FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0051771

Facility Name: Symphony of Decatur

Address: 2530 North Monroe (Number) | Decatur (City) | 62526 (Zip Code)

County: Macon

Telephone Number: (217) 875-0920 **Fax #** (217) 876-9351

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 Symphony of Decatur # 0051771 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	195	Skilled (SNF)	195	71,175	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	195	TOTALS	195	71,175	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			8,602	8,602	8
9	SNF/PED					9
10	ICF	47,450	4,855	1,610	53,915	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,450	4,855	10,212	62,517	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.84%

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 195 and days of care provided 8,178

Medicare Intermediary Wisconsin Physician 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 Symphony of Decatur # 0051771 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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	325,141	52,341	17,530	395,012		395,012		395,012			1
2	Food Purchase		348,155		348,155		348,155		348,155			2
3	Housekeeping	228,371	47,930		276,301		276,301		276,301			3
4	Laundry	127,988	18,185	5,484	151,657		151,657		151,657			4
5	Heat and Other Utilities			177,360	177,360		177,360	700	178,060			5
6	Maintenance	61,694	2,090	168,090	231,874		231,874	4,147	236,021			6
7	Other (specify):*											7
8	**TOTAL General Services**	743,194	468,701	368,464	1,580,359		1,580,359	4,847	1,585,206			8
	B. Health Care and Programs											
9	Medical Director			49,800	49,800		49,800		49,800			9
10	Nursing and Medical Records	3,397,042	179,865	45,716	3,622,623		3,622,623	(1,905)	3,620,718			10
10a	Therapy	9,897			9,897		9,897		9,897			10a
11	Activities	201,972		14,517	216,489		216,489		216,489			11
12	Social Services	99,551		2,780	102,331		102,331		102,331			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,708,462	179,865	112,813	4,001,140		4,001,140	(1,905)	3,999,235			16
	C. General Administration											
17	Administrative	264,809		536,917	801,726		801,726	(536,917)	264,809			17
18	Directors Fees											18
19	Professional Services			260,423	260,423		260,423	19,717	280,140			19
20	Dues, Fees, Subscriptions & Promotions			32,334	32,334		32,334	(5,049)	27,285			20
21	Clerical & General Office Expenses	177,790	50,258	69,080	297,128		297,128	144,503	441,631			21
22	Employee Benefits & Payroll Taxes			1,003,869	1,003,869		1,003,869		1,003,869			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,826	4,826		4,826	1,225	6,051			24
25	Other Admin. Staff Transportation			25,901	25,901		25,901		25,901			25
26	Insurance-Prop.Liab.Malpractice			310,119	310,119		310,119	9,012	319,131			26
27	Other (specify):* **Mgmt alloc of benef**							27,703	27,703			27
28	**TOTAL General Administration**	442,599	50,258	2,243,469	2,736,326		2,736,326	(339,806)	2,396,520			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,894,255	698,824	2,724,746	8,317,825		8,317,825	(336,864)	7,980,961			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 Symphony of Decatur #0051771 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			37,370	37,370		37,370	2,315	39,685			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,885	171,885		171,885	(77,729)	94,156			32
33	Real Estate Taxes			75,095	75,095		75,095		75,095			33
34	Rent-Facility & Grounds			1,521,607	1,521,607		1,521,607	11,161	1,532,768			34
35	Rent-Equipment & Vehicles			127,792	127,792		127,792	85	127,877			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,933,749	1,933,749		1,933,749	(64,168)	1,869,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			6,927	6,927		6,927		6,927			38
39	Ancillary Service Centers		194,187	1,174,239	1,368,426		1,368,426		1,368,426			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			436,601	436,601		436,601		436,601			42
43	Other (specify):* **Non-Allowable Cos**	(1,400)		320,206	318,806		318,806	(318,806)				43
44	**TOTAL Special Cost Centers**	(1,400)	194,187	1,937,973	2,130,760		2,130,760	(318,806)	1,811,954			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,892,855	893,011	6,596,468	12,382,334		12,382,334	(719,838)	11,662,496			45

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

Facility Name & ID Number Symphony of Decatur # 0051771 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	(15,676)	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	(77,729)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,857)	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	(5,166)	43		18
19	Entertainment				19
20	Contributions	(9,730)	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	(178,960)	43		24
25	Fund Raising, Advertising and Promotional	(9,825)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(276)	43		28
29	Other-Attach Schedule See Sch 5A	(101,227)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (402,446)		$	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)	(317,392)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (317,392)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (719,838)		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

Symphony of Decatur

ID# 0051771

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (56,393)	43	1
2	Laboratory Costs	(26,712)	43	2
3	X-Ray Costs	(5,632)	43	3
4	Theft and Damage Loss	(1,559)	43	4
5	Marketing Bonus (McKinley paid)	1,400	43	5
6	Lobbying Expense	(5,911)	20	6
7	Medicare and Medicare HMO ancillary	(6,420)	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**	(101,227)		49

Facility Name & ID Number Symphony of Decatur # 0051771 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 Symphony of Decatur # 0051771 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%	$ 700	$ 700	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	4,147	4,147	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	(1,905)	(1,905)	17
18	V	17	Administrative	536,917	Symphony Financial Services, LLC	100.00%		(536,917)	18
19	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	19,717	19,717	19
20	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	862	862	20
21	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	144,503	144,503	21
22	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	1,225	1,225	22
23	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	9,012	9,012	23
24	V	27	Other		Symphony Financial Services, LLC	100.00%	27,703	27,703	24
25	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	2,315	2,315	25
26	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	11,161	11,161	26
27	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	85	85	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			$ 536,917			$ 219,525	$ * (317,392)	39

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

Facility Name & ID Number Symphony of Decatur # 0051771 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 Symphony of Decatur # 0051771 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 Symphony of Decatur # 0051771 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		62,517	$ 700	1
2	6	Maintenance	Occupied Bed Days	422,236	8	28,009		62,517	4,147	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	422,236	8	(12,869)	(12,869)	62,517	(1,905)	3
4	19	Professional Services-Legal	Occupied Bed Days	422,236	8	6,403		62,517	948	4
5	19	Professional Services-Other	Occupied Bed Days	422,236	8	126,762		62,517	18,769	5
6	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	422,236	8	5,823		62,517	862	6
7	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	422,236	8	929,524	929,524	62,517	137,627	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	422,236	8	46,441		62,517	6,876	8
9	24	Travel & Seminar	Occupied Bed Days	422,236	8	8,276		62,517	1,225	9
10	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	422,236	8	60,868		62,517	9,012	10
11	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	422,236	8	187,104		62,517	27,703	11
12	30	Depreciation	Occupied Bed Days	422,236	8	15,633		62,517	2,315	12
13	34	Rent - Facility & Grounds	Occupied Bed Days	422,236	8	75,378		62,517	11,161	13
14	35	Rent - Equipment & Vehicles	Occupied Bed Days	422,236	8	572		62,517	85	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	$ 916,655		$ 219,525	25

Facility Name & ID Number Symphony of Decatur # 0051771 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	32,450	12/30/2014	0.0550	1,344	6
7	The Private Bank		X	Line of credit	Interest Only	12/30/2011	17,520,000	4,116,890	06/10/2014	0.0550	170,541	7
8												8
9	TOTAL Facility Related						$ 19,520,000	$ 4,149,340			$ 171,885	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(77,729)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (77,729)	14
15	TOTALS (line 9+line14)						$ 19,520,000	$ 4,149,340			$ 94,156	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 Symphony of Decatur **#** 0051771 **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.**	$ 81,700	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	$ 76,495	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,205)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 80,300	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.		$ 75,095	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	75,755	8
	2009	77,236	9
	2010	77,477	10
	2011	76,378	11
	2012	81,700	12

2013 Tax Accrual = $76,495 * 1.05 = $80,320; use $80,300

	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 Symphony of Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0051771

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.	04-12-03-251-014	Nursing Home	$ 76,495.36	$ 76,495.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,495.36	$ 76,495.36

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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 5

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 Symphony of Decatur # 0051771 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	New Piston & Cylinder for Elevator			2012	64,900	2,360	27.5	2,360		3,147	9
10	Drill new hole for elevator			2013	50,316	1,830	27.5	1,830		1,830	10
11	Elevator - shut off valve/oil line			2013	20,420	248	27.5	248		248	11
12	Cabling for EMR Kiosks			2013	7,721	187	27.5	187		187	12
13	Line Voltage Outlets			2013	5,740	104	27.5	104		104	13
14	Remodeling-Painting, wall coverings, millwork, ceiling			2013	487,979	1,479	27.5	1,479		1,479	14
15	architect fees, office conversions, lighting, flooring, doors,										15
16	fire sprinkler, plumbing, landscaping, paving, awnings -										16
17	Monroe Entrance, Vertical Circulation & Exits, Lobby, Hallways										17
18	Nurse' Station & Resident Rooms (2nd Floor), New Offices										18
19	Dining Room, Medical Room and Therapy Room (1st Floor)										19
20											20
21	Remodeling-Painting, Wall Coverings & Water Heater			2013	120,068	1,001	10	1,001		1,001	21
22	1st Floor - Lobby, offices/conference rooms, hallways,										22
23	laundry & dietary areas										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

Facility Name & ID Number Symphony of Decatur # 0051771 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)		$ 757,144	$ 7,209		$ 7,209	$	$ 7,996	70

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

Facility Name & ID Number Symphony of Decatur # 0051771 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	$ 15,030	$ 3,005	$ 3,005	$	5	$ 3,722	71
72	Current Year Purchases	306,181	27,156	27,156		5-7	27,156	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	21,687		2,315	2,315	5-7	2,400	74
75	TOTALS	$ 342,898	$ 30,161	$ 32,476	$ 2,315		$ 33,278	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,100,042	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,370	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,685	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,315	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 41,274	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 Symphony of Decatur # 0051771 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:	1973	195	12/31/2011	$ 1,518,120	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				11,161			6
7	TOTAL		195		$ 1,529,281 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,487
   This amount was calculated by dividing the total amount to be amortized 34,871
   by the length of the lease 10 .

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

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.	/2014	$ 1,100,000
13.	/2015	$ 1,122,000
14.	/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: $ 117,977 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	Chevy Tahoe	$ 900.00	9,900	17
18					18
19					19
20					20
21	TOTAL		$ 900.00	$ 9,900	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 Aspen Ridge **Schedule 14A**
Provider # 0051771
FYE: 12/31/2013

B (16) Movable Equipment Rental

Rental Description	Amount
Broda Chair, Broda Tray	186
Bed Bariatric, Air Compressor	10,963
Low Air Loss Mattress, Air Compressor	36,062
VAC Freedom	14,248
Cylinder	42
Oxygen Concentrator	6,459
Plant Rental	6,550
Cooler Infiniti FS CA	611
Chairs	610
Domestic Container	1,800
VAC ATS Therapy Unit	6,195
Industrial Gas	42
Copiers	31,442
Mail Machine	1,012
Computer	880
Digital Music	790
Allocated from Mgmt. Co.	85
	117,977

Facility Name & ID Number Symphony of Decatur # 0051771 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 Symphony of Decatur # 0051771 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	$	7,727	$ 556,319	$	7,727	$ 556,319	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		986	70,984		986	70,984	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,451	536,489		7,451	536,489	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				194,187		194,187	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Schedule 16A	39(3)			145	10,447		145	10,447	13
14	TOTAL			$	16,309	$ 1,174,239	$ 194,187	16,309	$ 1,368,426	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 Aspen Ridge **Schedule 16A**
FYE: December 31, 2013
Provider Number - 0051771

XIV. SPECIAL SERVICES (Direct Cost)
12. Other

Description	Units	Amount
INHALATION THERAPY-PRIVATE	1	73
INHALATION THERAPY-MEDICAID	5	331
PHYSICIANS-MEDICARE	1	90
OTHER SERVICES - MEDICAID	1	92
ONCOLOGIST	167	12,000
DENTAL SERVICES	(30)	(2,139)
	145	10,447

STATE OF ILLINOIS

Facility Name & ID Number Symphony of Decatur # 0051771 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	$ 378,323	$ 378,323	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 350,214)	4,113,001	4,113,001	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,373	1,373	6
7	Other Prepaid Expenses	20,836	20,836	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	696,490	696,490	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,210,023	$ 5,210,023	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	757,144	757,144	15
16	Equipment, at Historical Cost	321,211	342,898	16
17	Accumulated Depreciation (book methods)	(38,874)	(41,274)	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	27,897	27,897	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,067,378	$ 1,086,665	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,277,401	$ 6,296,688	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,301,617	$ 1,301,617	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,955	250,955	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,300	80,300	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,258,741	1,258,741	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,891,613	$ 2,891,613	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,149,340	4,149,340	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)**	$ 4,149,340	$ 4,149,340	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,040,953	$ 7,040,953	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (763,552)	$ (744,265)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,277,401	$ 6,296,688	48

***(See instructions.)**

Symphony Aspen Ridge **Schedule 17A**
Provider # 0051771
FYE: 12/31/2013

XV. Balance Sheet
Line 9 Other (specify):

Description	Operating	After Consolidation
Patient Personal Funds	25,650	25,650
Medicare/Other Coinsurance Receivable	375,592	375,592
Rent Prepaids	121,612	121,612
Security Deposit	146,744	146,744
Real Estate Escrow Deposit	23,391	23,391
Employee Loans/Wage Assignments	3,501	3,501
Total - Line 9	696,490	696,490

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

Description	Operating	After Consolidation
Security Deposit Payable	71,684	71,684
Operating Expenses	278,657	278,657
Management Fees - Symphony	121,832	121,832
Insurance Allowable - W/C & GLPL	218,198	218,198
Accrued Interest	854	854
State Unemployment Tax	5,543	5,543
Sales Tax	217	217
Payroll Taxes Other	26,044	26,044
Accrued Employee Benefits	239,537	239,537
FICA & W/H Fed	104	104
Due to IDPA - Add'tl Bed Tax	108,744	108,744
Due to/From the Kinsington	41,778	41,778
Due to Nucare	21,236	21,236
Due to Symphony	35,578	35,578
Due to McKinley Court	26,320	26,320
Patient Personal Funds	29,023	29,023
Deferred Rent Amortization	33,392	33,392
Total - Line 36	1,258,741	1,258,741

Facility Name & ID Number Symphony of Decatur # 0051771 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**	$ (389,605)	1	
2	Restatements (describe):		2	
3	**Rounding**	1	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (389,604)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(373,948)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (373,948)	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)**	$ (763,552)	24	*

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

Facility Name & ID Number Symphony of Decatur # 0051771 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	$ 11,296,217	1
2	Discounts and Allowances for all Levels	(1,838,271)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,457,946	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,148,202	6
7	Oxygen	18	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,148,220	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	277,288	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,477	19
20	Radiology and X-Ray	2,769	20
21	Other Medical Services	16,706	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 312,240	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	77,729	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 77,729	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare and Managed Care Rentals	12,251	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,251	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,008,386	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,580,359	31
32	Health Care	4,001,140	32
33	General Administration	2,736,326	33
	B. Capital Expense		
34	Ownership	1,933,749	34
	C. Ancillary Expense		
35	Special Cost Centers	1,694,159	35
36	Provider Participation Fee	436,601	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,382,334	40
41	**Income before Income Taxes (line 30 minus line 40)****	(373,948)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (373,948)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,832,661	44
45	Private Pay - Net Inpatient Revenue	722,151	45
46	Medicare - Net Inpatient Revenue	1,614,575	46
47	Other-(specify) Hospice	229,984	47
48	Other-(specify) Managed Care	58,575	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,457,946	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 Symphony of Decatur # 0051771 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	1,918	2,027	$ 85,043	$ 41.96	1
2	Assistant Director of Nursing	2,009	2,278	68,729	30.17	2
3	Registered Nurses	6,410	7,395	306,752	41.48	3
4	Licensed Practical Nurses	46,251	52,138	1,304,462	25.02	4
5	CNAs & Orderlies	107,971	118,231	1,526,389	12.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	700	767	9,897	12.90	8
9	Activity Director	2,189	2,474	41,929	16.95	9
10	Activity Assistants	9,958	11,895	160,043	13.45	10
11	Social Service Workers	2,999	3,147	99,551	31.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,331	31,893	325,141	10.19	15
16	Dishwashers					16
17	Maintenance Workers	2,506	2,623	61,694	23.52	17
18	Housekeepers	17,135	19,509	228,371	11.71	18
19	Laundry	11,796	13,042	127,988	9.81	19
20	Administrator	1,964	2,370	200,745	84.71	20
21	Assistant Administrator	1,918	2,250	64,064	28.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,196	11,288	177,790	15.75	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	1,883	2,136	33,330	15.60	31
32	Other Health C: Ward Clerk	3,929	4,589	72,337	15.76	32
33	Other(specify) Marketing Bonus			(1,400)		33
34	TOTAL (lines 1 - 33)	261,062	290,053	$ 4,892,855 *	$ 16.87	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	$ 17,530	1(3)	35
36	Medical Director	Monthly	49,800	9(3)	36
37	Medical Records Consultant	Monthly	1,760	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,316	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	2,780	11(3)	44
45	Social Service Consultant	Monthly	2,780	12(3)	45
46	Other(specify) Wound Care	Monthly	24,000	10(3)	46
47	Alzheimers	Monthly	8,640	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 118,606		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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Trudeau	Administrator	0	$ 200,745
Paula J. Pepple	Assistant Administrator	0	64,064
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 264,809

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	$ 536,917
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 536,917

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 260,423
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 260,423

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 218,538
Unemployment Compensation Insurance	57,087
FICA Taxes	369,971
Employee Health Insurance	306,758
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	26,147
Employee Benefits - Other	24,581
Employees' Physical Exams	787
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,003,869

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,268
Health Care Worker Background Check (Indicate # of checks performed 41)	1,433
Patient Background Checks 202	1,030
Miscellaneous Licenses & Fees	3,020
Illinois Council on Long Term Care	17,911
Miscellaneous Dues & Subscriptions	3,692
Lobbying Expense Offset	(5,911)
Allocated from Mgmt. Co.	862
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,285

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,453
Non-Allowable Out of State Travel	(2,627)
Allocated from Mgmt. Co.	1,225
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,051

* Attach copy of IMRF notifications

**See instructions.

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ABILITY NETWORK	SECURE EXCHANGE MANAGED	1,748
AON E SOLUTIONS	RISK CONSOLE SUPPORT	3,195
COMCAST	INTERNET	15,798
CREATIVE TECHNOLOGY	EMAIL PROTECTION	218
DELL MARKETING	MICROSOFT LICENSING	1,348
EHEALTH DATA SOLUTIONS	CARE WATCH BILLING	5,112
EITECHS	LOGITECH WEBCAM	186
EMDEON	BILLING	365
EVAULT	PROTECT ON 36 MO SERVER	1,731
HDSI	DATA PROCESSING	3,729
HIPP LAW OFFICES	COLLECTIONS	240
HK PAYROLL SERVICES	WORK TAX CREDITS	3,105
IIT/SOURCETECH	OPERATOR MONTHLY SUPPORT	1,380
MCGLADREY LLP	ACCOUNTING	21,625
MUCH SHELIST	STATUTORY REGISTED AGENT	522
NETWORK SOLUTIONS	WEB HOSTING	238
ON LINE COMMUNITCATIONS	PLUGS, CABLES	550
PERSONNEL PLANNERS INC	UI CLAIMS	1,083
PINNACLE QUALTY INSIGHT	CUSTOMER SATISFACTION	2,790
POINT B COMMUNICATOINS	WEB HOSTING	1,008
PROVINET SOLUTIONS	OUTSOURSING IT SERVICES	12,119
PSD SOLUTIONS	NETWORK INTEGRATION	1,833
STONE, MCGUIRE & SIEGEL	LEGAL - COMPLIANCE	15,798
SYMPHONY FINANCIAL SERVICES	CONSULTANTS	113,268
TELEMEDICINE	WOUNDROUND MANAGED CAR	21,816
WALMART	INTERNET ACCESS FOR RES	132
WESCOM SOLUTIONS	DATA PROCESSING BILLING	29,101
ZIRMED	IMPLEMENTATION FEE	385
Total agreeing to Schedule V, Line 19, Col 3		260,423

Allocated from Management Company Legal Fees 948

Allocated from Management Company Professional Services	18,769
Total (agree to Schedule V, line 19, column 8)	280,140

Facility Name & ID Number Symphony of Decatur # 0051771 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 Symphony of Decatur # 0051771 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 - $17,911**

(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?

(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. $ **457** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **436,601**
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. $ **0**
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.