,610,218	(2,117)	4,608,101			16
	C. General Administration											
17	Administrative	231,149		707,952	939,101		939,101	(707,952)	231,149			17
18	Directors Fees											18
19	Professional Services			339,285	339,285		339,285	21,904	361,189			19
20	Dues, Fees, Subscriptions & Promotions			33,561	33,561		33,561	(5,754)	27,807			20
21	Clerical & General Office Expenses	322,642	49,337	60,611	432,590		432,590	160,533	593,123			21
22	Employee Benefits & Payroll Taxes			1,198,510	1,198,510		1,198,510		1,198,510			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,577	5,577		5,577	1,361	6,938			24
25	Other Admin. Staff Transportation			10,535	10,535		10,535		10,535			25
26	Insurance-Prop.Liab.Malpractice			407,547	407,547		407,547	10,012	417,559			26
27	Other (specify):* Mgmt alloc of benef							30,776	30,776			27
28	TOTAL General Administration	553,791	49,337	2,763,578	3,366,706		3,366,706	(489,120)	2,877,586			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,615,497	877,714	3,241,594	9,734,805		9,734,805	(485,852)	9,248,953			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.

Facility Name & ID Number Countryside Care Centre #0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			125,724	125,724		125,724	2,571	128,295			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,336	143,336		143,336	(90,340)	52,996			32
33	Real Estate Taxes			254,175	254,175		254,175		254,175			33
34	Rent-Facility & Grounds			1,658,036	1,658,036		1,658,036	12,399	1,670,435			34
35	Rent-Equipment & Vehicles			69,276	69,276		69,276	94	69,370			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,250,547	2,250,547		2,250,547	(75,276)	2,175,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			32,101	32,101		32,101		32,101			38
39	Ancillary Service Centers		242,402	1,614,345	1,856,747		1,856,747		1,856,747			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			481,231	481,231		481,231		481,231			42
43	Other (specify):* **Non-Allowable Cos**	625		408,568	409,193		409,193	(409,193)				43
44	**TOTAL Special Cost Centers**	625	242,402	2,536,245	2,779,272		2,779,272	(409,193)	2,370,079			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,616,122	1,120,116	8,028,386	14,764,624		14,764,624	(970,321)	13,794,303			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 Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,605)	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				9
10	Interest and Other Investment Income	(90,340)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,230)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,688)	43		18
19	Entertainment				19
20	Contributions	(4,327)	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	(235,620)	43		24
25	Fund Raising, Advertising and Promotional	(10,752)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(29,228)	43		28
29	Other-Attach Schedule See Sch 5A	(107,455)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (506,245)		$	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)	(464,076)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (464,076)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (970,321)		37

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

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

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

Countryside Care Centre

ID# 0051763

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (51,764)	43	1
2	Laboratory Costs	(19,040)	43	2
3	X-Ray Costs	(22,024)	43	3
4	Marketing Salaries	(625)	43	4
5	Theft and damage loss	(500)	43	5
6	Lobbying Expense	(6,712)	20	6
7	Medicare and Medicare HMO ancillary costs	(6,790)	43	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				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**	(107,455)		49

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				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			$			$	$ *	14

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Symphony Financial Services, LLC	100.00%	$ 778	$ 778	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	4,607	4,607	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	(2,117)	(2,117)	17
18	V	17	Administrative	707,952	Symphony Financial Services, LLC	100.00%		(707,952)	18
19	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	21,904	21,904	19
20	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	958	958	20
21	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	160,533	160,533	21
22	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	1,361	1,361	22
23	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	10,012	10,012	23
24	V	27	Other		Symphony Financial Services, LLC	100.00%	30,776	30,776	24
25	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	2,571	2,571	25
26	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	12,399	12,399	26
27	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	94	94	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			$ 707,952			$ 243,876	$ * (464,076)	39

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony o	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere				5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7527 N. Lincoln Ave, L	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Seasons Hospice	Park Ridge	Hospice	13
14			Claremont - Hanover Park	Hanover Park	JLR Financial Service	Lincolnwood	Management Co.	14
15			Claridge Imperial, LTD.	Chicago	KFT Services, LLC	Lincolnwood	Management Co.	15
16			Jackson Corp	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	Clinical Consulting Se	Lincolnwood	Clinical Consult	17
18			Renaissance at 87th Street	Chicago	Quest Services Corp	Lincolnwood	Marketing	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Medical Su	19
20			Renaissance at South Shore	Chicago	Maple Leaf Insurance	Grand Cayman	Liability/Work Com	20
21			Renaissance at Park South	Chicago				21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona				24
25			Renaissance West	Mesa, Arizona				25
26			Renaissance Village IL	Mesa, Arizona				26
27			Renaissance Village AL	Mesa, Arizona				27
28								28
29								29
30								30

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

Name of Related Organization: Symphony Financial Services, LLC
Street Address: 7358 N. Lincoln, Suite 120
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((847) 933-2600
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	5	Utilities	Occupied Bed Days	422,236	8	$ 4,728		69,452	$ 778	1
2	6	Maintenance	Occupied Bed Days	422,236	8	28,009		69,452	4,607	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	422,236	8	(12,869)	(12,869)	69,452	(2,117)	3
4	19	Professional Services-Legal	Occupied Bed Days	422,236	8	6,403		69,452	1,053	4
5	19	Professional Services-Other	Occupied Bed Days	422,236	8	126,762		69,452	20,851	5
6	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	422,236	8	5,823		69,452	958	6
7	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	422,236	8	929,524		69,452	152,894	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	422,236	8	46,441		69,452	7,639	8
9	24	Travel & Seminar	Occupied Bed Days	422,236	8	8,276		69,452	1,361	9
10	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	422,236	8	60,868		69,452	10,012	10
11	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	422,236	8	187,104		69,452	30,776	11
12	30	Depreciation	Occupied Bed Days	422,236	8	15,633		69,452	2,571	12
13	34	Rent - Facility & Grounds	Occupied Bed Days	422,236	8	75,378		69,452	12,399	13
14	35	Rent - Equipment & Vehicles	Occupied Bed Days	422,236	8	572		69,452	94	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,482,652	$		$ 243,876	25

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Capital Improvements	Interest Only	12/30/2011	2,000,000	246,898	12/30/2014	0.0550	11,852	6
7	The Private Bank		X	Line of credit	Interest Only	12/30/2011	17,520,000	2,739,101	06/10/2014	0.0550	131,484	7
8												8
9	TOTAL Facility Related						$ 19,520,000	$ 2,985,999			$ 143,336	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(90,340)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (90,340)	14
15	TOTALS (line 9+line14)						$ 19,520,000	$ 2,985,999			$ 52,996	15

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

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

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 217,900	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.)	2012	$ 230,275	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,375	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 241,800	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
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.		$ 254,175	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	193,854	8
	2009	171,414	9
	2010	178,035	10
	2011	203,590	11
	2012	230,275	12

2013 Tax Accrual = $230,275 * 1.05 = $241,788.75, use $241,800

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryside Care Centre COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0051763

CONTACT PERSON REGARDING THIS REPORT Liz Koshy

TELEPHONE (847) 933-2600 FAX #: (847) 673-2284

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	Nursing Home	$ 230,274.96	$ 230,274.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 230,274.96	$ 230,274.96

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 X _____ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MRC			2013	198,047	6,902	27.5	6,902		6,902	9
10	MRC			2013	116,913	4,074	27.5	4,074		4,074	10
11	Interior painting, replace storefront glass, wall and floor coverings			2013	22,173	672	27.5	672		672	11
12	Repiped water line to 3 compartments			2013	2,630	72	27.5	72		72	12
13	demo/carpentry & drywall			2013	54,915	1,664	27.5	1,664		1,664	13
14	interior electrical alarms			2013	16,460	499	27.5	499		499	14
15	Exterior demo/carpentry			2013	50,619	1,381	27.5	1,381		1,381	15
16	Carpet Removal			2013	10,856	296	27.5	296		296	16
17	Roofing			2013	10,000	273	27.5	273		273	17
18	Lounge 500 - New Carpet			2013	3,100	295	7	295		295	18
19	Demo/Carpentry/Drywall			2013	303,589	6,090	27.5	6,090		6,090	19
20	Fencing in patio			2013	2,922	81	15	81		81	20
21	Electircal work for office			2013	4,391	53	27.5	53		53	21
22	Demo/Carpentry/Drywall			2013	49,040	446	27.5	446		446	22
23	Painting/Carpentry			2013	13,180	471	7	471		471	23
24	Demo/Carpentry/Drywall			2013	53,564	162	27.5	162		162	24
25	Painting/Carpentry			2013	1,980	24	7	24		24	25
26	Roof Garden			2013	8,595	48	15	48		48	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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 922,974	$ 23,503		$ 23,503	$	$ 23,503	70

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 473,099	$ 79,080	$ 79,080	$	5-7	$ 95,792	71
72	Current Year Purchases	176,245	21,897	21,897		5-7	21,897	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	24,092		2,571	2,571	5-7	2,666	74
75	TOTALS	$ 673,436	$ 100,977	$ 103,548	$ 2,571		$ 120,355	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2008 Ford Van	2013	$ 16,587	$ 1,244	$ 1,244	$	10	$ 1,244	76
77										77
78										78
79										79
80	TOTALS			$ 16,587	$ 1,244	$ 1,244	$		$ 1,244	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)	$ 1,612,997	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 125,724	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,295	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,571	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 145,102	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.

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Diana Master Landlord, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	203	12/31/2011	$ 1,654,716	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				12,399			6
7	TOTAL		203		$ 1,667,115 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,320
   This amount was calculated by dividing the total amount to be amortized 33,198
   by the length of the lease 10 .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 12/31/2011
    Ending 12/31/2021

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2014	$ 1,100,000
13.	12/31/2015	$ 1,122,000
14.	12/31/2016	$ 1,144,440

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 65,388 Description: See Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2008 Ford E350	$ 1,327.19	$ 3,982	17
18					18
19					19
20					20
21	TOTAL		$ 1,327.19	$ 3,982	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.

Symphony Countryside
FYE: December 31, 2013
Provider Number - 0051763

Schedule 14A

XII. RENTAL COSTS
B 16. Rental Amounts

Description	Amount
Bariatric Bed	4,325
Oxygen Concentrator	19,522
Blood Pressure Machine	1,386
Maintenance Equip	20
3 Spot Coolers	4,950
Ice Maker	4,520
Water Machine	121
Printers	26,666
Mailing Machine	1,370
Aquarium	2,414
Allocated from Mgmt. Co.	94
Total B16	65,388

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	9,360	$ 673,943	$	9,360	$ 673,943	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,873	278,881		3,873	278,881	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,091	654,540		9,091	654,540	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				242,402		242,402	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)			97	6,981		97	6,981	12
13	Other (specify):									13
14	TOTAL			$	22,421	$ 1,614,345	$ 242,402	22,421	$ 1,856,747	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.

Symphony Countryside **Schedule 16A**
FYE: December 31, 2013
Provider Number - 0051763

XIV. SPECIAL SERVICES
Line 12 Other

Description	Units	Amount
I.V. THERAPY-MEDICAID	23	1,673
RESPIRATORY	69	4,950
PROGRAM CONSULTANT	5	358
Total Line 11	97	6,981

STATE OF ILLINOIS

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 61,265	$ 61,265	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 428,942)	5,509,646	5,509,646	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	915	915	6
7	Other Prepaid Expenses	143,274	143,274	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	515,615	515,615	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,230,715	$ 6,230,715	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	922,974	922,974	15
16	Equipment, at Historical Cost	665,931	690,023	16
17	Accumulated Depreciation (book methods)	(142,436)	(145,102)	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 (spe Lease Cost	26,558	26,558	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,473,027	$ 1,494,453	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,703,742	$ 7,725,168	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 776,491	$ 776,491	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,480	143,480	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	241,800	241,800	32
33	Accrued Interest Payable	1,033	1,033	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,898,762	1,898,762	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,061,566	$ 3,061,566	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,985,999	2,985,999	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,985,999	$ 2,985,999	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,047,565	$ 6,047,565	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,656,177	$ 1,677,603	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,703,742	$ 7,725,168	48

