

Facility Name & ID Number Symphony of Joliet

0051797 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	214	Skilled (SNF)	214	78,110	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	214	TOTALS	214	78,110	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			11,502	11,502	8
9	SNF/PED					9
10	ICF	44,739	4,623	1,209	50,571	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,739	4,623	12,711	62,073	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.47%

D. How many bed-hold days during this year were paid by the Department?

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 12/31/11 NO

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

YES NO If YES, enter number of beds certified 214 and days of care provided 9,135

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Symphony of Joliet

0051797

Report Period Beginning:

01/01/2014

Ending:

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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	308,512	35,364	20,124	364,000		364,000		364,000		1
2	Food Purchase		364,445		364,445		364,445		364,445		2
3	Housekeeping	212,941	58,633		271,574		271,574		271,574		3
4	Laundry	92,020	20,743	2,981	115,744		115,744		115,744		4
5	Heat and Other Utilities			222,406	222,406		222,406	762	223,168		5
6	Maintenance	115,462	1,102	110,938	227,502		227,502	7,013	234,515		6
7	Other (specify):*										7
8	TOTAL General Services	728,935	480,287	356,449	1,565,671		1,565,671	7,775	1,573,446		8
	B. Health Care and Programs										
9	Medical Director			132,815	132,815		132,815		132,815		9
10	Nursing and Medical Records	3,627,371	198,166	13,440	3,838,977		3,838,977	57,517	3,896,494		10
10a	Therapy	68,141			68,141		68,141		68,141		10a
11	Activities	200,489		7,881	208,370		208,370		208,370		11
12	Social Services	57,118			57,118		57,118		57,118		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt alloc of benef							11,491	11,491		15
16	TOTAL Health Care and Programs	3,953,119	198,166	154,136	4,305,421		4,305,421	69,008	4,374,429		16
	C. General Administration										
17	Administrative	183,687		689,078	872,765		872,765	(689,078)	183,687		17
18	Directors Fees										18
19	Professional Services			301,395	301,395		301,395	23,277	324,672		19
20	Dues, Fees, Subscriptions & Promotions			39,493	39,493		39,493	(3,313)	36,180		20
21	Clerical & General Office Expenses	333,350	31,208	77,144	441,702		441,702	215,362	657,064		21
22	Employee Benefits & Payroll Taxes			895,874	895,874		895,874		895,874		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,294	4,294		4,294	17,012	21,306		24
25	Other Admin. Staff Transportation			7,036	7,036		7,036	(3,110)	3,926		25
26	Insurance-Prop.Liab.Malpractice			476,590	476,590		476,590	9,503	486,093		26
27	Other (specify):* Mgmt alloc of benef							33,480	33,480		27
28	TOTAL General Administration	517,037	31,208	2,490,904	3,039,149		3,039,149	(396,867)	2,642,282		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,199,091	709,661	3,001,489	8,910,241		8,910,241	(320,084)	8,590,157		29

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

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

Facility Name & ID Number

Symphony of Joliet

#0051797

Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			124,176	124,176		124,176	4,819	128,995			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,819	64,819		64,819	(12,770)	52,049			32
33	Real Estate Taxes			152,340	152,340		152,340		152,340			33
34	Rent-Facility & Grounds			2,342,836	2,342,836		2,342,836	(151,885)	2,190,951			34
35	Rent-Equipment & Vehicles			122,801	122,801		122,801	4,248	127,049			35
36	Other (specify):*											36
37	TOTAL Ownership			2,806,972	2,806,972		2,806,972	(155,588)	2,651,384			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,506	2,506		2,506		2,506			38
39	Ancillary Service Centers		344,274	1,804,682	2,148,956		2,148,956		2,148,956			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			438,499	438,499		438,499		438,499			42
43	Other (specify):* Non-Allowable Co			360,025	360,025		360,025	(360,025)				43
44	TOTAL Special Cost Centers		344,274	2,605,712	2,949,986		2,949,986	(360,025)	2,589,961			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,199,091	1,053,935	8,414,173	14,667,199		14,667,199	(835,697)	13,831,502			45

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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,718)	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	(12,770)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,429)	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	(2,412)	43		18
19	Entertainment				19
20	Contributions	(5,999)	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	(229,692)	43		24
25	Fund Raising, Advertising and Promotional	(15,316)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(338)	43		28
29	Other-Attach Schedule See Page 5A	(137,955)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (409,629)		\$	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	2	
		Amount	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)	(426,068)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (426,068)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (835,697)		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	2	3	4	
		Yes	No	Amount	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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (60,476)	43	1
2	Laboratory Costs	(19,457)	43	2
3	X-Ray Costs	(20,288)	43	3
4	Lobbying expense	(7,076)	20	4
5	Medicare & Medicare HMO	(900)	43	5
6	Nonallowable legal	(6,161)	19	6
7	Nonallowable other admin. staff transportation	(3,110)	25	7
8	Admitting	(20,487)	21	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		(137,955)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				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	5 Utilities	\$	Symphony Financial Services, LLC	100.00%	\$ 762	\$ 762
16	V	6 Maintenance		Symphony Financial Services, LLC	100.00%	7,013	7,013
17	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	57,517	57,517
18	V	15 Other		Symphony Financial Services, LLC	100.00%	11,491	11,491
19	V	17 Administrative	689,078	Symphony Financial Services, LLC	100.00%		(689,078)
20	V	19 Professional Services		Symphony Financial Services, LLC	100.00%	29,438	29,438
21	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	3,763	3,763
22	V	21 Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	235,849	235,849
23	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	17,012	17,012
24	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	9,503	9,503
25	V	27 Other		Symphony Financial Services, LLC	100.00%	33,480	33,480
26	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	4,819	4,819
27	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(151,885)	(151,885)
28	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	4,248	4,248
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 689,078			\$ 263,010	\$ * (426,068)

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

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Report Period Beginning:

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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 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	7257 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	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			24
25			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

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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	No owners receive compensation from this facility.								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Symphony of Joliet

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Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Occupied Bed Days	418,769	8	\$ 5,138	\$ 62,073	\$ 762	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313	62,073	7,013	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	418,769	8	388,030	388,030	57,517	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521	62,073	11,491	4
5	19	Professional Services-Legal	Occupied Bed Days	418,769	8	14,326	62,073	2,124	5
6	19	Professional Services-Other	Occupied Bed Days	418,769	8	184,271	62,073	27,314	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386	62,073	3,763	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276	1,490,276	220,900	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	100,854	62,073	14,949	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768	62,073	17,012	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109	62,073	9,503	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869	62,073	33,480	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512	62,073	4,819	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)	62,073	(151,885)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271	62,073	2,560	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389	62,073	1,688	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,774,356	\$ 1,878,306	\$ 263,010	25

Facility Name & ID Number

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Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	The Private Bank		X	Capital Improvements	Interest Only	12/30/2011	2,000,000	157,678	12/30/2017	0.0525	4,842						
7	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	27,000,000	1,953,146	12/30/2015	0.0450	59,977						
8																	
9	TOTAL Facility Related						\$ 29,000,000	\$ 2,110,824			\$ 64,819						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (12,770)						
15	TOTALS (line 9+line14)						\$ 29,000,000	\$ 2,110,824			\$ 52,049						

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.				\$	<u>132,700</u>	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.)	2013			\$	<u>139,040</u>	2
3. Under or (over) accrual (line 2 minus line 1).				\$	<u>6,340</u>	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<u>146,000</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<u>152,340</u>	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	<u>94,807</u>	8	FOR BHF USE ONLY		
	2010	<u>102,835</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011	<u>112,034</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012	<u>126,335</u>	11	15	LESS REFUND FROM LINE 6 \$	15
	2013	<u>139,040</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2014 Tax Accrual = \$139,040 * 1.05 = \$145,992; use \$146,000						

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Symphony of Joliet COUNTY Will
 FACILITY IDPH LICENSE NUMBER 0051797
 CONTACT PERSON REGARDING THIS REPORT Elizabeth Koshy
 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>30-07-07-401-034-0000</u>	<u>Nursing Home</u>	\$ <u>139,040.46</u>	\$ <u>139,040.46</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>139,040.46</u></u>	\$ <u><u>139,040.46</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? 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Symphony of Joliet

0051797 Report Period Beginning:

01/01/2014 Ending:

12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,380 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **Symphony of Joliet**# **0051797**

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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		Power Receptacles/Electrical Work	2013		10,699	596	20	596		793	9
10		Interior Electrical Alarm - 1st Floor	2013		24,618	1,231	20	1,231		1,949	10
11											11
12		Wallpaper/Paint - 1st & 2nd Floor - Lobby, Hallways, Admission Office, Therapy, North Bedrooms, East Bedrooms	2013		25,654	1,282	20	1,282		1,887	12
13		Nurse's station, Conference Room and Activity Room									13
14											14
15											15
16		First & Second Floor - East and North Wings	2013		42,950	2,147	20	2,147		3,400	16
17		-Refinish walls, sconces & wood trims around door (Hallway)									17
18		- Resident Lounge - Wood Panel & Trims									18
19											19
20		Spa/Shower floors, walls, sconces, chalk layers and counter walls - East Wing/Rooms	2013		19,826	991	20	991		1,487	20
21											21
22											22
23		Glass windows - 1st Floor - Dining Room	2013		5,640	282	20	282		306	23
24											24
25		Plumbing / Valves in bathroom - 1st floor - Lobby, Dining Room	2013		2,511	126	20	126		136	25
26											26
27		Demolition/Carpentry - 1st Floor - bathrooms in East Bedrooms, Lobby, Dining Room; Front West Side (Exterior)	2013		439,856	21,993	20	21,993		33,319	27
28											28
29											29
30		Frames/Wood Doors - 1st Fl. - Lobby, Dining, Admissions & Conf.	2013		4,794	240	20	240		360	30
31											31
32		Masonry Work - Exterior Renovation (Open Wall for Windows)	2013		6,270	313	20	313		496	32
33											33
34		Signage - Exterior, Vestibule and Dining Room (1st Floor)	2013		14,365	719	20	719		1,172	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Symphony of Joliet

0051797

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	Remove/Install of flooring - 1st Floor -	2013	\$ 60,699	\$ 3,035	20	\$ 3,035	\$	\$ 3,943	37
38	Lobby, Hallway, Dining Room, Admissions & Conf. Rooms, Therapy								38
39	North, East and South Bedrooms								39
40									40
41	Custom Millwork -1st Floor-Lobby, Dining Room and Therapy	2013	130,000	6,500	20	6,500		9,750	41
42									42
43	Construction Draw-1st Fl - Lobby, Dining & Resident Rooms	2013	125,563	6,278	20	6,278		9,767	43
44	(North, East and South Bedrooms), Exterior, Admissions & Conf. Rooms								44
45									45
46	Architecture Fees & Structural Engineering (Throughout Facility)	2013	21,665	1,084	20	1,084		1,694	46
47	-1st Floor - Dining Room & Resident Rooms (North, East and South Bedrooms)								47
48									48
49									49
50	Facility Remodeling	2014	425,942	11,848	20	11,848		11,848	50
51	-Interior Demo, Carpentry Drywall (Throughout Facility)								51
52	-General Contracting & Architectural Fees (Throughout Facility)								52
53	-Remove & Reinstall Electric & Phone: 1st & 2nd Fl. Nurses' Station								53
54	-Install Coax Cable in Wall in New TV Room 2nd Floor								54
55	-Replace Outlets in New TV Room 2nd Floor								55
56	-Rough in 2 Outlets for Sink (Beauty Salon)								56
57	-Rough in Electric for New TV Room 2nd Floor								57
58	-2 Washroom Floors - Florim Layers (Beauty Salon)								58
59	-Plumbing: Reinstall Hand Sink & Foot Pedals (Beauty Salon)								59
60	-Widen 2 Openings in 8" Block Wall - Bigger Doors for								60
61	Beauty Salon / Nurses' Station								61
62	-Furnish & Install New Shaw & Wall Base: Nurses' Station								62
63	-Laminate/Granite Tops: P.T. Room Nurses' Station								63
64	-Interior Painting, Interior Demo/Carpentry/Drywall,								64
65	Floor Coverings, Interior Electrical/Alarms, Plumbing								65
66	Therapy Room Nurses' Station								66
67	-Interior Electrical/Alarms for Elevator								67
68	-Exterior Demo/Framing/Carpentry-Facade, Roof, Storefront, Stucco								68
69	-Engineering for Roof Framing Revisions								69
70	TOTAL (lines 4 thru 69)		\$ 1,361,052	\$ 58,665		\$ 58,665	\$	\$ 82,307	70

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

Facility Name & ID Number Symphony of Joliet

0051797

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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		
1		\$ 1,361,052	\$ 58,665		\$ 58,665		\$ 82,307		1
2									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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34		\$ 1,361,052	\$ 58,665		\$ 58,665		\$ 82,307		34

**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	\$ 357,017	\$ 57,819	\$ 57,819	\$	5-7	\$ 112,243	71
72	Current Year Purchases	83,131	7,692	7,692		5-7	7,692	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	26,364		4,819	4,819	5-7	7,235	74
75	TOTALS	\$ 466,512	\$ 65,511	\$ 70,330	\$ 4,819		\$ 127,170	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,827,564	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,176	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 128,995	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,819	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 209,477	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Symphony of Joliet

0051797

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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:	1975	214	12/31/2011	\$ 2,337,404	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(151,885)			6
7	TOTAL		214		\$ 2,185,519			7

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. /2015 \$ 1,836,000

13. /2016 \$ 1,872,720

14. /2017 \$ 1,910,174

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.

5,432

54,324

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: \$ 121,053

Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Toyota Corolla	\$ 359.00	\$ 4,308	17
18					18
19					19
20	Allocated from Mgmt. Co.			1,688	20
21	TOTAL		\$ 359.00	\$ 5,996	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name: Symphony of Joliet
IDPH License ID Number: 0051797
Fiscal Year End: 12/31/2014

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxygen	21,086
Bed/Mattress	11,500
wheelchair	4,316
Vac Freedom	34,751
CPAP/Bipap/compressor	721
Patient Lift	2,752
Blood Pressure Machine	3,720
Generator	2,295
Cooler	147
Rodding Machine	172
Water Machine	440
Copier	22,712
Digital Music	439
Mailing Machine	1,222
Printers for EMR Machines	11,259
Computer	959
Allocated from Mgmt Co	2,560
Total - Line 16	121,053

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	9,373	\$ 674,880	\$	9,373	\$ 674,880	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,962	213,295		2,962	213,295	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(3)	hrs		10,437	751,465		10,437	751,465	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 prescripts				341,137		341,137	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>See Schedule 16A</u>	39(3)				165,042			165,042	12	
13	Other (specify): <u>Oxygen</u>	39(2)					3,137		3,137	13	
14	TOTAL			\$	22,772	\$ 1,804,682	\$ 344,274	22,772	\$ 2,148,956	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: Symphony of Joliet
IDPH License ID Number: 0051797
Fiscal Year End: 12/31/2014

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

<u>Description</u>	<u>Units</u>	<u>Amount</u>
5751 OTHER SERVICES - PRIVATE		107,230
5753 OTHER SERVICES-MEDICARE		(179)
5853 IV THERAPY-MEDICARE		1,825
5858 IV THERAPY-MANAGED CARE		175
15886 CARDIOLOGIST CONSULTANT		8,625
15888 PROGRAM CONSULTANT		4,033
15882 PSYCHOLOGIST		17,380
15885 RESPIRATORY		25,953
Total - Line 12	-	165,042

Facility Name & ID Number Symphony of Joliet# 0051797Report Period Beginning: 01/01/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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	\$ 231,589	\$ 231,589	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>313,237</u>)	4,827,544	4,827,544	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,667	2,667	6
7	Other Prepaid Expenses	266,282	266,282	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,328,082	\$ 5,328,082	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,361,052	1,361,052	15
16	Equipment, at Historical Cost	440,148	466,512	16
17	Accumulated Depreciation (book methods)	(202,242)	(209,477)	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 <u>Lease Cost, net</u>)	38,027	38,027	22
23	Other(specify): <u>See Schedule 17A</u>	586,553	586,553	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,223,538	\$ 2,242,667	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,551,620	\$ 7,570,749	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,101,466	\$ 1,101,466	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,721	89,721	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	146,000	146,000	32
33	Accrued Interest Payable	458	458	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	2,354,910	2,354,910	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,692,555	\$ 3,692,555	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,110,824	2,110,824	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,110,824	\$ 2,110,824	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,803,379	\$ 5,803,379	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,748,241	\$ 1,767,370	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,551,620	\$ 7,570,749	48

*(See instructions.)

Facility Name: Symphony of Joliet
IDPH License ID Number: 0051797
Fiscal Year End: 12/31/2014

Schedule 17A

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
1125 SECURITY DEPOSIT	281,475	281,475
1126 REAL ESTATE ESCROW DEPOSIT	305,078	305,078
Total - Line 23	586,553	586,553

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
1204 EXCHANGE FORMATION L/H	1,103,201	1,103,201
1209 SECURITY DEPOSIT PAYABLE	81,409	81,409
1210 OPERATING EXPENSES	107,906	107,906
1212 MANAGEMENT FEES - SYMPHONY	312,151	312,151
1214 INSURANCE ALLOWANCE-DEDUCTIBLES/STLMNTS	224,848	224,848
1220 ACCUMULATED AMORTIZATION DEFERRED RENT	(60,488)	(60,488)
1221 STATE UNEMPLOYMENT TAX	12,513	12,513
1222 FEDERAL UNEMPLOYMENT TAX	1,284	1,284
1223 SALES TAX	163	163
1224 PAYROLL TAXES OTHER	9,832	9,832
1226 ACCRUED EMPLOYEE BENEFITS	275,435	275,435
1232 FICA & W/H FED	53,163	53,163
1233 ILL W/H	9,306	9,306

1242 DUE TO IDPA-ADD'TL BED TAX	55,085	55,085
1244 DUE TO KENSINGTON GROUP	59,019	59,019
1252 DUE TO NUCARE	32,841	32,841
1253 DUE TO SYMPHONY	23,796	23,796
1257 WAGE ASSIGNMENT & GARNISHMENT	930	930
1258 PATIENT PERSONAL FUNDS	52,516	52,516
Total - Line 36	2,354,910	2,354,910

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,072,148	1
2	Restatements (describe):		2
3	Prior Period Adjustment	5,715	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,077,863	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	670,378	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)	\$ 670,378	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,748,241	24 *

* This must agree with page 17, line 47.

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	\$ 14,706,398	1
2	Discounts and Allowances for all Levels	(3,304,263)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,402,135	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,406,214	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,406,214	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	367,412	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,019	19
20	Radiology and X-Ray	16,441	20
21	Other Medical Services	45,130	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 504,002	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,770	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,770	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare and Managed Care Rentals	12,456	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,456	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,337,577	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,565,671	31
32	Health Care	4,305,421	32
33	General Administration	3,039,149	33
B. Capital Expense			
34	Ownership	2,806,972	34
C. Ancillary Expense			
35	Special Cost Centers	2,511,487	35
36	Provider Participation Fee	438,499	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,667,199	40
41	Income before Income Taxes (line 30 minus line 40)**	670,378	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 670,378	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,664,307	44
45	Private Pay - Net Inpatient Revenue	870,012	45
46	Medicare - Net Inpatient Revenue	2,292,361	46
47	Other-(specify) <u>Hospice</u>	225,159	47
48	Other-(specify) <u>Managed Care</u>	350,296	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,402,135	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

^ Tax Return prepared on cash basis

Facility Name: Symphony of Joliet
IDPH License ID Number: 0051797
Fiscal Year End: 12/31/2014

Schedule 19C

XVII. Income Statement

Line 47 Net Inpatient Revenue detailed by Payer Source Other (specify):

	<u>Description</u>	<u>Amount</u>
4170	HOSPICE - ROUTINE	225,159
	Total - Line 47	<u>225,159</u>

XVII. Income Statement

Line 48 Net Inpatient Revenue detailed by Payer Source Other (specify):

	<u>Description</u>	<u>Amount</u>
4180	MANAGED CARE - ROUTINE	869,287
4228	MED SUPPLY C/A - MANAGED CARE	(9,236)
4278	RX - MANAGED CARE CONTRACTUAL ADJUSTMENT	2,494
4528	PHYSICAL TPY-CONT ADJ MNG CAR	(225,471)
4578	SPEECH THERAPY C/A - MANAGE CARE	(76,480)
4628	OCCUP. TPY-MAN CARE CONT ADJ	(204,588)
4878	IV THERAPY MAN CARE CONT ADJ	(5,710)
	Total - Line 48	<u>350,296</u>

Facility Name & ID Number Symphony of Joliet

0051797

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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	1,842	1,941	\$ 97,446	\$ 50.20	1
2	Assistant Director of Nursing	1,696	1,819	71,493	39.30	2
3	Registered Nurses	41,658	45,513	1,404,030	30.85	3
4	Licensed Practical Nurses	25,394	27,032	729,904	27.00	4
5	CNAs & Orderlies	96,437	100,845	1,259,362	12.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,488	4,647	68,141	14.66	8
9	Activity Director	5,635	6,885	124,362	18.06	9
10	Activity Assistants	6,427	7,198	76,127	10.58	10
11	Social Service Workers	2,561	3,226	57,118	17.71	11
12	Dietician					12
13	Food Service Supervisor	1,963	2,155	49,811	23.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,967	24,669	258,701	10.49	15
16	Dishwashers					16
17	Maintenance Workers	5,367	6,259	115,462	18.45	17
18	Housekeepers	16,657	17,875	212,941	11.91	18
19	Laundry	9,265	10,175	92,020	9.04	19
20	Administrator	1,931	2,275	108,451	47.68	20
21	Assistant Administrator	1,928	2,248	75,236	33.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,772	23,981	364,894	15.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,872	3,086	33,592	10.89	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	269,858	291,828	\$ 5,199,091 *	\$ 17.82	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	\$ 20,124	1(3)	35
36	Medical Director	Monthly	132,815	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,440	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	1,760	11(3)	44
45	Social Service Consultant				45
46	Other(specify) <u>Cardiologist</u>	Monthly	8,625	39(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 176,764		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	
Tammy Stoneberger	Administrator	0	\$ 108,451	Workers' Compensation Insurance	\$ 134,645	IDPH License Fee	\$ 1,990	
Amy Hammond	Assistant Administrator	0	75,236	Unemployment Compensation Insurance	101,311	Advertising: Employee Recruitment	2,074	
				FICA Taxes	387,941	Health Care Worker Background Check	6,743	
				Employee Health Insurance	240,472	(Indicate # of checks performed <u>562</u>)		
				Employee Meals		<u>Patient Background Checks</u>	<u>236</u> 2,837	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	902	
				Employee Retirement	17,377	Illinois Council on Long Term Care	21,443	
				Employee Benefits - Other	12,152	Miscellaneous Dues & Subscriptions	3,504	
				Employees' Physical Exams	1,976	Lobbying Offset	(7,076)	
						Allocated from Mgmt. Co.	3,763	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 183,687				\$ 895,874			\$ 36,180	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (Eliminated in Col. 7)			\$ 689,078	N/A		\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	4,294
							Allocated from Mgmt Co.	17,012
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 689,078				\$			\$ 21,306	
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule 21A			\$ 301,395					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 301,395								

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Symphony of Joliet
IDPH License ID Number: 0051797
Fiscal Year End: 12/31/2014

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ABILITY NETWORK	SECURE EXCHANGE MANAGED SERV	1,938
ACHIEVE ACCREDITATION LLC	ACCREDITATION	13,772
ADMINISTRATION CONSULTANTS	ADMINISTRATION CONSULTING	1,284
ALLSCRIPTS	MGMT FACILITY SUBSCRIPTION	3,270
AMY HAMMOND	JACHO CREDINTIALS	241
AON SOLUTIONS	RISKCONSOLE	1,716
BOA - M. HARTMAN	WEB HOSTING	40
COMCAST	CABLE/INTERNET	27,147
CREATIVE TECHNOLOGY	MONTHLY IT SUPPORT	15,702
DOCUMENTATION SOLUTIONS	THERAPY COMPLIANCE AUDITS	1,283
EHEALTH DATA SOLUTIONS	RISKWATCH	5,112
EVAVLT INC	CLOUD BACKUP	1,584
HDSI	MICRO-FICHE AP/PR MAINT	4,742
HIPP LAW OFFICE	COLLECTIOSN	6,161
HK PAYROLL SERVICES CO	WORK TAX CREDIT	4,027
IIT/SOURCETECH	OPERATOR MONTHLY SUPPORT	1,380
JEREMY PIERSON	WEBSITE	121
MCGLADREY LLP	ACCOUNTING	29,080
MEGAPATH	BILLING	1,080
MERCER	MEDICAL STOP LOSS PRICING	309
MUCH SHELIST	LEGAL	1,407
PERSONNEL PLANNERS INC	QUARTERLY UNEMPLOY CLAIMS	4,649
PINNACLE QUALITY	CUSTOMER SATISFACTION	1,200
POINT COMMUNICATION	WEBSITE	339
PROVINET	INFRASTRUCTURE HOSTING SERVICES	1,353
STONE MCGUIRE & SIEGEL	LEGAL- COMPLIANCE	14,512

SYMPHONY FINANCIAL SERV	PROFESSIONAL FEES	105,162
TELEMEDICINE SOLUTIONS	WOUND ROUNDS CARE	18,549
THE JOINT COMMISSION	ANN'L MEDICARE BASED OPT 2	2,700
WESCOME SOLUTIONS, INC	CLINICAL/BOOKKEEPING/DATA PROCESSING	30,961
ZIRMED	ELIGIBILITY VERFICATION	575

Total (agree to Schedule V, line 19, column 3) 301,395

Allocated from Management Company Legal Fees	2,124
Allocated from Management Company Professional Services	27,314
Less: Non-Allowable Legal Fees	(6,161)

Total (agree to Schedule V, line 19, column 8) 324,672

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3											N/A	
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Symphony of Joliet# 0051797Report Period Beginning: 01/01/2014 Ending: 12/31/2014**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 - \$14,367
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 185 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. \$ 438,499
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 5
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.