

Facility Name & ID Number Symphony of Decatur

0051771 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	195	Skilled (SNF)	195	71,175	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	195	TOTALS	195	71,175	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	33,001	4,839	21,394	59,234	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,001	4,839	21,394	59,234	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.22%

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 12/31/2011 NO

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

YES NO If YES, enter number of beds certified 195 and days of care provided 7,967

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number

Symphony of Decatur

0051771

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	323,785	47,418	17,294	388,497		388,497	2,200	390,697		1
2	Food Purchase		317,009		317,009		317,009		317,009		2
3	Housekeeping	261,046	72,876		333,922		333,922		333,922		3
4	Laundry	131,791	17,508	6,106	155,405		155,405		155,405		4
5	Heat and Other Utilities			189,695	189,695		189,695	548	190,243		5
6	Maintenance	57,500	3,823	179,981	241,304		241,304	5,985	247,289		6
7	Other (specify):*										7
8	TOTAL General Services	774,122	458,634	393,076	1,625,832		1,625,832	8,733	1,634,565		8
	B. Health Care and Programs										
9	Medical Director			55,300	55,300		55,300		55,300		9
10	Nursing and Medical Records	3,466,633	203,745	26,944	3,697,322		3,697,322	64,853	3,762,175		10
10a	Therapy	98,309			98,309		98,309		98,309		10a
11	Activities	134,591		8,411	143,002		143,002		143,002		11
12	Social Services	51,176		8,249	59,425		59,425		59,425		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt alloc of benef							12,947	12,947		15
16	TOTAL Health Care and Programs	3,750,709	203,745	98,904	4,053,358		4,053,358	77,800	4,131,158		16
	C. General Administration										
17	Administrative	399,286		560,836	960,122		960,122	(560,742)	399,380		17
18	Directors Fees										18
19	Professional Services			168,791	168,791		168,791	47,368	216,159		19
20	Dues, Fees, Subscriptions & Promotions			(37,388)	(37,388)		(37,388)	51,182	13,794		20
21	Clerical & General Office Expenses	307,906	77,006	87,629	472,541		472,541	257,110	729,651		21
22	Employee Benefits & Payroll Taxes			981,842	981,842		981,842		981,842		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,365	5,365		5,365	9,798	15,163		24
25	Other Admin. Staff Transportation			24,618	24,618		24,618	549	25,167		25
26	Insurance-Prop.Liab.Malpractice			452,418	452,418		452,418	12,201	464,619		26
27	Other (specify):* Mgmt alloc of benef							47,169	47,169		27
28	TOTAL General Administration	707,192	77,006	2,244,111	3,028,309		3,028,309	(135,365)	2,892,944		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,232,023	739,385	2,736,091	8,707,499		8,707,499	(48,832)	8,658,667		29

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

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

Facility Name & ID Number

Symphony of Decatur

#0051771

Report Period Beginning:

01/01/2015

Ending:

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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			118,635	118,635		118,635	4,754	123,389			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			226,671	226,671		226,671	(2,203)	224,468			32
33	Real Estate Taxes			72,231	72,231		72,231	590	72,821			33
34	Rent-Facility & Grounds			1,662,002	1,662,002		1,662,002	(67,317)	1,594,685			34
35	Rent-Equipment & Vehicles			108,879	108,879		108,879	6,096	114,975			35
36	Other (specify):*											36
37	TOTAL Ownership			2,188,418	2,188,418		2,188,418	(58,080)	2,130,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			49,169	49,169		49,169		49,169			38
39	Ancillary Service Centers		274,440	1,225,927	1,500,367		1,500,367		1,500,367			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			417,923	417,923		417,923		417,923			42
43	Other (specify):* Non-Allowable Co			285,442	285,442		285,442	(285,442)				43
44	TOTAL Special Cost Centers		274,440	1,978,461	2,252,901		2,252,901	(285,442)	1,967,459			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,232,023	1,013,825	6,902,970	13,148,818		13,148,818	(392,354)	12,756,464			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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0051771

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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	(16,238)	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	(2,337)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(972)	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	(2,090)	43		18
19	Entertainment				19
20	Contributions	(7,444)	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	(186,946)	43		24
25	Fund Raising, Advertising and Promotional	(9,182)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(73)	43		28
29	Other-Attach Schedule See Page 5A	(15,336)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (240,618)		\$	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)	(151,736)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (151,736)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (392,354)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Symphony of Decatur

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (47,164)	43	1
2	Laboratory Costs	(10,038)	43	2
3	X-Ray Costs	(5,295)	43	3
4	IL Council LTC	47,623	20	4
5	Nonallowable Legal	(2,552)	19	5
6	To expense building improvement less than \$2500	2,200	6	6
7	To adjust depreciation related to expensed BI	(110)	30	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
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30				30
31				31
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33				33
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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		(15,336)	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			N/A				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ * 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%	\$ 415	\$	415	15
16	V	6 Maintenance		Symphony Financial Services, LLC	100.00%	2,983		2,983	16
17	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	41,796		41,796	17
18	V	15 Other		Symphony Financial Services, LLC	100.00%	7,673		7,673	18
19	V	17 Administrative	469,908	Symphony Financial Services, LLC	100.00%			(469,908)	19
20	V	19 Professional Services		Symphony Financial Services, LLC	100.00%	45,070		45,070	20
21	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	963		963	21
22	V	21 Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	199,449		199,449	22
23	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	8,334		8,334	23
24	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	12,201		12,201	24
25	V	27 Other		Symphony Financial Services, LLC	100.00%	35,387		35,387	25
26	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	3,849		3,849	26
27	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(67,812)		(67,812)	27
28	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	4,206		4,206	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		\$ 469,908			\$ 294,514	\$ *	(175,394)	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 Utilities	\$	Maestro Consulting Services	100.00%	\$ 133	\$	133	15
16	V	6 Maintenance Salaries		Maestro Consulting Services	100.00%	2,164		2,164	16
17	V	6 Maintenance Expenses		Maestro Consulting Services	100.00%	838		838	17
18	V	7 Employee Benefits - Maintenance		Maestro Consulting Services	100.00%	495		495	18
19	V	10 Clinical Salaries		Maestro Consulting Services	100.00%	23,057		23,057	19
20	V	15 Employee Benefits - Clinical		Maestro Consulting Services	100.00%	5,274		5,274	20
21	V	17 Administrative Salaries	90,928	Maestro Consulting Services	100.00%	94		(90,834)	21
22	V	19 Professional Fees		Maestro Consulting Services	100.00%	4,850		4,850	22
23	V	20 Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100.00%	2,596		2,596	23
24	V	21 Clerical & General Salaries		Maestro Consulting Services	100.00%	51,417		51,417	24
25	V	21 Clerical & General Expenses		Maestro Consulting Services	100.00%	6,244		6,244	25
26	V	24 Seminars and Education		Maestro Consulting Services	100.00%	1,464		1,464	26
27	V	25 Transportation		Maestro Consulting Services	100.00%	549		549	27
28	V	27 Employee Benefits - Administrative		Maestro Consulting Services	100.00%	11,782		11,782	28
29	V	30 Depreciation		Maestro Consulting Services	100.00%	1,019		1,019	29
30	V	32 Interest Expense		Maestro Consulting Services	100.00%	134		134	30
31	V	33 Real Estate Tax		Maestro Consulting Services	100.00%	590		590	31
32	V	35 Equipment Rental		Maestro Consulting Services	100.00%	1,352		1,352	32
33	V	35 Auto Lease		Maestro Consulting Services	100.00%	538		538	33
34	V	30 Depreciation		Maestro Consulting Services	100.00%	(4)		(4)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 90,928			\$ 114,586	\$ *	23,658	39

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

Facility Name & ID Number

Symphony of Decatur

0051771

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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 Countryside, LLC D/B/A Countrysid	Aurora	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Crestwood, LLC D/B/A Symphony of	Crestwood	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Deerbrook, LLC D/B/A Symphony of	Joliet	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				5
6	Rena Dickman	4.50	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				6
7	Robert Hartman	4.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				7
8	Jack Hartman	3.00	Symphony Evanston Healthcare	Evanston				8
9	Joseph Hartman	3.00	Symphony of Dyer	Indiana				9
10	David J. Hartman	20.00	Symphony of Crown Point	Indiana				10
11	Jay Flatt	3.00			Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00			7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Bronzeville Park	Chicago	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Claremont Rehab. & Living	Buffalo Grove	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Claremont - Hanover Park	Hanover Park	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Claridge Imperial, LTD.	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Jackson Corp	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Monroe Pavillion	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at 87th Street	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Renaissance at Midway	Chicago				22
23			Renaissance at South Shore	Chicago				23
24			Renaissance at Park South	Chicago	* No expense paid by h			24
25			Aria Post Acute Care	Hillside	entity, therefore no pa			25
26			Seven Oaks	Glendale, Wiscosin	** No expense of this r			26
27			Renaissance East	Mesa, Arizona	allocated to homes			27
28			Renaissance West	Mesa, Arizona				28
29			Renaissance Village IL	Mesa, Arizona				29
30			Renaissance Village AL	Mesa, Arizona				30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Symphony of Decatur

0051771 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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	372,227	11	\$ 3,116	\$ 49,557	\$ 415	1
2	6	Maintenance	Occupied Bed Days	372,227	11	22,405	49,557	2,983	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	372,227	11	313,972	313,972	41,801	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,227	11	57,644	49,557	7,675	4
5	19	Professional Services-Legal	Occupied Bed Days	372,227	11	5,442	49,557	725	5
6	19	Professional Services-Other	Occupied Bed Days	372,227	11	333,134	49,557	44,352	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	372,227	11	7,234	49,557	963	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	372,227	11	1,244,063	1,244,063	165,630	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	372,227	11	254,217	49,557	33,846	9
10	24	Travel & Seminar	Occupied Bed Days	372,227	11	62,607	49,557	8,335	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	372,227	11	91,654	49,557	12,202	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,227	11	265,831	49,557	35,392	12
13	30	Depreciation	Occupied Bed Days	372,227	11	28,917	49,557	3,850	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	372,227	11	(509,407)	49,557	(67,821)	14
15	35	Rent - Equipment	Occupied Bed Days	372,227	11	14,362	49,557	1,912	15
16	35	Rent - Vehicles	Occupied Bed Days	372,227	11	17,234	49,557	2,294	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,212,425	\$ 1,558,035		\$ 294,554	25

Facility Name & ID Number Symphony of Decatur

0051771 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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 Maestro Consulting Services
 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	Bed Days Available	307,257	28	\$ 3,424	\$ 11,895	\$ 133	1
2	6	Maintenance Salaries	Bed Days Available	307,257	28	55,893	11,895	2,164	2
3	6	Maintenance Expenses	Bed Days Available	307,257	28	21,648	11,895	838	3
4	7	Employee Benefits - Maintenance	Bed Days Available	307,257	28	12,799	11,895	495	4
5	10	Clinical Salaries	Bed Days Available	307,257	28	595,582	595,582	23,057	5
6	15	Employee Benefits - Clinical	Bed Days Available	307,257	28	136,244	11,895	5,274	6
7	17	Administrative Salaries	Bed Days Available	307,257	28	2,420	2,420	94	7
8	19	Professional Fees	Bed Days Available	307,257	28	125,288	11,895	4,850	8
9	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	307,257	28	67,058	11,895	2,596	9
10	21	Clerical & General Salaries	Bed Days Available	307,257	28	1,328,131	1,328,131	51,417	10
11	21	Clerical & General Expenses	Bed Days Available	307,257	28	161,289	11,895	6,244	11
12	24	Seminars and Education	Bed Days Available	307,257	28	37,815	11,895	1,464	12
13	25	Transportation	Bed Days Available	307,257	28	14,185	11,895	549	13
14	27	Employee Benefits - Administrative	Bed Days Available	307,257	28	304,341	11,895	11,782	14
15	30	Depreciation	Bed Days Available	307,257	28	26,334	11,895	1,019	15
16	32	Interest Expense	Bed Days Available	307,257	28	3,464	11,895	134	16
17	33	Real Estate Tax	Bed Days Available	307,257	28	15,239	11,895	590	17
18	35	Equipment Rental	Bed Days Available	307,257	28	34,911	11,895	1,352	18
19	35	Auto Lease	Bed Days Available	307,257	28	13,885	11,895	538	19
20	30	Depreciation	Direct					(4)	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,959,950	\$ 1,982,026	\$ 114,586	25

Facility Name & ID Number

Symphony of Decatur

0051771

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	Reporting Period Interest Expense					
		Related**					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	Capital Improvements	Interest Only	12/30/2011	2,000,000	21,112	12/30/2017	0.0525	980	6					
7	The Private Bank		X	Line of credit	Interest Only	12/30/2011	27,000,000	4,862,805	12/29/2016	0.0450	225,691	7					
8												8					
9	TOTAL Facility Related						\$	29,000,000	\$	4,883,917		\$	226,671	9			
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$		\$			\$	(2,203)	14			
15	TOTALS (line 9+line14)						\$	29,000,000	\$	4,883,917		\$	224,468	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

		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 2014 report.				\$	78,650	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.)	2014			\$	73,581	2														
3. Under or (over) accrual (line 2 minus line 1).				\$	(5,069)	3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	77,300	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5														
			Allocated from Management Co.		590															
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.				\$	72,821	7														
Real Estate Tax History:																				
Real Estate Tax Bill for Calendar Year:	2010	<u>77,477</u>	8	<table border="1"> <tr> <td colspan="2">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																				
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																		
14	PLUS APPEAL COST FROM LINE 5 \$	14																		
15	LESS REFUND FROM LINE 6 \$	15																		
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																		
	2011	<u>76,378</u>	9																	
	2012	<u>81,700</u>	10																	
	2013	<u>74,873</u>	11																	
	2014	<u>73,581</u>	12																	
2015 Tax Accrual = \$73,581 * 1.05 = \$77,260; use \$77,300																				

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Symphony Aspen Ridge, LLC D/B/A Symphony of Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0051771

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 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-12-03-251-014</u>	<u>Nursing Home</u>	\$ <u>73,581.46</u>	\$ <u>73,581.46</u>
2. <u>10-27-319-028-0000</u>	<u>Land & Property Mgmt. Co.</u>	\$ <u>15,239.04</u>	\$ <u>1,490.28</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>88,820.50</u></u>	\$ <u><u>75,071.74</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Symphony of Decatur

0051771 Report Period Beginning:

01/01/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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>Alloc Fr Maestro 7257</u>			\$ <u>1,033</u>	1
2					2
3	TOTALS			\$ <u>1,033</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8	Allocated from Maestro 7257	2004		9,293		39	238	238	3,219	8
	Improvement Type**									
9	New Piston & Cylinder for Elevator		2012	64,900	3,245	20	3,245		10,522	9
10	Drill new hole for elevator		2013	50,316	2,515	20	2,515		7,547	10
11	Elevator - shut off valve/oil line		2013	20,420	1,021	20	1,021		2,382	11
12	Cabling for EMR Kiosks		2013	7,721	387	20	387		1,030	12
13	Line Voltage Outlets		2013	5,740	287	20	287		718	13
14	Remodeling-Painting, wall coverings, millwork, ceiling		2013	487,979	24,401	20	24,401		50,833	14
15	architect fees, office conversions, lighting, flooring, doors,									15
16	fire sprinkler, plumbing, landscaping, paving, awnings -									16
17	Monroe Entrance, Vertical Circulation & Exits, Lobby, Hallways									17
18	Nurse' Station & Resident Rooms (2nd Floor), New Offices									18
19	Dining Room, Medical Room and Therapy Room (1st Floor)									19
20										20
21	Remodeling-Painting, Wall Coverings & Water Heater		2013	120,068	12,008	10	12,008		25,015	21
22	1st Floor - Lobby, offices/conference rooms, hallways,									22
23	laundry & dietary areas									23
24										24
25	Facility Remodeling		2014	195,750	10,943	5-20	10,943		18,270	25
26	-Electrical : lobby, therapy, dining rm, nurse station									26
27	-Demo/carpentry/drywall: elevator area									27
28	-Floor covering: lobby									28
29	-Plumbing: 2nd floor shower & beauty salon									29
30	-Engineering: new entry vestibule									30
31	-Gazebo									31
32	-Tile: lobby									32
33	-Custom millwork: throughout facility									33
34	-Architectural services									34
35	-Signage for rooms: throughout facility									35
36	-Painting staircases: east & west staircases									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Symphony of Decatur

0051771

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	Continued from Page 12		\$	\$		\$	\$	\$	37
38	-Mid rails: throughout facility								38
39	-Asphalt: previous location of trailer								39
40	-Spandrel Glass: lobby								40
41	-Stucco: front of building								41
42	-Entry								42
43	-General contractors fees								43
44									44
45	Architectural Fee, Electrical, Sign Installation for New Façade	2015	18,405	767		767		767	45
46									46
47									47
48	Depreciation for BI reclass to R&M			110			(110)		48
49									49
50	Phone system throughout the facility	2015	40,663	678	5	678		678	50
51									51
52	Allocated from Maestro Consulting Services	2003	453		39	4	4	271	52
53	Allocated from Maestro Consulting Services	2004	9,206		39	89	89	5,401	53
54	Allocated from Maestro Consulting Services	2005	546		39	5	5	292	54
55	Allocated from Maestro Consulting Services	2006	740		39	7	7	340	55
56	Allocated from Maestro Consulting Services	2008	780		39	8	8	277	56
57	Allocated from Maestro Consulting Services	2009	12,561		20	122	122	4,046	57
58	Allocated from Maestro Consulting Services	2010	1,930		20	19	19	435	58
59	Allocated from Maestro Consulting Services	2011	104		20	1	1	25	59
60	Allocated from Maestro Consulting Services	2012	116		20	1	1	21	60
61	Allocated from Maestro Consulting Services	2014	1,452		20	14	14	104	61
62	Allocated from Maestro Consulting Services	2015	408		20			3	62
63									63
64	Allocated from Maestro 7257	2004	185		20			106	64
65	Allocated from Maestro 7257	2005	847		10	6	6	561	65
66	Allocated from Maestro 7257	2015	146		10	3	3	3	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,050,729	\$ 56,362		\$ 56,769	\$ 407	\$ 132,866	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	\$ 357,101	\$ 60,105	\$ 60,105	\$	5-7	\$ 148,972	71
72	Current Year Purchases	17,470	2,168	2,168		5-7	2,168	72
73	Fully Depreciated Assets							73
74	See Sch 13A	90,422		4,344	4,344	5-7	48,640	74
75	TOTALS	\$ 464,993	\$ 62,273	\$ 66,617	\$ 4,344		\$ 199,780	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			\$ 343	\$	\$ 3	\$ 3		\$ 343	76
77										77
78										78
79										79
80	TOTALS			\$ 343	\$	\$ 3	\$ 3		\$ 343	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)	\$ 1,517,098	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,635	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,389	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,754	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 332,989	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: Symphony of Decatur
IDPH License ID Number: 0051771
Fiscal Year End: 12/31/2015

Schedule 13A

XI. Ownership Costs

Line 74 - Equipment Costs - Excluding Transportation

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
Allocated from Symphony Financial Services, LLC	23,549		3,849	3,849	5-7	9,449
Allocated from Maestro Consulting Services	66,873		494	494	5-10	39,191
				-		
TOTAL	90,422	-	4,343	4,343		48,640

Facility Name & ID Number

Symphony of Decatur

0051771

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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>1973</u>	<u>195</u>	<u>12/31/2011</u>	\$ <u>1,658,515</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	<u>Allocated from Mgmt. Co.</u>				<u>(67,317)</u>			6
7	TOTAL		<u>195</u>		\$ <u>1,591,198</u>			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. /2016 \$ 1,144,440

13. /2017 \$ 1,167,329

14. /2018 \$ 1,190,675

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.

3,487

34,871

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: \$ 106,179

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>Administrative</u>	<u>Chevy Tahoe</u>	\$ <u>900.00</u>	\$ <u>2,700</u>	17
18					18
19					19
20	<u>Allocated from Mgmt. Co.</u>			<u>6,096</u>	20
21	TOTAL		\$ <u>900.00</u>	\$ <u>8,796</u>	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 Decatur
IDPH License ID Number: 0051771
Fiscal Year End: 12/31/2015

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxygen Concentrator	5,384
Annual Cylinder Lease	72
Plant Rental	6,576
Blood Pressure Machine	3,564
Cooler	494
Domestic Container	2,380
Computer	959
Voice Media	749
Mail Machine	1,441
Kyocera Copier	37,008
CPAP	13,626
Bed Bariatric, Air Compressor	22,364
Vac ATS Therapy Unit	11,562
Total - Line 16	<u>106,179</u>

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

<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		3	4
		1	2		
		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.)

	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	\$	7,235	\$	520,914	\$	7,235	\$	520,914	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,194		85,979		1,194		85,979	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(3)	hrs		8,220		591,828		8,220		591,828	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					266,818			266,818	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Oxygen</u>	39(2)						7,622			7,622	12	
13	Other (specify): <u>See Schedule 16A</u>	39(3)					27,206				27,206	13	
14	TOTAL			\$	16,649	\$	1,225,927	\$	274,440	16,649	\$	1,500,367	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 Decatur
IDPH License ID Number: 0051771
Fiscal Year End: 12/31/2015

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

<u>Description</u>	<u>Units</u>	<u>Amount</u>
5753 OTHER SERVICES - MEDICARE		140
5853 I.V. THERAPY - MEDICARE		13,277
5858 I.V. THERAPY - MANAGED CARE		1,789
15887 ONCOLOGIST		12,000
Total - Line 12	-	27,206

Facility Name & ID Number **Symphony of Decatur**

0051771

Report Period Beginning: **01/01/2015**

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2015**

(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	\$ 47,294	\$ 47,294	1
2	Cash-Patient Deposits	105,369	105,369	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>378,054</u>)	5,904,602	5,904,602	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,135	116,135	6
7	Other Prepaid Expenses	208,900	208,900	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	54,684	54,684	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,436,984	\$ 6,436,984	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,033	13
14	Buildings, at Historical Cost		9,293	14
15	Leasehold Improvements, at Historical Cost	973,499	1,041,436	15
16	Equipment, at Historical Cost	415,234	465,336	16
17	Accumulated Depreciation (book methods)	(269,012)	(332,989)	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</u>)	20,923	20,923	22
23	Other(specify): <u>See Schedule 17A</u>	359,689	359,689	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,500,333	\$ 1,564,721	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,937,317	\$ 8,001,705	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,390,549	\$ 1,390,549	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,336	69,336	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,300	77,300	32
33	Accrued Interest Payable	611	611	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	3,139,213	3,139,213	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,677,009	\$ 4,677,009	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	4,883,917	4,883,917	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,883,917	\$ 4,883,917	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,560,926	\$ 9,560,926	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,623,609)	\$ (1,559,221)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,937,317	\$ 8,001,705	48

*(See instructions.)

Facility Name: Symphony of Decatur
IDPH License ID Number: 0051771
Fiscal Year End: 12/31/2015

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
1127 RESERVE FOR CAPEX	42,353	42,353
1147 DUE FROM PRIOR OWNER	12,331	12,331
Total - Line 9	54,684	54,684

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
1125 SECURITY DEPOSIT	146,744	146,744
1126 REAL ESTATE ESCROW DEPOSIT	212,945	212,945
Total - Line 23	359,689	359,689

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
1204 EXCHANGE FORMATION LEASHOLDS	1,010,609	1,010,609
1206 DUE TO DPA	13,274	13,274
1209 SECURITY DEPOSIT PAYABLE	40,731	40,731
1210 OPERATING EXPENSES	304,462	304,462
1212 MANAGEMENT FEES - SYMPHONY	310,737	310,737
1214 INSURANCE ALLOWANCE - W/C & GLPL	58,105	58,105
1220 ACCUMULATED AMORTIZATION DEFERRED RENT	(104,703)	(104,703)

1221 STATE UNEMPLOYMENT TAX	5,566	5,566
1222 FEDERAL UNEMPLOYMENT TAX	610	610
1223 SALES TAX	303	303
1224 PAYROLL TAXES OTHER	7,307	7,307
1226 ACCRUED EMPLOYEE BENEFITS	164,053	164,053
1232 FICA & W/H FED	44,327	44,327
1233 ILL W/H	5,672	5,672
1237 401-K PLAN DEDUCTION	3,330	3,330
1240 401(K) LOAN REPAYMENT	1,304	1,304
1242 DUE TO IDPA - ADD'TL BED TAX	52,117	52,117
1249 DUE TO RELATED PARTY	335,062	335,062
1252 DUE TO NUCARE	21,236	21,236
1253 DUE TO SYMPHONY FINANCIAL	227,405	227,405
1254 DUE TO MCKINLEY COURT	599,866	599,866
1257 WAGE ASSIGN & GARNISHMENTS	3,938	3,938
1258 PATIENT PERSONAL FUNDS	33,902	33,902
Total - Line 36	3,139,213	3,139,213

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (945,959)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	2,905	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (943,054)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(680,555)	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)	\$ (680,555)	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)	\$ (1,623,609)	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	\$ 11,944,013	1
2	Discounts and Allowances for all Levels	(2,233,139)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,710,874	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,378,797	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,378,797	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	323,584	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,531	19
20	Radiology and X-Ray	922	20
21	Other Medical Services	30,529	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 363,566	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,337	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,337	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Discounts Earned</u>	2,894	28
28a	<u>Rentals - Medicare</u>	9,795	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,689	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,468,263	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,625,832	31
32	Health Care	4,053,358	32
33	General Administration	3,028,309	33
B. Capital Expense			
34	Ownership	2,188,418	34
C. Ancillary Expense			
35	Special Cost Centers	1,834,978	35
36	Provider Participation Fee	417,923	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,148,818	40
41	Income before Income Taxes (line 30 minus line 40)**	(680,555)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (680,555)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,008,986	44
45	Private Pay - Net Inpatient Revenue	785,747	45
46	Medicare - Net Inpatient Revenue	1,641,911	46
47	Other-(specify) <u>Hospice</u>	212,803	47
48	Other-(specify) <u>Managed Care</u>	61,427	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,710,874	49

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

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

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

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

^ - Tax Return prepared on cash basis

Facility Name & ID Number Symphony of Decatur

0051771

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	1,965	2,100	\$ 98,799	\$ 47.05	1
2	Assistant Director of Nursing	2,006	2,248	70,012	31.14	2
3	Registered Nurses	14,823	16,075	443,860	27.61	3
4	Licensed Practical Nurses	43,177	46,851	1,204,800	25.72	4
5	CNAs & Orderlies	106,577	113,991	1,582,052	13.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,558	7,186	98,309	13.68	8
9	Activity Director	2,289	2,637	52,213	19.80	9
10	Activity Assistants	5,651	6,163	82,378	13.37	10
11	Social Service Workers	1,807	1,970	51,176	25.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,347	28,338	323,785	11.43	15
16	Dishwashers					16
17	Maintenance Workers	2,302	2,572	57,500	22.36	17
18	Housekeepers	21,629	23,298	261,046	11.20	18
19	Laundry	11,647	12,708	131,791	10.37	19
20	Administrator	2,073	2,302	285,674	124.10	20
21	Assistant Administrator	2,658	2,993	113,612	37.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,249	18,141	307,906	16.97	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	1,724	2,056	35,176	17.11	31
32	Other Health C: <u>Ward Clerk</u>	1,829	2,028	31,934	15.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	271,311	293,657	\$ 5,232,023 *	\$ 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	\$ 17,294	1(3) 35
36	Medical Director	Monthly	55,300	9(3) 36
37	Medical Records Consultant	Monthly	1,679	10(3) 37
38	Nurse Consultant	Monthly	1,265	10(3) 38
39	Pharmacist Consultant			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	2,503	11(3) 44
45	Social Service Consultant	Monthly	1,437	12(3) 45
46	Other(specify) <u>Wound Care</u>	Monthly	24,000	10(3) 46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 103,478	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	
Lisa Trudeau	Administrator	0	\$ 285,674	Workers' Compensation Insurance	\$ 191,780	IDPH License Fee	\$ 3,980	
Paula J. Pepple	Assistant Administrator	0	113,612	Unemployment Compensation Insurance	66,852	Advertising: Employee Recruitment		
				FICA Taxes	376,555	Health Care Worker Background Check		
				Employee Health Insurance	306,685	(Indicate # of checks performed <u>77</u>)	918	
				Employee Meals		Patient Background Checks <u>45</u>	535	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,058	
				Employee Retirement	26,257	Miscellaneous Dues & Subscriptions	3,744	
				Employee Benefits - Other	12,611			
				Employees' Physical Exams	1,102	Allocated from Mgmt. Co.	3,559	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 399,286					
B. Administrative - Other								
Description			Amount					
Management Fees (Eliminated in Col. 7)			\$ 560,836					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 560,836					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Schedule 21C	See Schedule 21C		\$ 168,791	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	5,365
							Allocated from Mgmt. Co.	9,798
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 168,791				TOTAL	\$ 15,163

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Symphony of Decatur
IDPH License ID Number: 0051771
Fiscal Year End: 12/31/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	16,634
Symphony Financial	Accounting/Data Processing	13,794
Comcast Cable	Cable	2,235
Creative Technology	Monthly IT Support	14,006
E-Health Data Solutions	Carewatch/Riskwatch	5,112
Evault Inc	Back Up and Recovery Cloud	1,728
Health Data Systems	AP/PR Services	4,634
IIT/Sourcetek	Clinical Billing	1,380
Infinite Technology	Data Network	2,381
NuCare Services	Microsoft Service	625
Point B Communications	Web Hosting	240
Telemedicine	Woundrounds Care Management	15,382
Wescom	Clinical Billing	29,045
Ability Network Inc	Data Processing	1,516
Hipp Law Office	Collection	2,552
Much Shelist	Legal	457
Stone, McGuire & Siegel	Legal	15,736
Personnel Planners	Claims Management	1,919
Stout Risius Ross	Appraisal	3,500
Maestro	Accounting Mgmt fees	35,915
Total (agree to Schedule V, line 19, column 3)		168,791
Allocated from Management Company Legal Fees		724
Allocated from Management Company Professional Services		49,196
Less: Non-Allowable Legal Fees		(2,552)

Total (agree to Schedule V, line 19, column 8) 216,159

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 Decatur# 0051771Report Period Beginning: 01/01/2015 Ending: 12/31/2015**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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \$ 417,923
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 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? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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.