***(See instructions.)**

Symphony Countryside **Schedule 17A**
Provider # 0051763
FYE: 12/31/2013

XV. Balance Sheet
Line 9 Other (specify):

Description	Operating	After Consolidation
Cash in Bank Money Market	(67,847)	(67,847)
Medicaid Coinsurance Receivable	143,862	143,862
Security Deposit	271,874	271,874
Real Estate Escrow Deposit	166,343	166,343
Employee Loans/Wage Assignments	1,383	1,383
Total - Line 9	515,615	515,615

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

Description	Operating	After Consolidation
Deferred Rent	434,350	434,350
Due to Symphony Crestwood	136,668	136,668
Security Deposit Payable	322,936	322,936
Operating Expenses	158,279	158,279
Management Fees - Symphony	152,005	152,005
Insurance Allowable - W/C & GLPL	8,977	8,977
State Unemployment Tax	181	181
Sales Tax	14,894	14,894
Payroll Taxes Other	347,832	347,832
Accrued Employee Benefits	54,960	54,960
FICA & W/H Fed	10,239	10,239
ILL W/H	128,842	128,842
Due to IDPA - Add'tl Bed Tax	11,303	11,303
Due to/From the Kinsington	20,238	20,238
Due to Nucare	31,189	31,189
Due to Symphony	41,738	41,738
Patient Personal Funds	24,131	24,131

1,898,762	1,898,762

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 859,328	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(843)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 858,485	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,047,692	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) **Withdrawals**	(250,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 797,692	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,656,177	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,901,373	1
2	Discounts and Allowances for all Levels	(2,596,972)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,304,401	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,129,023	6
7	Oxygen	969	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,129,992	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	229,958	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,367	19
20	Radiology and X-Ray	12,697	20
21	Other Medical Services	13,561	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 287,583	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	90,340	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90,340	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)**	$ 15,812,316	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,757,881	31
32	Health Care	4,610,218	32
33	General Administration	3,366,706	33
	B. Capital Expense		
34	Ownership	2,250,547	34
	C. Ancillary Expense		
35	Special Cost Centers	2,298,041	35
36	Provider Participation Fee	481,231	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,764,624	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,047,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,047,692	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,399,565	44
45	Private Pay - Net Inpatient Revenue	1,111,450	45
46	Medicare - Net Inpatient Revenue	4,202,546	46
47	Other-(specify) Hospice	1,251,463	47
48	Other-(specify) Managed Care	339,377	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,304,401	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.**

^ **Tax return prepared on cash basis.**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,842	2,084	$ 75,520	$ 36.24	1
2	Assistant Director of Nursing	5,987	6,543	133,265	20.37	2
3	Registered Nurses	27,086	29,503	1,011,881	34.30	3
4	Licensed Practical Nurses	29,138	32,153	821,017	25.53	4
5	CNAs & Orderlies	131,216	142,262	1,807,582	12.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,608	8,487	190,741	22.47	8
9	Activity Director	3,556	4,155	68,278	16.43	9
10	Activity Assistants	5,163	6,383	61,238	9.59	10
11	Social Service Workers	3,789	4,123	70,739	17.16	11
12	Dietician					12
13	Food Service Supervisor	3,289	3,772	49,666	13.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,727	35,122	331,086	9.43	15
16	Dishwashers					16
17	Maintenance Workers	1,870	2,096	58,350	27.84	17
18	Housekeepers	18,227	20,343	247,984	12.19	18
19	Laundry	7,008	7,626	88,059	11.55	19
20	Administrator	1,745	2,013	169,970	84.43	20
21	Assistant Administrator	2,031	2,483	61,179	24.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,900	12,349	322,642	26.13	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 C: Ward Clerk	2,891	3,228	46,300	14.34	32
33	Other(specify) Marketing Bonus			625		33
34	TOTAL (lines 1 - 33)	295,074	324,724	$ 5,616,122 *	$ 17.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 22,274	1(3)	35
36	Medical Director	Monthly	14,550	9(3)	36
37	Medical Records Consultant	Monthly	1,568	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,585	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,948	11(3)	44
45	Social Service Consultant	Monthly	1,136	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 56,061		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Kohls	Administrator	0	$ 169,970
Lynn M. Blackburn	Assistant Administrator	0	27,953
Danielle Clevenger	Assistant Administrator	0	33,226
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 231,149

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in col. 7)	$ 707,952
TOTAL (agree to Schedule V, line 17, col. 3)	$ 707,952
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 339,285
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 339,285

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 172,121
Unemployment Compensation Insurance	88,351
FICA Taxes	425,864
Employee Health Insurance	487,711
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	12,287
Employee Benefits - Other	6,428
Employees' Physical Exams	5,748
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,198,510

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	755
Health Care Worker Background Check	
(Indicate # of checks performed 327)	3,923
Patient Background Checks 172	2,065
Miscellaneous Licenses & Fees	1,175
Illinois Council on Long Term Care	20,341
Miscellaneous Dues & Subscriptions	3,312
Lobbying Expense	(6,712)
Allocated from Mgmt. Co.	958
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,807

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,577
Allocated from Mgmt. Co.	1,361
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,938

**See instructions.

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ABILITY NETWORK	SECURE EXCHANGE MANAGED SERVIC	1,747
ACHIEVE ACCREDITATION	CONSULTATION DAY HONORARIUM	10,636
ALLEN A LEFTKOVITZ	LEGAL	7,742
ALL SCRIPTS	MGMNT FACILITY SUBSCRIPTION FEE	2,932
AMA	CREDENTIAL FOR DOCTORS	350
AON E SOLUTIONS INC	RISK MGMT SFTWR/MAINT	3,513
ARI KIRSHNER	LEGAL	14
COMCAST	INTERNET	21,647
DELL MARKETING	MICROSOFT LICENSING	1,403
DOCUMENTATION SOLUTIONS	CLAIM REVIEWS	1,960
EHEALTH DATA SOLUTIONS	CAREWATCH BILLING	5,112
EITECH	LOGITECH WEBCAM	197
EMDEON BUSINESS SERVICES	BILLING	611
HDSI	DATA PROCESSING	4,544
HIPP LAW OFFICE	COLLECTION	1,469
HK PAYROLL SERVICES	WORK TAX CREDIT	360
IT/SOURCETECH	OPERATOR MONTHLY SUPPORT FEE	1,380
MARK HARTMAN	WEB HOSTING	213
MCGLADREY	ACCOUNTING	21,907
MUCH SHELIST	ANNUAL REPRESENTATION	350
PERSONNEL PLANNERS INC	QTRLY UNEMPLOYMENT CLAIMS	1,090
PETTY CASH	CREDENTIALING FOR PHYSICIANS	200
PINNACLE QUALITY INSIGHT	CUSTOMER SATISFACTION	2,790
POINT B COMMUNICATION	YEARLY WEB HOSTING	144
PROVINET SOLUTIONS	OUTSOURCED IT SERVICES	15,459
PSD COLUTIONS	NETWORK INTEGRATION SERVICE	7,170
SAS ARCHITECTS	ARCHITECTURAL SERV	4,171
STONE, MCGUIRE & SIEGEL	LEGAL - COMPLIANCE	14,511
SUBURBAN LUND ASSOC.	PROFESSIONAL FEES	438
SYMPHONY FINANCIAL	PROFESSIONAL FEES	152,401
TELEMEDICINE SOLUTIONS	WOUND ROUNDS CARE	19,179

THE JOINT COMMISSION	ANNUAL FEE JCAHO	5,570
WESCOM SOLUTIONS	DATA PROCESSING	27,674
ZIRMED	ELIGIBILITY VERIFICATION	401
Total agreeing to Schedule V, Line 19, Col 3		339,285
Allocated from Management Company Legal Fees		1,053
Allocated from Management Company Professional Services		20,851
Total (agree to Schedule V, line 19, column 8)		361,189

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3											N/A		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC - $20,341**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,577** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **No** 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. $ **481,231**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **5**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.