

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0051813 Facility Name: Northwoods Care Centre Address: 2250 Pearl StreetBelvidere61008 County: Boone Telephone Number: (815) 544-0358Fax #: (815) 544-5006 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	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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 Northwoods Care Centre# 0051813 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,358</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>113</u>	TOTALS	<u>113</u>	<u>41,358</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,258</u>	<u>7,954</u>	<u>8,178</u>	<u>35,390</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,258</u>	<u>7,954</u>	<u>8,178</u>	<u>35,390</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.57%

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 113 and days of care provided 3,651

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2016Fiscal Year: 12/31/2016

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	249,602	33,591	9,028	292,221		292,221		292,221			1
2	Food Purchase		181,366		181,366		181,366		181,366			2
3	Housekeeping	142,044	28,976		171,020		171,020		171,020			3
4	Laundry	86,973	10,354	6,122	103,449		103,449		103,449			4
5	Heat and Other Utilities			85,901	85,901		85,901	1,169	87,070			5
6	Maintenance	51,405	674	80,410	132,489		132,489	13,131	145,620			6
7	Other (specify):* Mgmt. Co. Benefits							1,917	1,917			7
8	TOTAL General Services	530,024	254,961	181,461	966,446		966,446	16,217	982,663			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	2,068,671	94,674	27,492	2,190,837		2,190,837	73,734	2,264,571			10
10a	Therapy											10a
11	Activities	183,255		14,053	197,308		197,308		197,308			11
12	Social Services	49,830		19,200	69,030		69,030		69,030			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Benefits							11,447	11,447			15
16	TOTAL Health Care and Programs	2,301,756	94,674	83,545	2,479,975		2,479,975	85,181	2,565,156			16
	C. General Administration											
17	Administrative	160,611		422,086	582,697		582,697	(401,082)	181,615			17
18	Directors Fees											18
19	Professional Services			195,796	195,796		195,796	(20,878)	174,918			19
20	Dues, Fees, Subscriptions & Promotions			19,768	19,768		19,768	5,538	25,306			20
21	Clerical & General Office Expenses	87,595	20,665	37,937	146,197		146,197	177,273	323,470			21
22	Employee Benefits & Payroll Taxes			578,500	578,500		578,500		578,500			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,933	2,933		2,933	731	3,664			24
25	Other Admin. Staff Transportation			2,686	2,686		2,686	1,699	4,385			25
26	Insurance-Prop.Liab.Malpractice			197,930	197,930		197,930	1,987	199,917			26
27	Other (specify):* Mgmt. Co. Benefits							26,456	26,456			27
28	TOTAL General Administration	248,206	20,665	1,457,636	1,726,507		1,726,507	(208,276)	1,518,231			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,079,986	370,300	1,722,642	5,172,928		5,172,928	(106,878)	5,066,050			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			86,413	86,413		86,413	3,010	89,423			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,090	2,090		2,090	2,444	4,534			32
33	Real Estate Taxes			89,168	89,168		89,168	2,611	91,779			33
34	Rent-Facility & Grounds			1,000,436	1,000,436		1,000,436	3,559	1,003,995			34
35	Rent-Equipment & Vehicles			67,313	67,313		67,313	3,309	70,622			35
36	Other (specify):*											36
37	TOTAL Ownership			1,245,420	1,245,420		1,245,420	14,933	1,260,353			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,801	4,801		4,801		4,801			38
39	Ancillary Service Centers		135,165	988,925	1,124,090		1,124,090		1,124,090			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			255,306	255,306		255,306		255,306			42
43	Other (specify):* Non-Allowable Cos	33,653		837,783	871,436		871,436	(871,436)				43
44	TOTAL Special Cost Centers	33,653	135,165	2,086,815	2,255,633		2,255,633	(871,436)	1,384,197			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,113,639	505,465	5,054,877	8,673,981		8,673,981	(963,381)	7,710,600			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(21,843)	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	(12)	30		9
