

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0051805 Facility Name: Symphony of Crestwood Address: 14255 South Cicero Avenue Crestwood 60445 County: Cook Telephone Number: (708) 371-0400 Fax #: (708) 371-5871 HFS ID Number: Date of Initial License for Current Owners: 01/01/2012 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County 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 01/01/2012 to 12/31/2012 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) 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
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Facility Name & ID Number Symphony of Crestwood# 0051805 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>303</u>	Skilled (SNF)	<u>303</u>	<u>110,898</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>303</u>	TOTALS	<u>303</u>	<u>110,898</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>14,193</u>	<u>14,193</u>	8
9	SNF/PED					9
10	ICF	<u>56,346</u>	<u>7,520</u>	<u>4,854</u>	<u>68,720</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,346</u>	<u>7,520</u>	<u>19,047</u>	<u>82,913</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.77%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

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

YES ☐NO ☒

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

Date started 01/01/2012

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

YES ☒Date 12/31/2011NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 303 and days of care provided 12,021Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	589,977	46,108	25,233	661,318		661,318		661,318			1
2	Food Purchase		462,335		462,335		462,335		462,335			2
3	Housekeeping	341,125	80,107		421,232		421,232		421,232			3
4	Laundry	219,239	49,835	8,154	277,228		277,228		277,228			4
5	Heat and Other Utilities			199,577	199,577		199,577		199,577			5
6	Maintenance	87,103	1,755	224,681	313,539		313,539	568	314,107			6
7	Other (specify):*											7
8	TOTAL General Services	1,237,444	640,140	457,645	2,335,229		2,335,229	568	2,335,797			8
	B. Health Care and Programs											
9	Medical Director			48,250	48,250		48,250		48,250			9
10	Nursing and Medical Records	4,938,558	331,321	37,888	5,307,767		5,307,767	35,844	5,343,611			10
10a	Therapy											10a
11	Activities	240,357		3,779	244,136		244,136		244,136			11
12	Social Services	171,236		1,875	173,111		173,111		173,111			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							13,146	13,146			15
16	TOTAL Health Care and Programs	5,350,151	331,321	91,792	5,773,264		5,773,264	48,990	5,822,254			16
	C. General Administration											
17	Administrative	290,135		853,975	1,144,110		1,144,110	(830,430)	313,680			17
18	Directors Fees											18
19	Professional Services			247,419	247,419		247,419	(42,522)	204,897			19
20	Dues, Fees, Subscriptions & Promotions			74,317	74,317		74,317	949	75,266			20
21	Clerical & General Office Expenses	298,022		120,729	418,751		418,751	175,377	594,128			21
22	Employee Benefits & Payroll Taxes			1,683,953	1,683,953		1,683,953		1,683,953			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,864	6,864		6,864	1,572	8,436			24
25	Other Admin. Staff Transportation			7,496	7,496		7,496		7,496			25
26	Insurance-Prop.Liab.Malpractice			444,130	444,130		444,130	1,366	445,496			26
27	Other (specify):* Mgmt alloc of benef							37,383	37,383			27
28	TOTAL General Administration	588,157		3,438,883	4,027,040		4,027,040	(656,305)	3,370,735			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,175,752	971,461	3,988,320	12,135,533		12,135,533	(606,747)	11,528,786			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,099	15,099		15,099	112	15,211			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			236,369	236,369		236,369	150	236,519			32
33	Real Estate Taxes			666,800	666,800		666,800	(13,092)	653,708			33
34	Rent-Facility & Grounds			2,489,985	2,489,985		2,489,985	1,430	2,491,415			34
35	Rent-Equipment & Vehicles			302,332	302,332		302,332	6,148	308,480			35
36	Other (specify):*											36
37	TOTAL Ownership			3,710,585	3,710,585		3,710,585	(5,252)	3,705,333			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,984	8,984		8,984		8,984			38
39	Ancillary Service Centers		540,453	1,609,707	2,150,160		2,150,160		2,150,160			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			596,662	596,662		596,662		596,662			42
43	Other (specify):* Non-Allowable Co	138,239		421,686	559,925		559,925	(559,925)				43
44	TOTAL Special Cost Centers	138,239	540,453	2,637,039	3,315,731		3,315,731	(559,925)	2,755,806			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,313,991	1,511,914	10,335,944	19,161,849		19,161,849	(1,171,924)	17,989,925			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 Crestwood # 0051805 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,180)	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	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,615)	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	(24,022)	43		18
19	Entertainment				19
20	Contributions	(10,625)	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	(284,659)	43		24
25	Fund Raising, Advertising and Promotional	(6,935)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(232,417)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (573,475)		\$	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)	(598,449)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (598,449)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,171,924)		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 Crestwood

ID# 0051805

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (31,550)	43	1
2	Laboratory Costs	(27,047)	43	2
3	X-Ray Costs	(20,253)	43	3
4	Theft and Damages Loss	(1,800)	43	4
5	Real Estate Taxes	(13,092)	33	5
6	Marketing Salaries	(138,239)	43	6
7	Non-Allowable Legal Fees	(436)	19	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	(232,417)		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	Symphony Financial Services, LLC	100.00%	\$ 568	\$ 568	15
16	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	35,844	35,844	16
17	V	15	Other		Symphony Financial Services, LLC	100.00%	13,146	13,146	17
18	V	17	Administrative	853,975	Symphony Financial Services, LLC	100.00%	23,545	(830,430)	18
19	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	(42,086)	(42,086)	19
20	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	949	949	20
21	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	175,377	175,377	21
22	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	1,572	1,572	22
23	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	1,366	1,366	23
24	V	27	Other		Symphony Financial Services, LLC	100.00%	37,383	37,383	24
25	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	112	112	25
26	V	32	Interest		Symphony Financial Services, LLC	100.00%	172	172	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	1,430	1,430	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	6,148	6,148	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			\$ 853,975			\$ 255,526	\$ * (598,449)	39

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

Facility Name & ID Number

Symphony of Crestwood

0051805

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	Morton Grove	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid Aurora		Symphony M.L., LLC	Morton Grove	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of Crestwood		Symphony HMG, LLC	Morton Grove	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of Joliet		Symphony Financial S	Morton Grove	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Crest 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, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	Seasons Hospice	Park Ridge	Hospice	14
15			Claridge Imperial, LTD.	Chicago	JLR Financial Service	Lincolnwood	Management Co.	15
16			Jackson Corp	Chicago	KFT Services, LLC	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	17
18			Renaissance at 87th Street	Chicago	Clinical Consulting Se	Lincolnwood	Clinical Consult	18
19			Renaissance at Midway	Chicago	Quest Services Corp	Lincolnwood	Marketing	19
20			Renaissance at South Shore	Chicago	Integra Healthcare Eq	Elmhurst	DME & Medical Su	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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Munter	Owner	Administrative	10.00	185,555	5.63	11.26	Grntd pmts	\$ 23,545	17(7)	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	\$ 23,545		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 Crestwood# 0051805

Report Period Beginning:

01/01/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Symphony Financial Services, LLC

Street Address

8140 River Drive

City / State / Zip Code

Morton Grove, IL 60053

Phone Number

(847) 583-0100

Fax Number

()

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

	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	6	Maintenance	Occupied Bed Days	424,571	8	\$ 2,907	\$	82,913	\$ 568	1
2	10	Nursing & Med Records - Sal	Occupied Bed Days	424,571	8	183,547	183,547	82,913	35,844	2
3	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	424,571	8	67,318		82,913	13,146	3
4	17	Admin-Gntd pmts	Occupied Bed Days	50	8	209,100	209,100	6	23,545	4
5	19	Consulting (owner)	Occupied Bed Days	424,571	8	(232,247)	(232,247)	82,913	(45,355)	5
6	19	Professional Services-Legal	Occupied Bed Days	424,571	8	6,427		82,913	1,255	6
7	19	Professional Services-Other	Occupied Bed Days	424,571	8	10,315		82,913	2,014	7
8	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	424,571	8	4,860		82,913	949	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	424,571	8	847,289	847,289	82,913	165,464	9
10	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	424,571	8	50,761		82,913	9,913	10
11	24	Travel & Seminar	Occupied Bed Days	424,571	8	8,050		82,913	1,572	11
12	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	424,571	8	6,997		82,913	1,366	12
13	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	424,571	8	191,428		82,913	37,383	13
14	30	Depreciation	Occupied Bed Days	424,571	8	569		82,913	111	14
15	32	Interest	Occupied Bed Days	424,571	8	879		82,913	172	15
16	34	Rent-Facility & Grounds	Occupied Bed Days	424,571	8	7,324		82,913	1,430	16
17	35	Rent-Equipment & Vehicles	Occupied Bed Days	424,571	8	31,481		82,913	6,149	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,397,005	\$ 1,007,689		\$ 255,526	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	The Private Bank		X	Mortgage	Interest Only	12/30/2011	\$ 17,520,000	\$ 4,817,705	06/11/2013	0.0550	\$ 179,865	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	1,513,452	12/30/2014	0.0550	56,504	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 19,520,000	\$ 6,331,157			\$ 236,369	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income Offset				(22)	12	
13							Management company allocation				172	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 150	14	
15	TOTALS (line 9+line14)						\$ 19,520,000	\$ 6,331,157			\$ 236,519	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$		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.)		2011		\$	653,708	2
3. Under or (over) accrual (line 2 minus line 1).				\$	653,708	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	666,800	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.)				\$	(666,800)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	653,708	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	492,056	8
2008	519,666	9
2009	532,779	10
2010	542,455	11
2011	653,708	12

[See attached accrual worksheet.](#)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Symphony of Crestwood

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0051805

CONTACT PERSON REGARDING THIS REPORT
Liz Koshy

TELEPHONE
(847) 583-0100
FAX #:
(847) 583-8873

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 28-03-303-012-0000	Nursing Home	\$ 416,595.00	\$ 416,595.00
2. 28-03-303-011-0000	Nursing Home	\$ 228,708.00	\$ 228,708.00
3. 28-03-303-038-0000	Nursing Home	\$ 8,405.00	\$ 8,405.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 653,708.00	\$ 653,708.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

91,960

B. General Construction Type:

Exterior

Stone

Frame

Steel

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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:

N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Architectural Fees			2012	30,284	597	27.5	597		597	9	
10	Elevator - Electrical			2012	19,950	91	27.5	91		91	10	
11	Exterior Aluminum			2012	52,666	239	27.5	239		239	11	
12	Exterior Painting - Back Entrance			2012	53,000	883	27.5	883		883	12	
13	Interior Painting - First Floor			2012	16,140	220	27.5	220		220	13	
14	Interior Painting - Second Floor			2012	32,000	145	27.5	145		145	14	
15	Front Entrance - West & S			2012	19,000	29	27.5	29		29	15	
16	Cooling Tower - Replace			2012	31,138	425	27.5	425		425	16	
17	Floor Coverings			2012	213,242	323	27.5	323		323	17	
18	Elevator - Fix Car Sills			2012	242,100	367	27.5	367		367	18	
19	Sprinkler System - Entire			2012	326,853	495	27.5	495		495	19	
20	Standby Generator for Service Elevator			2012	55,000	917	5	917		917	20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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)		\$ 1,091,373	\$ 4,731		\$ 4,731	\$	\$ 4,731	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	598,469	10,368	10,368		5-7	10,368	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	1,118		112	112		112	74
75	TOTALS	\$ 599,587	\$ 10,368	\$ 10,480	\$ 112		\$ 10,480	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				\$	\$	\$	\$		\$	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)	\$ 1,690,960	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,099	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,211	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 112	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 15,211	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Railings and window trmt	\$ 53,644	92
93	Demo/Carpentry Drywall	321,511	93
94	Interior Electrical Alarm	74,207	94
95		\$ 449,362	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.
- ☐ 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:	1974	303	12/31/2011	\$ 2,483,532	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				1,430			6
7	TOTAL		303		\$ 2,484,962			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- 6,453
64,527
10

9. Option to Buy:
- ☐ YES☒ NO
- Terms: N/A
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 292,747
- 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	Facility Use	Ford F250	\$ 780.00	\$ 9,364	17
18	Facility Use	Ford E350 Bus	1,405.00	4,215	18
19	Facility Use	Ford 450 Mini Bus	1,279.00	1,279	19
20	Administrative	Toyota Corolla	298.00	875	20
21	TOTAL		\$ 3,762.00	\$ 15,733	21

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.	12/31/2013	\$ #####
13.	12/31/2014	\$ #####
14.	12/31/2015	\$ #####

* 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 Crestwood
Provider # 0051805
FYE: 12/31/2012

Schedule 14A

B (16) Movable Equipment Rental

Rental Description	Amount
Low Air Loss Mattress	140,428
Vac Freedom	24,690
Oxy gen Concentrator	7,074
CPAP, BIPAP, CONCT, BIPAPR	6,856
Air Cleaner	2,941
Ice Maker	6,533
Water System	2,349
Copiers	92,162
Computers	959
Muzak Services Music Sound	255
Mailing System	2,352
Allocated from Mgmt. Co.	6,148
	<u>292,747</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	8,557	\$ 616,105	\$	8,557	\$ 616,105	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,325	167,409		2,325	167,409	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		10,232	736,690		10,232	736,690	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				540,453		540,453	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)			1,233	88,772		1,233	88,772	12
13	Other (specify):									13
14	TOTAL			\$	22,347	\$ 1,608,976	\$ 540,453	22,347	\$ 2,149,429	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 Crestwood
FYE: December 31, 2012
Provider Number - 0051805

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost)
12. Other

Description	Amount
INHALATION THERAPY-MEDICARE	250
INHALATION THERAPY-MEDICAID	81
INHALATION THERAPY-MAN. CARE	312
I.V. THERAPY-MEDICARE	41,581
I.V. THERAPY-MEDICAID	2,476
I.V. THERAPY-MANAGED CARE	4,837
RESPIRATORY	15,887
CARDIOLOGIST CONSULTANT	6,250
RN CONSULTANT	17,098
	88,772

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	\$ 2,000	\$ 2,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 225,345)	7,393,762	7,393,762	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,730	151,730	6
7	Other Prepaid Expenses	81,226	81,226	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,697,172	1,697,172	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,325,890	\$ 9,325,890	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	1,036,373	1,091,373	15
16	Equipment, at Historical Cost	653,469	599,587	16
17	Accumulated Depreciation (book methods)	(15,099)	(15,211)	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 (spec Lease Cost	58,074	58,074	22
23	Other(specify): Construction in progress	449,362	449,362	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,182,179	\$ 2,183,185	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,508,069	\$ 11,509,075	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,635,444	\$ 1,635,444	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,669	261,669	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	666,800	666,800	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	2,716,593	2,716,593	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,280,506	\$ 5,280,506	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,331,157	6,331,157	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)	\$ 6,331,157	\$ 6,331,157	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,611,663	\$ 11,611,663	46
47	TOTAL EQUITY(page 18, line 24)	\$ (103,594)	\$ (102,588)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,508,069	\$ 11,509,075	48

*(See instructions.)

XV. Balance Sheet

Line 9 Other (specify):

Description	Operating	After Consolidation
Patient Personal Funds	70,592	70,592
Medicaid Co-Ins Receivables	(52,206)	(52,206)
Inter Company Receivables	112,200	112,200
Security Deposit	172,732	172,732
Real Estate Escrow Deposit	682,326	682,326
Wage Assignment & Garnishment	1,701	1,701
Due from Prior Owner - Emp Benefits	709,827	709,827
Total - Line 9	1,697,172	1,697,172

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Exchange Formation L/H	500,000	500,000
Security Deposit Payable	172,732	172,732
Operating Expenses	301,983	301,983
Management Fees - Symphony	214,607	214,607
Ins Workmans Comp Deduct/Settlement	234,276	234,276
State Unemployment Tax	13,909	13,909
Federal Unemployment Tax	1,029	1,029
Sales Tax	445	445
Payroll Taxes Other	31,969	31,969
Accrued Employee Benefits	635,988	635,988
FICA & W/H Fed	68	68
Second State Withholdings	77	77
Due to IDPA - Add'tl Bed Tax	288,240	288,240
Due to/From the TKG	120,546	120,546
Due to Nucare	41,393	41,393
Due to Symphony	89,185	89,185
Patient Personal Funds	70,146	70,146
	2,716,593	2,716,593

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(103,594)	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)	\$ (103,594)	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)	\$ (103,594)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Crestwood# 0051805Report Period Beginning: 01/01/2012Ending: 12/31/2012**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,537,754	1
2	Discounts and Allowances for all Levels	(3,347,378)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,190,376	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,090,118	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,090,118	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	595,254	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,587	19
20	Radiology and X-Ray	14,484	20
21	Other Medical Services	63,839	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 693,164	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Rental and unclassified income</u>	84,575	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 84,575	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,058,255	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,335,229	31
32	Health Care	5,773,264	32
33	General Administration	4,027,040	33
	B. Capital Expense		
34	Ownership	3,710,585	34
	C. Ancillary Expense		
35	Special Cost Centers	2,719,069	35
36	Provider Participation Fee	596,662	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,161,849	40
41	Income before Income Taxes (line 30 minus line 40)**	(103,594)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (103,594)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,258,503	44
45	Private Pay - Net Inpatient Revenue	1,186,595	45
46	Medicare - Net Inpatient Revenue	3,461,074	46
47	Other-(specify) <u>Hospice</u>	797,205	47
48	Other-(specify) <u>Managed Care</u>	486,999	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,190,376	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 Crestwood# 0051805Report Period Beginning: 01/01/2012Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,912	2,120	\$ 125,650	\$ 59.27	1
2	Assistant Director of Nursing	2,008	2,916	90,443	31.02	2
3	Registered Nurses	28,379	33,947	1,170,465	34.48	3
4	Licensed Practical Nurses	62,426	70,840	1,676,397	23.66	4
5	CNAs & Orderlies	122,059	133,952	1,644,751	12.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,615	8,710	112,310	12.89	8
9	Activity Director	2,224	2,564	47,681	18.60	9
10	Activity Assistants	16,177	18,715	192,676	10.30	10
11	Social Service Workers	7,416	9,423	171,236	18.17	11
12	Dietician					12
13	Food Service Supervisor	10,074	11,096	113,447	10.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,349	36,129	476,530	13.19	15
16	Dishwashers					16
17	Maintenance Workers	4,094	4,900	87,103	17.78	17
18	Housekeepers	24,528	27,884	341,125	12.23	18
19	Laundry	16,933	18,796	219,239	11.66	19
20	Administrator	2,000	2,712	217,921	80.35	20
21	Assistant Administrator	1,936	2,120	72,214	34.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,871	18,949	298,022	15.73	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	2,183	2,433	36,924	15.18	31
32	Other Health Care <u>See Schedule 20A</u>	3,921	5,128	81,618	15.92	32
33	Other(specify) <u>Marketing</u>	3,040	3,784	138,239	36.53	33
34	TOTAL (lines 1 - 33)	365,145	417,118	\$ 7,313,991 *	\$ 17.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 25,233	1(3)	35
36	Medical Director	Monthly	48,250	9(3)	36
37	Medical Records Consultant	Monthly	3,465	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,223	10(3)	39
40	Physical Therapy Consultant	Monthly	731	39(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,470	11(3)	44
45	Social Service Consultant	Monthly	1,875	12(2)	45
46	Other(specify) <u>Wound Care</u>	Monthly	23,200	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 115,447		49

C. CONTRACT NURSES

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

XVIII. A. STAFFING AND SALARY COSTS

32. Other Health Care

Description	Hrs Paid	Hrs Worked	Salaries
Care Plan Technicia	234	242	4,285
Ward Clerk	2,591	2,828	43,215
Alzheimers Director	1,096	2,058	34,118
	3,921	5,128	81,618

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
Eliana Casella	Administrator	0	\$ 217,921	Workers' Compensation Insurance	\$	341,872	IDPH License Fee	\$ 2,186
Kathleen Smith	Assistant Administrator	0	46,407	Unemployment Compensation Insurance		147,687	Advertising: Employee Recruitment	22,963
Laura A. Aranda	Assistant Administrator	0	25,807	FICA Taxes		540,896	Health Care Worker Background Check (Indicate # of checks performed <u>381</u>)	4,568
				Employee Health Insurance		621,008	Patient Background Checks <u>229</u>	2,750
				Employee Meals			Miscellaneous Licenses & Fees	8,935
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Council of LTC	29,361
				Employee Retirement		22,871	Miscellaneous Dues & Subscriptions	3,554
				Employee Benefits - Other		7,605		
				Employees' Physical Exams		2,014	Allocated from Mgmt. Co.	949
							Less: Public Relations Expense ()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 290,135				Non-allowable advertising ()	
B. Administrative - Other							Yellow page advertising ()	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)	\$	1,683,953	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 75,266
Management Fees (Eliminated in Col. 7)			\$ 853,975					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 853,975	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
See Schedule 21A			\$ 247,419	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	6,864
							Allocated from Mgmt. Co.	1,572
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 247,419	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 8,436

*** Attach copy of IMRF notifications**

****See instructions.**

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Ability Network	Secure Exchange Managed Serv	1,683
Allscripts	Mgmt Facility Subscription Fee	797
AT&T	Internet	21
Comcast	Cable TV & Internet	900
Daytrina	Ipad	100
E-Health Data Solutions	Carewatch Service	3,584
Emdeon Business Services	Billing	684
Evault Inc	Protectone Servers	2,984
HDSI	Maintenance	5,034
IIT/Sourcetek	Operator Support	1,150
PSD Solutions	Network Integration Service	7,131
Telemedicine Solutions Inc	Woundrounds Care	2,821
Wescom Solutions Inc	Clinical/Bookkeeping/Data Processing	41,458
Zir-Med	Eligibility Verification	374
ADR Systems	Legal Fees	1,200
Cook County Clerk of Court	Legal Fees	436
HIPP Law Office	Legal Fees	2,208
Joseph R Becker	Legal Fees	128
Much Shelist	Legal Fees	11,810
Nucare	Legal Fees	1,159
Stone McGuire & Siegel	Legal Fees	14,505
Stone Pogrund & Korey LLC	Legal Fees	1,392
US Legal Support, Inc	Legal Fees	387
Vedder Price	Legal Fees	1,250
Achieve Accreditation	Consultation Day Honorarium	4,360
Amy Cordell Design	Graphic Design Services	516
Joe Park	Resume Reviews	113
Personnel Planners, Inc	Claims management	2,397
Pinnacle Quality Insight	Customer Satisfaction Consulting	4,320
Symphony Financial	Consultant	107,217
McGladrey LLP	Accounting Fees	25,300
Total agreeing to Schedule V, Line 19, Col 3		247,419
Non-Allowable Legal Fees		(436)
Allocated from Management Company Legal Fees		1,255
Allocated from Management Company Professional Services		(43,341)
Total (agree to Schedule V, line 20, column 8)		204,897

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?
If YES, give association name and amount.

Yes
IL Council LTC - \$29,361

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 18,491 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 596,662

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
No

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
McGladrey LLP

(18)

Have all costs which do not relate to the provision of long term care been adjusted 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?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes