

		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: 0051789

Facility Name: Symphony of Lincoln

Address: 2202 N Kickapoo Street Lincoln 62656
Number City Zip Code

County: Logan

Telephone Number: (217) 735-1538 Fax # (217) 732-4848

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ 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) _____ (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 Lincoln# 0051789 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>101</u>	Skilled (SNF)	<u>101</u>	<u>36,966</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>25</u>	Intermediate (ICF)	<u>25</u>	<u>9,150</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>126</u>	TOTALS	<u>126</u>	<u>46,116</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>1,907</u>		<u>4,392</u>	<u>6,299</u>	8
9	SNF/PED					9
10	ICF	<u>21,026</u>	<u>5,014</u>	<u>2,320</u>	<u>28,360</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,933</u>	<u>5,014</u>	<u>6,712</u>	<u>34,659</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.16%

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 42 and days of care provided 4,188Medicare 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.

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	199,275	28,013	12,395	239,683		239,683		239,683			1
2	Food Purchase		226,860		226,860		226,860		226,860			2
3	Housekeeping	125,221	29,712		154,933		154,933		154,933			3
4	Laundry	42,341	24,003	1,183	67,527		67,527		67,527			4
5	Heat and Other Utilities			183,773	183,773		183,773		183,773			5
6	Maintenance	54,708	400	87,837	142,945		142,945	237	143,182			6
7	Other (specify):*											7
8	TOTAL General Services	421,545	308,988	285,188	1,015,721		1,015,721	237	1,015,958			8
	B. Health Care and Programs											
9	Medical Director			74,600	74,600		74,600		74,600			9
10	Nursing and Medical Records	2,353,243	231,367	12,737	2,597,347		2,597,347	14,984	2,612,331			10
10a	Therapy											10a
11	Activities	53,759		10,863	64,622		64,622		64,622			11
12	Social Services	46,559		3,162	49,721		49,721		49,721			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							5,495	5,495			15
16	TOTAL Health Care and Programs	2,453,561	231,367	101,362	2,786,290		2,786,290	20,479	2,806,769			16
	C. General Administration											
17	Administrative	109,796		337,894	447,690		447,690	(314,349)	133,341			17
18	Directors Fees											18
19	Professional Services			126,970	126,970		126,970	(17,592)	109,378			19
20	Dues, Fees, Subscriptions & Promotions			38,482	38,482		38,482	397	38,879			20
21	Clerical & General Office Expenses	149,011		67,242	216,253		216,253	73,311	289,564			21
22	Employee Benefits & Payroll Taxes			719,797	719,797		719,797		719,797			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,835	7,835		7,835	657	8,492			24
25	Other Admin. Staff Transportation			14,308	14,308		14,308		14,308			25
26	Insurance-Prop.Liab.Malpractice			159,668	159,668		159,668	571	160,239			26
27	Other (specify):* Mgmt alloc of benef							15,627	15,627			27
28	TOTAL General Administration	258,807		1,472,196	1,731,003		1,731,003	(241,378)	1,489,625			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,133,913	540,355	1,858,746	5,533,014		5,533,014	(220,662)	5,312,352			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			745	745		745	47	792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,000	55,000		55,000	63	55,063			32
33	Real Estate Taxes			45,900	45,900		45,900	(3,030)	42,870			33
34	Rent-Facility & Grounds			338,971	338,971		338,971	598	339,569			34
35	Rent-Equipment & Vehicles			120,796	120,796		120,796	2,570	123,366			35
36	Other (specify):*											36
37	TOTAL Ownership			561,412	561,412		561,412	248	561,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			11,620	11,620		11,620		11,620			38
39	Ancillary Service Centers		201,452	483,889	685,341		685,341		685,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			254,133	254,133		254,133		254,133			42
43	Other (specify):* Non-Allowable Co	39,515		262,481	301,996		301,996	(301,996)				43
44	TOTAL Special Cost Centers	39,515	201,452	1,012,123	1,253,090		1,253,090	(301,996)	951,094			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,173,428	741,807	3,432,281	7,347,516		7,347,516	(522,410)	6,825,106			45

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

		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	(22,851)	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	(9)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,149)	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	(24,563)	43		18
19	Entertainment				19
20	Contributions	(6,675)	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	(112,461)	43		24
25	Fund Raising, Advertising and Promotional	(33,229)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(640)	43		28
29	Other-Attach Schedule See Pg 5A	(101,458)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (305,035)		\$	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)	(217,375)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,375)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (522,410)		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 Lincoln

Report Period Beginning:

Ending:

ID#005178901/01/201212/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (24,856)	43	1
2	Laboratory Costs	(21,616)	43	2
3	X-Ray Costs	(12,441)	43	3
4	Real Estate Taxes	(3,030)	33	4
5	Marketing Salaries	(39,515)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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	(101,458)		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			\$	N/A		\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 237	\$	237 15
16	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	14,984		14,984 16
17	V	15 Other		Symphony Financial Services, LLC	100.00%	5,495		5,495 17
18	V	17 Administrative	337,894	Symphony Financial Services, LLC	100.00%	23,545		(314,349) 18
19	V	19 Professional Services		Symphony Financial Services, LLC	100.00%	(17,592)		(17,592) 19
20	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	397		397 20
21	V	21 Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	73,311		73,311 21
22	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	657		657 22
23	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	571		571 23
24	V	27 Other		Symphony Financial Services, LLC	100.00%	15,627		15,627 24
25	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	47		47 25
26	V	32 Interest		Symphony Financial Services, LLC	100.00%	72		72 26
27	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	598		598 27
28	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	2,570		2,570 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		\$ 337,894			\$ 120,519	\$ *	(217,375) 39

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

Facility Name & ID Number

Symphony of Lincoln

0051789

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

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	\$ 1,870,688	06/11/2013	0.0550	\$ 54,649	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	12,000	12/30/2014	0.0550	351	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 19,520,000	\$ 1,882,688			\$ 55,000	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income Offset				(9)	12	
13							Management company allocation				72	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 63	14	
15	TOTALS (line 9+line14)						\$ 19,520,000	\$ 1,882,688			\$ 55,063	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		\$	42,870	2
3. Under or (over) accrual (line 2 minus line 1).				\$	42,870	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	45,900	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.)				\$	(45,900)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	42,870	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	41,688	8
2008	41,646	9
2009	42,890	10
2010	42,738	11
2011	42,870	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 Lincoln

COUNTY
Logan

FACILITY IDPH LICENSE NUMBER
0051789

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.	08-029-019-00	Nursing Home	\$ 42,869.58	\$ 42,869.58
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 42,869.58	\$ 42,869.58

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:

33,852

B. General Construction Type:

Exterior

Masonry

Frame

Steel/Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

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	Wiring for EMR 24 Port Pan, Wire Mold, Cable Ties			2012	6,545					9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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
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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)		\$ 6,545	\$		\$	\$	\$	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	8,466	745	745		3-7	745	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	467		47	47	5	47	74
75	TOTALS	\$ 8,933	\$ 745	\$ 792	\$ 47		\$ 792	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)	\$ 15,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 792	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 792	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	Exterior Signs	\$ 44,320	92
93			93
94			94
95		\$ 44,320	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:	1973	126	12/31/2011	\$ 338,216	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				598			6
7	TOTAL		126		\$ 338,814			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
- 755

7,545

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?
16. Rental Amount for movable equipment: \$ 120,012
- Description: See Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Toyota Corolla	\$ 359.40	\$ 3,354	17
18					18
19					19
20					20
21	TOTAL		\$ 359.40	\$ 3,354	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	\$ 250,000
13.	12/31/2014	\$ 250,000
14.	12/31/2015	\$ 255,000

* 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.

B (16) Movable Equipment Rental

Rental Description	Amount
Ventilator T-bird	69,559
Mattress	6,779
Broda Chair	3,875
VACfreedom	895
Bipap Auto, Heated Humidifire	4,971
Basic Recliner	1,300
Oxygen	492
Gas	2,002
Wheelchair Anti-rollback	1,369
Patient Lift	302
Plant Rental And Service	2,796
Show Machine	35
Cooler Infinity	1,026
Culligan Water	195
Hallrenta	125
Dishmachine	787
Securjty Container	3,070
40x80 High Peak. Ch. White Pole	1,050
Cotton Candy Machine	75
Copier	14,618
Computer Lease	959
Mailing System	763
Digital Music	399
Allocated from Mgmt. Co.	2,570
	<u>120,012</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	\$	2,557	\$ 184,096	\$	2,557	\$ 184,096	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,593	114,689		1,593	114,689	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,247	161,815		2,247	161,815	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				201,452		201,452	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)			364	26,233		364	26,233	12
13	Other (specify): 									13
14	TOTAL			\$	6,761	\$ 486,833	\$ 201,452	6,761	\$ 688,285	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.

XIV. SPECIAL SERVICES (Direct Cost)
12. Other

Description	Amount
INHALATION THERAPY-PRIVATE	1,446
INHALATION THERAPY-MEDICARE	3,271
INHALATION THERAPY-MEDICAID	2,177
INHALATION THERAPY-VETERAN	176
INHALATION TPY-MANAGED CARE	138
INHALATION THERAPY-VENT PROC	1,723
OTHER SERVICES-VETERAN	142
PHYSICIANS-VETERAN	653
I.V. THERAPY-MEDICARE	9,585
I.V. THERAPY-VETERAN	946
I.V. THERAPY-MANAGED CARE	707
DENTAL	2,325
	<u>23,289</u>

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	\$ 133,721	\$ 133,721	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 76,387)	2,700,268	2,700,268	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,449	65,449	6
7	Other Prepaid Expenses	11,081	11,081	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	446,651	446,651	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,357,170	\$ 3,357,170	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	6,545	6,545	15
16	Equipment, at Historical Cost	8,466	8,933	16
17	Accumulated Depreciation (book methods)	(745)	(792)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Lease Costs	6,790	6,790	22
23	Other(specify): Construction in Progress	44,320	44,320	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,376	\$ 65,796	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,422,546	\$ 3,422,966	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 500,139	\$ 500,139	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,403	77,403	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,900	45,900	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	773,568	773,568	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,397,010	\$ 1,397,010	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,882,688	1,882,688	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)	\$ 1,882,688	\$ 1,882,688	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,279,698	\$ 3,279,698	46
47	TOTAL EQUITY (page 18, line 24)	\$ 142,848	\$ 143,268	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,422,546	\$ 3,422,966	48

*(See instructions.)

Symphony Maple Ridge
Provider # 0051789
FYE: 12/31/2012

Schedule 17A

XV. Balance Sheet

Line 9 Other (specify):

Description	Operating	After Consolidation
Trust Fund	22,985	22,985
Medicaid Co-Ins Receivables	169,370	169,370
Security Deposit	44,108	44,108
Real Estate Escrow Deposit	76,738	76,738
Due from Prior Owner - Emp Benefits	133,450	133,450
Total - Line 9	446,651	446,651

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Security Deposit Payable	53,105	53,105
Operating Expenses	72,477	72,477
Management Fees - Symphony	79,690	79,690
Clm. Wrkns Comp. Dudct/Settlement	85,260	85,260
State Unemployment Tax	15,475	15,475
Federal Unemployment Tax	770	770
Sales Tax	575	575
Payroll Taxes Other	10,819	10,819
Accrued Employee Benefits	253,317	253,317
FICA & W/H Fed	25,283	25,283
Ill W/H	4,984	4,984
Due to IDPA - Add'tl Bed Tax	121,024	121,024
Due to/From the Kinsington	7,224	7,224
Due to Nucare	4,935	4,935
Due to Symphony	4,146	4,146
Wage Assign & Garnishments	674	674
Patient Personal Funds	33,810	33,810
	773,568	773,568

XVI. STATEMENT OF CHANGES IN EQUITY

		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)	142,848	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)	\$ 142,848	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)	\$ 142,848	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Symphony of Lincoln# 0051789Report 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	\$ 7,197,179	1
2	Discounts and Allowances for all Levels	(1,006,441)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,190,738	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	884,868	6
7	Oxygen	1,235	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 886,103	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	169,456	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	159,265	19
20	Radiology and X-Ray	42,415	20
21	Other Medical Services	39,072	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 410,208	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare and Managed Care Rentals	3,306	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,306	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,490,364	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,015,721	31
32	Health Care	2,786,290	32
33	General Administration	1,731,003	33
	B. Capital Expense		
34	Ownership	561,412	34
	C. Ancillary Expense		
35	Special Cost Centers	998,957	35
36	Provider Participation Fee	254,133	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,347,516	40
41	Income before Income Taxes (line 30 minus line 40)**	142,848	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 142,848	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,940,149	44
45	Private Pay - Net Inpatient Revenue	825,610	45
46	Medicare - Net Inpatient Revenue	904,953	46
47	Other-(specify) <u>Hospice</u>	332,987	47
48	Other-(specify) <u>Managed Care, Veteran & ALF</u>	187,039	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,190,738	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.

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	2,025	2,192	\$ 92,360	\$ 42.14	1
2	Assistant Director of Nursing	2,212	2,343	74,871	31.96	2
3	Registered Nurses	14,577	16,142	496,460	30.76	3
4	Licensed Practical Nurses	34,062	37,153	908,172	24.44	4
5	CNAs & Orderlies	58,137	62,447	749,366	12.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,517	2,828	32,014	11.32	8
9	Activity Director	4,243	4,994	53,759	10.76	9
10	Activity Assistants					10
11	Social Service Workers	2,077	2,534	46,559	18.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,690	17,638	199,275	11.30	15
16	Dishwashers					16
17	Maintenance Workers	2,191	2,417	54,708	22.63	17
18	Housekeepers	11,047	11,725	125,221	10.68	18
19	Laundry	4,246	4,823	42,341	8.78	19
20	Administrator	1,985	2,374	109,796	46.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,589	9,451	149,011	15.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,049	1,067	39,515	37.03	33
34	TOTAL (lines 1 - 33)	165,647	180,128	\$ 3,173,428 *	\$ 17.62	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	\$ 12,395	1(3)	35
36	Medical Director	Monthly	74,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,737	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	4,094	11(3)	44
45	Social Service Consultant	Monthly	3,162	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 106,988		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Douglas Rutter	Administrator	0	\$ 109,796	Workers' Compensation Insurance		\$ 151,258	IDPH License Fee	\$ 2,748	
				Unemployment Compensation Insurance		102,929	Advertising: Employee Recruitment	5,973	
				FICA Taxes		222,728	Health Care Worker Background Check		
				Employee Health Insurance		222,459	(Indicate # of checks performed 522)	6,263	
				Employee Meals			Patient Background Checks 34	405	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	2,859	
				Employee Retirement		12,392	Illinois Council on Long Term Care	11,983	
				Employee Benefits - Other		6,001	Miscellaneous Dues & Subscriptions	8,251	
				Employees' Physical Exams		2,030			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Allocated from Mgmt. Co.	397	
							Less: Public Relations Expense (	)	
							Non-allowable advertising (	)	
							Yellow page advertising (	)	
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 38,879		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 719,797		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									

*** Attach copy of IMRF notifications**

****See instructions.**

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Anderson, Rasor & Partners	Legal Fees	779
Corporate Service Company	Legal Fees	520
Joseph R. Becker	Legal Fees	128
Kith Drutchas Wagner	Legal Fees	780
Much Shelist	Legal Fees	1,641
Stone, Mcguire & Siegel	Legal Fees	14,512
Ability Network	Payer Transactions	1,683
Allscripts	Ecin Facility Activation	750
Comcast	Internet	2,103
E-haelth Data Solutions	Carewatch	3,097
Emdeon	Billing	825
Evault	Protect-one-server2k	1,944
Frontier	Web Hosting	95
HDSI	Data Retrieval	4,903
Iit/sourcotech	Monthly Support Fee	1,380
Pds Solutions	Network Integration Services	375
South Central Aiv	Digital Muzik	114
Wesom Solutions	Billing	17,863
Zir-med	Billing	155
Achieve Accreditation	Consultation	8,152
Amy Cordell Design	Managed Care Contract Sheet	236
Documentation Solutions	Compliance Audits	519
Executive Search	Hrdirecto	333
Hshs Medical Group	Va Contract	13
Personnel Planners	Quarterly U.I. Claims Mgt Fees	1,235
Pinnacle Quality Insight	Customer Satisfaction	4,050
Symphony Financial	Consultants	43,592
McGladrey LLP	Accounting Fees	15,193
Total agreeing to Schedule V, Line 19, Col 3		126,970
Allocated from Management Company Legal Fees		525
Allocated from Management Company Professional Services		(18,117)
Total (agree to Schedule V, line 20, column 8)		109,378

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 - \$11,983

(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.

\$ 2,758 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)?
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.

(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.

\$ 254,133

(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.
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.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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
5
Adequate records have been maintained.
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