10	Interest and Other Investment Income	(79)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,159)	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	(2,688)	43		18
19	Entertainment				19
20	Contributions	(14,670)	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	(700,241)	43		24
25	Fund Raising, Advertising and Promotional	(6,830)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(167,403)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (915,925)		\$	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)	(47,456)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (47,456)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (963,381)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (66,706)	43	1
2	Laboratory Costs	(8,928)	43	2
3	X-Ray Costs	(13,718)	43	3
4	Lobbying Expense Offset	(3,199)	20	4
5	Nonallowable Legal	(4,179)	19	5
6	Admission	(5,780)	43	6
7	Nonallowable Professional Collection Fees	(37,020)	19	7
8	Community Relations	(6,854)	43	8
9	Guest Relations	(21,019)	43	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	(167,403)		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			\$			\$	\$ * 0	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	19	Professional Services-Other	\$ 981	Symphony Financial Services, LLC	100%	\$	(981)	15
16	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100%	22,091	22,091	16
17	V	24	Travel & Seminar		Symphony Financial Services, LLC	100%	45	45	17
18	V	30	Depreciation		Symphony Financial Services, LLC	100%	1,972	1,972	18
19	V	32	Interest		Symphony Financial Services, LLC	100%	2,523	2,523	19
20	V	34	Rent - Facility & Grounds		Symphony Financial Services, LLC	100%	151	151	20
21	V	35	Rent - Equipment & Vehicles		Symphony Financial Services, LLC	100%	1	1	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 981			\$ 26,783	\$ * 25,802	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	<u>Utilities</u>	\$	<u>Maestro Consulting Services</u>	100%	\$ 1,169	\$ 1,169	15
16	V	6	<u>Maintenance Salaries</u>		<u>Maestro Consulting Services</u>	100%	10,705	10,705	16
17	V	6	<u>Maintenance Expenses</u>		<u>Maestro Consulting Services</u>	100%	2,426	2,426	17
18	V	7	<u>Employee Benefits - Maintenance</u>		<u>Maestro Consulting Services</u>	100%	1,917	1,917	18
19	V	10	<u>Clinical Salaries</u>		<u>Maestro Consulting Services</u>	100%	73,734	73,734	19
20	V	15	<u>Employee Benefits - Clinical</u>		<u>Maestro Consulting Services</u>	100%	11,447	11,447	20
21	V	17	<u>Administrative Salaries</u>	422,086	<u>Maestro Consulting Services</u>	100%	21,004	(401,082)	21
22	V	19	<u>Professional Fees</u>		<u>Maestro Consulting Services</u>	100%	21,302	21,302	22
23	V	20	<u>Dues, Fees, Subscriptions, etc.</u>		<u>Maestro Consulting Services</u>	100%	8,737	8,737	23
24	V	21	<u>Clerical & General Salaries</u>		<u>Maestro Consulting Services</u>	100%	137,998	137,998	24
25	V	21	<u>Clerical & General Expenses</u>		<u>Maestro Consulting Services</u>	100%	17,184	17,184	25
26	V	24	<u>Seminars And Education</u>		<u>Maestro Consulting Services</u>	100%	686	686	26
27	V	25	<u>Transportation</u>		<u>Maestro Consulting Services</u>	100%	1,699	1,699	27
28	V	26	<u>Insurance</u>		<u>Maestro Consulting Services</u>	100%	1,987	1,987	28
29	V	27	<u>Employee Benefits - Administrative</u>		<u>Maestro Consulting Services</u>	100%	26,456	26,456	29
30	V	30	<u>Depreciation</u>		<u>Maestro Consulting Services</u>	100%	1,050	1,050	30
31	V	33	<u>Real Estate Tax</u>		<u>Maestro Consulting Services</u>	100%	2,611	2,611	31
32	V	34	<u>Building Rental</u>		<u>Maestro Consulting Services</u>	100%	3,408	3,408	32
33	V	35	<u>Equipment Rental</u>		<u>Maestro Consulting Services</u>	100%	1,473	1,473	33
34	V	35	<u>Auto Lease</u>		<u>Maestro Consulting Services</u>	100%	1,835	1,835	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 422,086			\$ 348,828	\$ * (73,258)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent-Equipment & Vehicles	\$ 15,976	Integra Healthcare Equipment, LLC		\$ 15,976	\$	15
16	V	39	DME & Medical Supplies	1,090	Integra Healthcare Equipment, LLC		1,090		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 17,066			\$ 17,066	\$ * 0	39

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

Facility Name & ID Number

Northwoods Care Centre

0051813

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cres	Belvidere	Maestro Consulting Se	Lincolnwood	Mgmt. Co.	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	Symphony Evanston Healthcare	Evanston				9
10	David J. Hartman	20.00	Symphony of Dyer	Indiana				10
11	Jay Flatt	3.00	Symphony of Crown Point	Indiana	Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00	Symphony of Chesterton	Indiana	7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14					Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Monroe Pavillion	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Sycamore Village	Swansea	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Symphony of Aria	Hillside	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Symphony at 87th Street	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Symphony at Midway	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Symphony at Tillers	Oswego	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Symphony at Bronzeville	Chicago	Lifemed Pharmacy	Bensenville	Pharmacy	22
23			Symphony of Buffalo Grove	Buffalo Grove	ConcertoHealth	Chicago	Clinical Services	23
24			Symphony of Chicago West	Chicago				24
25			Symphony of Glendale	Glendale, Wiscosin	* No expense paid by home to the related			25
26			Symphony of Hanover Park	Hanover Park	entity, therefore no page 6 or 8.			26
27			Symphony of Lincoln Park	Chicago	** No expense of this related business			27
28			Symphony of Morgan Park	Chicago	allocated to homes			28
29			Symphony of South Shore	Chicago				29
30			Symphony Residences of Lincoln Park	Chicago				30

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	No owners receive compensation from this facility.			0.00					\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Symphony Financial Services, LLC
Street Address 7257 N. Lincoln Ave,
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 933-2600
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Professional Services-Other	Occupied Bed Days	502,430	12	\$ (13,929)	\$	35,390	\$ (981)	1
2	21	Clerical & General Office Exp	Occupied Bed Days	502,430	12	313,631		35,390	22,091	2
3	24	Travel & Seminar	Occupied Bed Days	502,430	12	638		35,390	45	3
4	30	Depreciation	Occupied Bed Days	502,430	12	28,003		35,390	1,972	4
5	32	Interest	Occupied Bed Days	502,430	12	35,825		35,390	2,523	5
6	34	Rent - Facility & Grounds	Occupied Bed Days	502,430	12	2,143		35,390	151	6
7	35	Rent - Equipment & Vehicles	Occupied Bed Days	502,430	12	14		35,390	1	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 366,325	\$		\$ 25,802	25

Facility Name & ID Number Northwoods Care Centre# 0051813

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Maestro Consulting Services

Street Address

7257 N. Lincoln Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 933-2600

Fax Number

()

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	5	Utilities	Bed Days Available	28	\$ 51,919	\$	41,358	\$ 1,169	1
2	6	Maintenance Salaries	Bed Days Available	28	475,288	475,288	41,358	10,705	2
3	6	Maintenance Expenses	Bed Days Available	28	107,711		41,358	2,426	3
4	7	Employee Benefits - Maintenance	Bed Days Available	28	85,090		41,358	1,917	4
5	10	Clinical Salaries	Bed Days Available	28	3,273,643	3,273,643	41,358	73,734	5
6	15	Employee Benefits - Clinical	Bed Days Available	28	508,220		41,358	11,447	6
7	17	Administrative Salaries	Bed Days Available	28	932,558	932,558	41,358	21,004	7
8	19	Professional Fees	Bed Days Available	28	945,768		41,358	21,302	8
9	20	Dues, Fees, Subscriptions, etc.	Bed Days Available	28	387,900		41,358	8,737	9
10	21	Clerical & General Salaries	Bed Days Available	28	6,126,863	6,126,863	41,358	137,998	10
11	21	Clerical & General Expenses	Bed Days Available	28	762,920		41,358	17,184	11
12	24	Seminars And Education	Bed Days Available	28	30,439		41,358	686	12
13	25	Transportation	Bed Days Available	28	75,434		41,358	1,699	13
14	26	Insurance	Bed Days Available	28	88,214		41,358	1,987	14
15	27	Employee Benefits - Administrative	Bed Days Available	28	1,174,614		41,358	26,456	15
16	30	Depreciation	Bed Days Available	28	46,621		41,358	1,050	16
17	33	Real Estate Tax	Bed Days Available	28	115,912		41,358	2,611	17
18	34	Building Rental	Bed Days Available	28	151,288		41,358	3,408	18
19	35	Equipment Rental	Bed Days Available	28	65,399		41,358	1,473	19
20	35	Auto Lease	Bed Days Available	28	81,453		41,358	1,835	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 15,487,254	\$ 10,808,352		\$ 348,828	25

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Integra Healthcare Equipment, LLC
Street Address 747 Church Road
City / State / Zip Code Elmhurst, IL 60126
Phone Number (630) 834-3700
Fax Number (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Rent-Equipment & Vehicles	Direct Allocation			\$	\$		\$ 15,976	1
2	39	DME & Medical Supplies	Direct Allocation						1,090	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 17,066	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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	27,000,000	(109,789)	4/22/2017	0.0450	2,090		6
7													7
8													8
9	TOTAL Facility Related						\$ 27,000,000	\$ (109,789)			\$ 2,090		9
	B. Non-Facility Related*												
10													10
11													11
12								Offset Interest Income				(79)	12
13								Allocated from Mgmt Co.				2,523	13
14	TOTAL Non-Facility Related						\$	\$			\$ 2,444		14
15	TOTALS (line 9+line14)						\$ 27,000,000	\$ (109,789)			\$ 4,534		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 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	88,200	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.)		2015	\$	84,758	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,442)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	92,610	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.		Alloc. Fr. Mgmt Co.		2,611	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	91,779	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	68,552	8	
		2012	78,717	9	
		2013	81,086	10	
		2014	83,975	11	
		2015	84,758	12	
2016 Tax Accrual = \$84,758 x 1.092 = \$92,556; Use \$92,610					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$ 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Symphony Northwoods, LLC D/B/A Northwoods Care Centre COUNTY Boone

FACILITY IDPH LICENSE NUMBER 0051813

CONTACT PERSON REGARDING THIS REPORT David Davis

TELEPHONE (847) 745-6205 FAX #: (847) 673-2284

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>07-01-151-003</u>	<u>Nursing Home</u>	\$ <u>84,758.00</u>	\$ <u>84,758.00</u>
2. <u>10-27-319-028-0000</u>	<u>Land & Property Mgmt. Co.</u>	\$ <u>95,270.31</u>	\$ <u>2,611.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>180,028.31</u></u>	\$ <u><u>87,369.00</u></u>

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? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2/Basement

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:

(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	Alloc Fr Maestro 7257	-	2004	\$ 3,604	1
2					2
3	TOTALS			\$ 3,604	3

Facility Name & ID Number Northwoods Care Centre

0051813

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Allocated from Maestro 7257		2004		32,434		39	832	832	12,163
	Improvement Type**									
9	Concrete Sidewalk Repair		2012		3,115	156	20	156		689
10	Valley - EGINEERING/Design throughout facility		2013		155,300	7,765	20	7,765		25,236
11	Wi-Fi Cables for Nurses Station		2013		5,108	255	20	255		915
12										12
13	Facility Remodeling		2014		696,403	42,787	5 - 20	42,787		123,931
14	-Demolition/carpentry/soffits throughout facility									14
15	-Wall coverings, painting - 1st floor dining room, front offices,									15
16	resident rooms and lower level									16
17	-Plumbing - cafeteria									17
18	-Interior soffit enclosure - throughout facility									18
19	-Counter tops, laminate - coffee, reception areas and nurses station									19
20	-Electrical work - throughout facility									20
21	-Floor covering - Basement, 1st Floor Corridors/Offices/									21
22	Nurses Station/Resident Rooms/Dining Room/Vestibule									22
23	-Interior painting - 1st floor dining room, front offices, resident rooms									23
24	and lower level									24
25	-Interior electrical / alarm - throughout facility									25
26	-Gazebo - outside									26
27	-Tile Flooring - South & East Lobby around Elevator									27
28	-Landscaping - along the building & by fire hydrant									28
29	-Room signage - hallways & restrooms									29
30	-Dining room window treatments									30
31	-Concrete Steps - outside building									31
32	-General Contractors Fee									32
33	-Permits									33
34										34
35	Masonry repairs on North Elevation		2015		10,880	544	20	544		680
36	- North side of building									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Northwoods Care Centre

0051813

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Installed drain tile/sump pump in storage room	2016	\$ 8,900	\$ 408	20	\$ 408	\$	\$ 408	37
38	Installed fresh air duct for laundry	2016	3,794	126	20	126		126	38
39	Installed trench and back filling for fire alarm system - 1st floor	2016	1,545	45	20	45		45	39
40	Installed PIV Installation for fire alarm system - 1st floor	2016	3,562	104	20	104		104	40
41	Updated Roofing, plumbing, landscaping for the entire building	2016	79,414	662	20	662		662	41
42									42
43									43
44	Allocated from Maestro Consulting Services	2003	264		20			173	44
45	Allocated from Maestro Consulting Services	2004	5,356		20			3,408	45
46	Allocated from Maestro Consulting Services	2005	318		20			188	46
47	Allocated from Maestro Consulting Services	2006	431		20			223	47
48	Allocated from Maestro Consulting Services	2008	454		20			187	48
49	Allocated from Maestro Consulting Services	2009	7,304		20			2,782	49
50	Allocated from Maestro Consulting Services	2010	1,123		20			365	50
51	Allocated from Maestro Consulting Services	2011	61		20			18	51
52	Allocated from Maestro Consulting Services	2012	68		20			16	52
53	Allocated from Maestro Consulting Services	2014	845		20			110	53
54	Allocated from Maestro Consulting Services	2015	238		20			16	54
55	Allocated from Maestro Consulting Services	2016	1,041		20	40	40	40	55
56									56
57	Allocated from Maestro 7257	2004	645		10			403	57
58	Allocated from Maestro 7257	2005	2,956		10	20	20	2,063	58
59	Allocated from Maestro 7257	2015	511		15	49	49	45	59
60									60
61									61
62	To tie to book depreciation			12			(12)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,022,070	\$ 52,864		\$ 53,793	\$ 929	\$ 174,996	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	\$180,357	\$30,699	\$30,699	\$-	5-7	\$97,100	71
72	Current Year Purchases	38,555	2,850	2,850	-	5-20	2,850	72
73	Fully Depreciated Assets				-			73
74	See Sch. 13A	51,950		2,081	2,081		45,961	74
75	TOTALS	\$270,862	\$33,549	\$35,630	\$2,081		\$145,911	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Maestro Consulting Services			\$200	\$	\$	\$-		\$200	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			\$200	\$-	\$-	\$-		\$200	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,296,736	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$86,413	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$89,423	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,010	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$321,107	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name: Northwoods Care Centre
IDPH License ID Number: 0051813
Fiscal Year End: 12/31/2016

Schedule 13A

XI. Ownership Costs
Line 74 - Equipment Costs - Excluding Transportation

Category of				Current Book	Straight Line		Component	Accumulated
Equipment	Cost			Depreciation	Depreciation	Adjustments	Life	Depreciation
Allocated from Symphony Financial Services, LLC		12,066			1,972	1,972	5-7	6,814
Allocated from Maestro Consulting Services		39,884			109	109	5-10	39,147
						-		
TOTAL		51,950		-	2,081	2,081		45,961

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:	<u>1972</u>	<u>113</u>	<u>12/31/2011</u>	\$ <u>998,315</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	<u>Allocated from Mgmt. Co.</u>				<u>3559</u>			6
7	TOTAL		<u>113</u>		\$ <u>1,001,874</u>			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 10 .

2,121
21,207

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: \$ 66,379 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	<u>Facility</u>	<u>2016 Ford Transit</u>	\$ <u>481.69</u>	\$ <u>2,408</u>	17
18					18
19	<u>Allocated from Mgmt. Co.</u>			<u>1,835</u>	19
20					20
21	TOTAL		\$ <u>481.69</u>	\$ <u>4,243</u>	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.	<u>/2017</u>	\$ <u>742,846</u>
13.	<u>/2018</u>	\$ <u>757,703</u>
14.	<u>/2019</u>	\$ <u>772,857</u>

* 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.

Facility Name:Northwoods Care Centre

IDPH License ID Number:0051813

Fiscal Year End:12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Mattresses	15,504
Vac Freedom	4,115
Computer Lease	959
Office Equipment	7,719
Printers/Copiers	30,663
Postage Machine Rental	375
Temp Cooler	180
Dishmachine	1,707
Propane Tank	175
Blood Pressure Equipment	2,425
Oxygen	423
Pipe in music service	660
Allocated from HO	1,474
Total - Line 16	66,379

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,196	\$ 446,113	\$	6,196	\$ 446,113	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		529	38,102		529	38,102	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,735	484,893		6,735	484,893	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				134,075		134,075	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)				19,817			19,817	12
13	Other (specify): Oxygen	39(2)					1,090		1,090	13
14	TOTAL			\$	13,460	\$ 988,925	\$ 135,165	13,460	\$ 1,124,090	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.

Facility Name: Northwoods Care Centre
IDPH License ID Number: 0051813
Fiscal Year End: 12/31/2016

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Units	Amount
INHALATION THERAPY-PRIVATE		971
INHALATION THERAPY - MEDICARE		4,866
INHALATION THERAPY-MEDICAID		1,988
INHALATION THERAPY - MAN. CARE		2,829
I.V. THERAPY - MEDICARE		6,603
I.V. THERAPY - MANAGED CARE		2,502
DENTAL		58
Total - Line 12	-	19,817

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$ 2,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 991,909)	2,863,008	2,863,008	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	275	275	6
7	Other Prepaid Expenses	37,922	37,922	7
8	Accounts Receivable (owners or related parties)	1,124,044	1,124,044	8
9	Other(specify): See Schedule 17A	207,584	207,584	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,234,833	\$ 4,234,833	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,604	13
14	Buildings, at Historical Cost		32,434	14
15	Leasehold Improvements, at Historical Cost	968,021	989,636	15
16	Equipment, at Historical Cost	218,911	271,062	16
17	Accumulated Depreciation (book methods)	(252,816)	(321,107)	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, Net	10,603	10,603	22
23	Other(specify): See Schedule 17A	454,398	454,398	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,399,117	\$ 1,440,630	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,633,950	\$ 5,675,463	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,252,991	\$ 1,252,991	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,912	123,912	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,610	92,610	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,945,417	1,945,417	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,414,930	\$ 3,414,930	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,414,930	\$ 3,414,930	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,219,020	\$ 2,260,533	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,633,950	\$ 5,675,463	48

*(See instructions.)

Facility Name: Northwoods Care Centre
IDPH License ID Number: 0051813
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After
		Consolidation
Patient Personal Funds	19,694	19,694
Reserve for Capex	73,038	73,038
A/R Maple Leaf Health Insurance	5,063	5,063
N/P-Refundable Overpayment	109,789	109,789
Total - Line 9	207,584	207,584

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After
		Consolidation
Security Deposit	115,846	115,846
Real Estate Escrow	204,557	204,557
Due T/F Other	133,995	133,995
Total - Line 23	454,398	454,398

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

Description	Operating	After
		Consolidation
Exchange Formation Leashold	852,012	852,012
Security Deposit Payable	-	-
Operating Expenses	(36,289)	(36,289)
Management Fees - Symphony	543,372	543,372
Ins Wrks Comp - Deduct/Settlement	(116,367)	(116,367)
State Unemployment Tax	1,462	1,462
Federal Unemployment Tax	568	568
Sales Tax	571	571
Payroll Taxes Other	10,788	10,788
Accrued Employee Benefits	216,145	216,145
FICA & W/H Fed	18	18
Due to IDPA - Addtl IL Bed Tax	32,553	32,553
Exchange Acct	34,945	34,945
Wage Assign & Garnishments	1,031	1,031
Patient Personal Funds	21,029	21,029
Due to/from Maestro - Expense	47,817	47,817
Due t/f Affiliated Company - HE	120,713	120,713
Due t/f Affiliated Company - RE	135,242	135,242
Deferred Rent Liability	204,496	204,496
Accumulated Amortization Deferred Rent	(124,689)	(124,689)
Total - Line 36	1,945,417	1,945,417

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,649,731	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(107,856)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,541,875	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(322,855)	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)	\$ (322,855)	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)	\$ 2,219,020	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Northwoods Care Centre

0051813

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,891,504	1
2	Discounts and Allowances for all Levels	(1,680,157)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,211,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,903,854	6
7	Oxygen	15	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,903,869	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	186,856	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,270	19
20	Radiology and X-Ray	2,942	20
21	Other Medical Services	12,794	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 230,862	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	79	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rentals and Other Unclassified Income	4,969	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,969	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,351,126	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	966,446	31
32	Health Care	2,479,975	32
33	General Administration	1,726,507	33
	B. Capital Expense		
34	Ownership	1,245,420	34
	C. Ancillary Expense		
35	Special Cost Centers	2,000,327	35
36	Provider Participation Fee	255,306	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,673,981	40
41	Income before Income Taxes (line 30 minus line 40)**	(322,855)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (322,855)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,014,033	44
45	Private Pay - Net Inpatient Revenue	1,462,021	45
46	Medicare - Net Inpatient Revenue	757,786	46
47	Other-(specify) <u>Hospice</u>	541,199	47
48	Other-(specify) <u>Managed Care</u>	436,308	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,211,347	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	1,959	2,120	\$ 79,168	\$ 37.34	1
2	Assistant Director of Nursing	2,192	2,373	64,652	27.24	2
3	Registered Nurses	22,658	24,522	708,766	28.90	3
4	Licensed Practical Nurses	9,694	10,492	248,957	23.73	4
5	CNAs & Orderlies	61,710	66,788	944,758	14.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,636	2,853	43,445	15.23	9
10	Activity Assistants	14,654	15,860	139,810	8.82	10
11	Social Service Workers	1,918	2,076	49,830	24.00	11
12	Dietician					12
13	Food Service Supervisor	1,680	1,818	45,451	25.00	13
14	Head Cook	4,406	4,769	58,901	12.35	14
15	Cook Helpers/Assistants	13,190	14,275	145,250	10.18	15
16	Dishwashers					16
17	Maintenance Workers	1,976	2,138	51,405	24.04	17
18	Housekeepers	11,972	12,957	142,044	10.96	18
19	Laundry	6,924	7,494	86,973	11.61	19
20	Administrator	1,904	2,060	111,231	54.00	20
21	Assistant Administrator	2,228	2,411	49,380	20.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,524	7,061	121,248	17.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,183	1,280	22,370	17.48	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,408	183,347	\$ 3,113,639 *	\$ 16.98	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	\$ 8,383	1(3)	35
36	Medical Director	Monthly	22,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,585	10(3)	38
39	Pharmacist Consultant	Monthly	17,114	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,530	11(3)	44
45	Social Service Consultant	Monthly	19,200	12(3)	45
46	Other(specify) Utilization Review	Monthly	4,200	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 76,812		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	45	\$ 1,461	10(3)	50
51	Licensed Practical Nurses	61	1,261	10(3)	51
52	Certified Nurse Assistants/Aides	46	693	10(3)	52
53	TOTAL (lines 50 - 52)	152	\$ 3,415		53

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	
Jennifer Cook	Administrator	0	\$ 111,231	Workers' Compensation Insurance		\$ 113,370	IDPH License Fee		\$	
Rebecca Schnor	Assistant Administrator	0	49,380	Unemployment Compensation Insurance		15,818	Advertising: Employee Recruitment		981	
				FICA Taxes		227,103	Health Care Worker Background Check			
				Employee Health Insurance		212,984	(Indicate # of checks performed 162)		1,947	
				Employee Meals			Patient Background Checks		148 1,775	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees		2,951	
				Employee Retirement		4,941	Illinois Council on Long Term Care		9,695	
				Employee Benefits - Other		3,724	Miscellaneous Dues & Subscriptions		2,419	
				Employees' Physical Exams		560	Lobbying Expense Offset		(3,199)	
TOTAL (agree to Schedule V, line 17, col. 1)							Allocated from Mgmt. Co.		8,737	
(List each licensed administrator separately.)							Less: Public Relations Expense		()	
							Non-allowable advertising		()	
							Yellow page advertising		()	
B. Administrative - Other							TOTAL (agree to Sch. V,		\$ 25,306	
							line 20, col. 8)			
Description										
Management Fees (Eliminated in Col. 7)										
TOTAL (agree to Schedule V, line 17, col. 3)							TOTAL (agree to Schedule V,		\$ 578,500	
(Attach a copy of any management service agreement)							line 22, col.8)			
C. Professional Services							E. Schedule of Non-Cash Compensation Paid			
Vendor/Payee	Type		Amount	Description		Line #	Amount	G. Schedule of Travel and Seminar**		
See Sch 21C	See Sch 21C		\$ 195,796	N/A			\$	Description		Amount
								Out-of-State Travel		\$
								In-State Travel		
								Seminar Expense		2,933
								Allocated from Mgmt. Co.		731
								Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)								line 24, col. 8)		\$ 3,664
								TOTAL		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Northwoods Care Centre
IDPH License ID Number: 0051813
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
ABILITY NETWORK , INC.	SECURE EXCHANGE MANAGED SERV	4,059
ACHIEVE ACCREDITATION	ACCREDITATION ASSISTANCE	8,568
ALLSCRIPTS LLC	REFERRAL MANAGEMENT CORE INTEGRA	2,052
AMERICAN EXPRESS	INTERNET	26,683
BARRACUDA NETWORKS, INC	CUDASIGN PREMIUM CLOUD 355	206
CARBONITE	CLOUD BACK-UP SERVICE	1,296
CARDMEMBER SERVICE	INBOX LOCAL/USAGE INBOUND LOCAL	339
CDW GOVERNMENT	AIRWATCH ORANGE MANAGEMENT	449
COMCAST	CABLE	7,416
CORPORATION SERVICE	STATUTORY REGISTERED AGENT	480
CREATIVE TECHNOLOGY	IT SUPPORT	9,199
DART CHART MAP AND TRACK SYSTEMS LLC	MAPPING OF HMO CONTRACT	93
EFAX CORPORATE	USAGE INBOUND/OUTBOUND LOCAL/USE.	374
E-HEALTH DATA SOLUTIONS	CAREWATCH/RISKW ATCH SERVICE	2,556
EMMI SOLUTIONS	SUBSCRIPTION	74
EMPOWER RETIREMENT	PROFESSIONAL FEES	43
EVault	PROTECTONE- 36 MO-SERVERONE	288
FORMATION HEALTHCARE GROUP	MONTHLY SUBSCRIPTION	418
FRONTIER	BUSINESS HIGH SPEED INTERNET	480
FYI SYSTEMS, INC	ALTERYX DESIGNER DESKTOP	241
GRANT POWELL	BUILDING MAINTENANCE CONSULTING	962
HEALTH DATA SYSTEMS	MICRO-FICHE SOFTWARE MAINTENANCE	4,432
HEALTH DIMENSIONS GROUP	PROFESSIONAL FEES	409
HK PAYROLL	WOTC PROGRAM	787
IIT/SOURCETECH	OPERATOR MONTHLY SUPPORT FEE	3,957
INTERMEDIA MARKETING SOLUTIONS	SALES/SURVEYS/PARITAL SURVEYS	299
MAESTRO CONSULTING FEES	WAGE ALLOCATIONS: MARKETING, CLINI	49,825
MARKET METRIX	SURVEYS	3,245
MEDICAL BUSINESS OFFICE	COLLECTION AGENCY	37,020
MICROSOFT CORPORATION	COMPUTER SOFTWARE	2,475
MOEO	CMS & API	144
MOOBILE	DEV ITERATION	116
OTHER	UNIDENTIFIED VENDOR PROFESSIONAL FI	(50,419)
PENSION FINANCIAL SERVICES, INC	PROFESSIONAL FEES	126
PERSONNEL PLANNERS	QTRLY UNEMPLOYMENT CLAIMS	780
POINT B COMMUNICATIONS	YEARLY WEB HOSTING	240
POINTCLICKCARE TECHNOLOGIES	A/R & A/P SYSTEM	9,326
PRIME CARE TECHNOLOGIES	PBJ REPORTING MODULE	50
QUALFON	SALES/SURVEYS/PARITAL SURVEYS	124
RSM US LLP	ACCOUNTING	24,575
STONE, MCGUIRE & SIEGEL	LEGAL FEES-COMPLIANCE	17,918
TELEMEDICINE SOLUTIONS	WOUNDCARE MGT SYSTEM IMPLEMEN	10,144
VENTIV TECHNOLOGY	RISKCONSOLE	1,309
WESCOM SOLUTIONS INC.	CLINICAL/BOOKKEEPING/DATA PROC	12,465
ZIR-MED	ELGIBILITY VERIFICATION	173
Total (agree to Schedule V, line 19, column 3)		195,796
Allocated from Management Company: Professional Services		20,321
Less: Non-Allowable Legal Fees		(4,179)
Less: Non-Allowable Professional Collections Fees		(37,020)
Total (agree to Schedule V, line 19, column 8)		174,918

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council LTC - \$9,695

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32 Line 10(2)

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 255,306
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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? No
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees