FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0051763

Facility Name: Countryside Care Centre

Address: 2330 West Galena Blvd (Number) Aurora (City) 60506 (Zip Code)

County: Kane

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2012

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,298	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	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,518	8,518	8
9	SNF/PED					9
10	ICF	52,247	4,042	4,631	60,920	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,247	4,042	13,149	69,438	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.46%

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 [X] 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 [X]

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 [X] Date 12/31/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 127 and days of care provided 6,769

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	412,467	55,860	17,314	485,641		485,641		485,641			1
2	Food Purchase		401,614		401,614		401,614		401,614			2
3	Housekeeping	258,286	74,428		332,714		332,714		332,714			3
4	Laundry	88,707	34,824	8,506	132,037		132,037		132,037			4
5	Heat and Other Utilities			210,311	210,311		210,311		210,311			5
6	Maintenance	58,604	1,480	170,488	230,572		230,572	475	231,047			6
7	Other (specify):*											7
8	TOTAL General Services	818,064	568,206	406,619	1,792,889		1,792,889	475	1,793,364			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	4,111,657	304,552	13,993	4,430,202		4,430,202	30,019	4,460,221			10
10a	Therapy											10a
11	Activities	138,597		11,756	150,353		150,353		150,353			11
12	Social Services	78,096		1,373	79,469		79,469		79,469			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							11,010	11,010			15
16	TOTAL Health Care and Programs	4,328,350	304,552	36,122	4,669,024		4,669,024	41,029	4,710,053			16
	C. General Administration											
17	Administrative	248,525		681,204	929,729		929,729	(657,659)	272,070			17
18	Directors Fees											18
19	Professional Services			186,432	186,432		186,432	(35,246)	151,186			19
20	Dues, Fees, Subscriptions & Promotions			36,804	36,804		36,804	795	37,599			20
21	Clerical & General Office Expenses	379,355		108,657	488,012		488,012	146,875	634,887			21
22	Employee Benefits & Payroll Taxes			1,215,101	1,215,101		1,215,101		1,215,101			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,050	5,050		5,050	1,317	6,367			24
25	Other Admin. Staff Transportation			10,598	10,598		10,598		10,598			25
26	Insurance-Prop.Liab.Malpractice			311,717	311,717		311,717	1,144	312,861			26
27	Other (specify):* Mgmt alloc of benef							31,308	31,308			27
28	TOTAL General Administration	627,880		2,555,563	3,183,443		3,183,443	(511,466)	2,671,977			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,774,294	872,758	2,998,304	9,645,356		9,645,356	(469,962)	9,175,394			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 Countryside Care Centre #0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,712	16,712		16,712	94	16,806			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			147,689	147,689		147,689	96	147,785			32
33	Real Estate Taxes			217,900	217,900		217,900	(14,310)	203,590			33
34	Rent-Facility & Grounds			1,417,863	1,417,863		1,417,863	1,198	1,419,061			34
35	Rent-Equipment & Vehicles			67,323	67,323		67,323	5,149	72,472			35
36	Other (specify):*											36
37	TOTAL Ownership			1,867,487	1,867,487		1,867,487	(7,773)	1,859,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			24,562	24,562		24,562		24,562			38
39	Ancillary Service Centers		272,291	1,553,768	1,826,059		1,826,059		1,826,059			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			491,849	491,849		491,849		491,849			42
43	Other (specify):* Non-Allowable Cos	56,539		373,734	430,273		430,273	(430,273)				43
44	TOTAL Special Cost Centers	56,539	272,291	2,443,913	2,772,743		2,772,743	(430,273)	2,342,470			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,830,833	1,145,049	7,309,704	14,285,586		14,285,586	(908,008)	13,377,578			45

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,653)	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	(48)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,643)	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	(7,450)	43		18
19	Entertainment				19
20	Contributions	(10,275)	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	(227,071)	43		24
25	Fund Raising, Advertising and Promotional	(3,476)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(29,775)	43		28
29	Other-Attach Schedule See Pg 5A	(141,240)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (444,631)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(463,377)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (463,377)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (908,008)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Countryside Care Centre

ID# 0051763

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (35,775)	43	1
2	Laboratory Costs	(19,215)	43	2
3	X-Ray Costs	(15,401)	43	3
4	Real Estate Taxes	(14,310)	33	4
5	Marketing Salaries	(56,539)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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22				22
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27				27
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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**	(141,240)		49

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Symphony Financial Services, LLC	100.00%	$ 475	$ 475	15
16	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	30,019	30,019	16
17	V	15	Other		Symphony Financial Services, LLC	100.00%	11,010	11,010	17
18	V	17	Administrative	681,204	Symphony Financial Services, LLC	100.00%	23,545	(657,659)	18
19	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	(35,246)	(35,246)	19
20	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	795	795	20
21	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	146,875	146,875	21
22	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	1,317	1,317	22
23	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	1,144	1,144	23
24	V	27	Other		Symphony Financial Services, LLC	100.00%	31,308	31,308	24
25	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	94	94	25
26	V	32	Interest		Symphony Financial Services, LLC	100.00%	144	144	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	1,198	1,198	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	5,149	5,149	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			$ 681,204			$ 217,827	$ * (463,377)	39

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Morton Grove	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Morton Grove	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony o	Crestwood	Symphony HMG, LLC	Morton Grove	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony Financial S	Morton Grove	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere				5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7527 N. Lincoln Ave, L	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	Seasons Hospice	Park Ridge	Hospice	14
15			Claridge Imperial, LTD.	Chicago	JLR Financial Service	Lincolnwood	Management Co.	15
16			Jackson Corp	Chicago	KFT Services, LLC	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	17
18			Renaissance at 87th Street	Chicago	Clinical Consulting Se	Lincolnwood	Clinical Consult	18
19			Renaissance at Midway	Chicago	Quest Services Corp	Lincolnwood	Marketing	19
20			Renaissance at South Shore	Chicago	Integra Healthcare Eq	Elmhurst	DME & Medical Su	20
21			Renaissance at Park South	Chicago				21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona				24
25			Renaissance West	Mesa, Arizona				25
26			Renaissance Village IL	Mesa, Arizona				26
27			Renaissance Village AL	Mesa, Arizona				27
28								28
29								29
30								30

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Munter	Owner	Administrative	10.00	185,555	5.63	11.26	Grntd pmts	$ 23,545	17(7)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,545		13

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

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Symphony Financial Services, LLC
Street Address: 8140 River Drive
City / State / Zip Code: Morton Grove, IL 60053
Phone Number: (847) 583-0100
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Occupied Bed Days	424,571	8	$ 2,907	$	69,438	$ 475	1
2	10	Nursing & Med Records - Sal	Occupied Bed Days	424,571	8	183,547	183,547	69,438	30,019	2
3	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	424,571	8	67,318		69,438	11,010	3
4	17	Admin-Gntd pmts	Occupied Bed Days	50	8	209,100	209,100	6	23,545	4
5	19	Consulting (owner)	Occupied Bed Days	424,571	8	(232,247)	(232,247)	69,438	(37,984)	5
6	19	Professional Services-Legal	Occupied Bed Days	424,571	8	6,427		69,438	1,051	6
7	19	Professional Services-Other	Occupied Bed Days	424,571	8	10,315		69,438	1,687	7
8	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	424,571	8	4,860		69,438	795	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	424,571	8	847,289	847,289	69,438	138,573	9
10	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	424,571	8	50,761		69,438	8,302	10
11	24	Travel & Seminar	Occupied Bed Days	424,571	8	8,050		69,438	1,317	11
12	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	424,571	8	6,997		69,438	1,144	12
13	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	424,571	8	191,428		69,438	31,308	13
14	30	Depreciation	Occupied Bed Days	424,571	8	569		69,438	93	14
15	32	Interest	Occupied Bed Days	424,571	8	879		69,438	144	15
16	34	Rent-Facility & Grounds	Occupied Bed Days	424,571	8	7,324		69,438	1,198	16
17	35	Rent-Equipment & Vehicles	Occupied Bed Days	424,571	8	31,481		69,438	5,150	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,397,005	$ 1,007,689		$ 217,827	25

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage	Interest Only	12/30/2011	$ 17,520,000	$ 2,998,500	06/11/2013	0.0550	$ 136,453	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	246,898	12/30/2014	0.0550	11,236	6
7												7
8												8
9	TOTAL Facility Related						$ 19,520,000	$ 3,245,398			$ 147,689	9
	B. Non-Facility Related*											
10												10
11												11
12							Interest Income Offset				(48)	12
13							Management company allocation				144	13
14	TOTAL Non-Facility Related						$	$			$ 96	14
15	TOTALS (line 9+line14)						$ 19,520,000	$ 3,245,398			$ 147,785	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.)**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011	$ 203,590	2
3. Under or (over) accrual (line 2 minus line 1).		$ 203,590	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 217,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
	To adjust for no PY accrual	(217,900)	
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.		$ 203,590	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	169,483	8
	2008	193,854	9
	2009	171,414	10
	2010	178,035	11
	2011	203,590	12

See attached accrual worksheet.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryside Care Centre COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0051763

CONTACT PERSON REGARDING THIS REPORT Liz Koshy

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

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

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	Nursing Home	$ 203,589.88	$ 203,589.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 203,589.88	$ 203,589.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 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. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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 Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	473,102	16,712	16,712		5-7	16,712	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	936		94	94		94	74
75	TOTALS	$ 474,038	$ 16,712	$ 16,806	$ 94		$ 16,806	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	474,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	16,712	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	16,806	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	94	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	16,806	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Architectural Fees	$ 198,047	92
93			93
94			94
95		$ 198,047	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 Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] 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:	1972	203	12/31/2011	$ 1,414,543	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				1,198			6
7	TOTAL		203		$ 1,415,741 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,320
   This amount was calculated by dividing the total amount to be amortized 33,198
   by the length of the lease 10 .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning 12/31/2011
    Ending 12/31/2021

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2013	$ ########
13.	12/31/2014	$ ########
14.	12/31/2015	$ ########

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 56,546 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	2008 Ford E350	$ 1,327.19	$ 15,926	17
18					18
19					19
20					20
21	TOTAL		$ 1,327.19	$ 15,926	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.

Symphony Countryside
FYE: December 31, 2012
Provider Number - 0051763

Schedule 14A

XII. RENTAL COSTS
B 16. Rental Amounts

Description	Amount
VAC Freedom	3,304
Specialty Chair	56
Bariatric Bed	7,174
Oxygen	3,318
Wheel Chairs	340
Maintenance Equip	600
3 Spot Coolers	2,700
Ice Maker	4,920
Water Machine	124
Printers	26,302
Mailing Machine	1,242
Aquarium	1,317
Allocated from Mgmt. C	5,149
Total B16	56,546

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	8,739	$ 629,214	$	8,739	$ 629,214	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,250	233,974		3,250	233,974	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,256	666,458		9,256	666,458	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				272,291		272,291	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)			335	24,112		335	24,112	12
13	Other (specify):									13
14	TOTAL			$	21,580	$ 1,553,758	$ 272,291	21,580	$ 1,826,049	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Symphony Countryside **Schedule 16A**
FYE: December 31, 2012
Provider Number - 0051763

XIV. SPECIAL SERVICES
Line 11 Other

Description	Amount
MANAGED CARE	437
I.V. THERAPY-MEDICARE	16,261
I.V. THERAPY-MEDICAID	4,819
I.V. THERAPY-MANAGED CARE	690
RESPIRATORY	1,915
Total Line 11	24,122

STATE OF ILLINOIS

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 263,235	$ 263,235	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 227,071)	5,490,707	5,490,707	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,017	120,017	6
7	Other Prepaid Expenses	2,713	2,713	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	695,852	695,852	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,572,524	$ 6,572,524	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			15
16	Equipment, at Historical Cost	473,102	474,038	16
17	Accumulated Depreciation (book methods)	(16,712)	(16,806)	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 (spe Lease Cost	29,878	29,878	22
23	Other(specify): Construction in Progress	198,047	198,047	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 684,315	$ 685,157	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,256,839	$ 7,257,681	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,294,317	$ 1,294,317	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,272	115,272	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	217,900	217,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,525,466	1,525,466	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,152,955	$ 3,152,955	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,245,398	3,245,398	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)**	$ 3,245,398	$ 3,245,398	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,398,353	$ 6,398,353	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 858,486	$ 859,328	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,256,839	$ 7,257,681	48

*(See instructions.)

Symphony Countryside **Schedule 17A**
Provider # 0051763
FYE: 12/31/2012

XV. Balance Sheet
Line 9 Other (specify):

Description	Operating	After Consolidation
Cash in Bank - Trust Fund	53,742	53,742
Medicaid Coinsurance Receivable	(19,800)	(19,800)
Security Deposit	157,271	157,271
Real Estate Escrow Deposit	198,420	198,420
Due from Prior Owner - Emp Benefits	306,219	306,219
Total - Line 9	695,852	695,852

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

Description	Operating	After Consolidation
Due to Symphony Crestwood	49,825	49,825
Security Deposit Payable	157,271	157,271
Operating Expenses	139,973	139,973
Management Fees - Symphony	170,875	170,875
Insurance Allowable - W/C & GLPL	78,372	78,372
State Unemployment Tax	9,224	9,224
Federal Unemployment Tax	919	919
Sales Tax	1,607	1,607
Payroll Taxes Other	12,891	12,891
Accrued Employee Benefits	472,667	472,667
FICA & W/H Fed	43,991	43,991
ILL W/H	9,140	9,140
Due to IDPA - Add'tl Bed Tax	252,846	252,846
Due to/From the Kinsington	3,569	3,569
Due to Nucare	22,478	22,478
Due to Symphony	60,233	60,233
Wage Assign & Garnishments	666	666
Patient Personal Funds	38,919	38,919
	1,525,466	1,525,466

Facility Name & ID Number Countryside Care Centre **#** 0051763 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	858,486		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)**	$ 858,486		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)**	$ 858,486		24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,110,098	1
2	Discounts and Allowances for all Levels	(2,359,798)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,750,300	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,115,306	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,115,306	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	234,694	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,421	19
20	Radiology and X-Ray	13,911	20
21	Other Medical Services	932	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 277,958	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	460	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 460	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,144,072	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,792,889	31
32	Health Care	4,669,024	32
33	General Administration	3,183,443	33
	B. Capital Expense		
34	Ownership	1,867,487	34
	C. Ancillary Expense		
35	Special Cost Centers	2,280,894	35
36	Provider Participation Fee	491,849	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,285,586	40
41	**Income before Income Taxes (line 30 minus line 40)****	858,486	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 858,486	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,437,318	44
45	Private Pay - Net Inpatient Revenue	808,255	45
46	Medicare - Net Inpatient Revenue	3,423,455	46
47	Other-(specify) Hospice	768,304	47
48	Other-(specify) Managed Care	312,968	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,750,300	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 Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,962	2,120	$ 81,921	$ 38.64	1
2	Assistant Director of Nursing	5,277	6,348	159,708	25.16	2
3	Registered Nurses	23,416	25,953	897,339	34.58	3
4	Licensed Practical Nurses	33,778	36,788	965,204	26.24	4
5	CNAs & Orderlies	119,942	128,430	1,779,099	13.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,583	8,344	186,632	22.37	8
9	Activity Director	3,693	4,321	73,015	16.90	9
10	Activity Assistants	5,206	6,377	65,582	10.28	10
11	Social Service Workers	3,924	4,432	78,096	17.62	11
12	Dietician					12
13	Food Service Supervisor	3,609	4,273	86,420	20.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,627	32,647	326,047	9.99	15
16	Dishwashers					16
17	Maintenance Workers	2,045	2,302	58,604	25.46	17
18	Housekeepers	20,107	22,475	258,286	11.49	18
19	Laundry	7,498	8,146	88,707	10.89	19
20	Administrator	1,904	2,088	187,313	89.71	20
21	Assistant Administrator	1,905	2,152	61,212	28.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,048	18,553	379,355	20.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Ward Clerk	2,059	2,391	41,754	17.46	32
33	Other(specify) Marketing	1,684	2,245	56,539	25.18	33
34	TOTAL (lines 1 - 33)	291,267	320,385	$ 5,830,833 *	$ 18.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 17,314	1(3)	35
36	Medical Director	Monthly	9,000	9(3)	36
37	Medical Records Consultant	Monthly	1,568	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,425	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	3,819	11(3)	44
45	Social Service Consultant	Monthly	1,373	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,499		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Kohls	Administrator	0	$ 187,313
Lynn M. Blackburn	Assistant Administrator	0	61,212
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 248,525

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in col. 7)	$ 681,204
TOTAL (agree to Schedule V, line 17, col. 3)	$ 681,204
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 186,432
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 186,432

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 156,237
Unemployment Compensation Insurance	95,839
FICA Taxes	415,507
Employee Health Insurance	516,754
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	13,873
Employee Benefits - Other	10,468
Employees' Physical Exams	6,423
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,215,101

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,870
Advertising: Employee Recruitment	333
Health Care Worker Background Check	
(Indicate # of checks performed 441)	5,291
Patient Background Checks 208	2,500
Miscellaneous Licenses & Fees	4,513
Illinois Council on Long Term Care	19,305
Miscellaneous Dues & Subscriptions	2,992
Allocated from Mgmt. Co.	795
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,599

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	656
Seminar Expense	4,394
Allocated from Mgmt. Co.	1,317
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,367

**See instructions.

Symphony Countryside **Schedule 21A**
Provider # 0051763
FYE: 12/31/2012

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Much Shelist	Legal Fees	244
Stone McGuire & Siegel	Legal Fees	14,570
US Legal Support Inc	Legal Fees	57
Vedder Price PC	Legal Fees	838
Ability Network	Data Processing	1,683
Allscripts	Mgmt Facility Subscription Fee	3,188
AT&T	Internet	16
Comcast	Internet	2,947
Ehealth Data Solutions	Care Watch Service	3,584
Emdeon Business Services	Billing	596
HDSI	File Retrieval	4,792
IIT/Sourcetech	Operator Support	1,380
PSD Solutions	Network Integration Service	2,362
Wescom Solutions Inc	Bookkeeping	28,778
Zir-Med	Eligibility Verification	250
Achieve Accreditation	Consultation Day Honorarium	8,975
American Medical Assoc.	Dr. Credentialing	312
Amy Cordell Design	Graphic Design Services	1,089
Documentation Solutions	Compliance Audits	779
Personnel Planners Inc	Unemployment Claims	1,520
Pinnacle Quality Insight	Customer Satisfaction	4,290
Symphony Financial Services	Nursing consultant	83,764
The Joint Commission	JCAHO	1,285
McGladrey LLP	Accounting Fees	19,133
Total agreeing to Schedule V, Line 19, Col 3		186,432
Allocated from Management Company	Legal Fees	1,051
Allocated from Management Company	Professional Services	(36,297)
	Total (agree to Schedule V, line 20, column 8)	151,186

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 - $19,305**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,691** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **No** 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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **491,849**
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. $ **0**

(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: **McGladrey LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.