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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051771

Facility Name: Symphony of Decatur

Address: 2530 North Monroe (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 875-0920 **Fax #** (217) 876-9351

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 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1 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	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,265	8,265	8
9	SNF/PED					9
10	ICF	49,241	5,457	1,538	56,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,241	5,457	9,803	64,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.62%

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 195 and days of care provided 7,645

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	317,851	54,320	17,494	389,665		389,665		389,665			1
2	Food Purchase		338,739		338,739		338,739		338,739			2
3	Housekeeping	293,266	64,648		357,914		357,914		357,914			3
4	Laundry	114,467	27,279	7,551	149,297		149,297		149,297			4
5	Heat and Other Utilities			185,906	185,906		185,906	791	186,697			5
6	Maintenance	63,726	785	190,383	254,894		254,894	7,287	262,181			6
7	Other (specify):*											7
8	**TOTAL General Services**	789,310	485,771	401,334	1,676,415		1,676,415	8,078	1,684,493			8
	B. Health Care and Programs											
9	Medical Director			48,840	48,840		48,840		48,840			9
10	Nursing and Medical Records	3,800,773	147,626	50,655	3,999,054		3,999,054	59,766	4,058,820			10
10a	Therapy	10,690			10,690		10,690		10,690			10a
11	Activities	228,418		14,543	242,961		242,961		242,961			11
12	Social Services	76,815		3,515	80,330		80,330		80,330			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							11,940	11,940			15
16	**TOTAL Health Care and Programs**	4,116,696	147,626	117,553	4,381,875		4,381,875	71,706	4,453,581			16
	C. General Administration											
17	Administrative	376,289		593,453	969,742		969,742	(593,453)	376,289			17
18	Directors Fees											18
19	Professional Services			267,346	267,346		267,346	21,704	289,050			19
20	Dues, Fees, Subscriptions & Promotions			30,064	30,064		30,064	(2,538)	27,526			20
21	Clerical & General Office Expenses	205,342	43,007	102,430	350,779		350,779	245,074	595,853			21
22	Employee Benefits & Payroll Taxes			729,510	729,510		729,510		729,510			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,486	10,486		10,486	17,677	28,163			24
25	Other Admin. Staff Transportation			25,176	25,176		25,176		25,176			25
26	Insurance-Prop.Liab.Malpractice			347,772	347,772		347,772	9,874	357,646			26
27	Other (specify):* Mgmt alloc of benef							34,790	34,790			27
28	**TOTAL General Administration**	581,631	43,007	2,106,237	2,730,875		2,730,875	(266,872)	2,464,003			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,487,637	676,404	2,625,124	8,789,165		8,789,165	(187,088)	8,602,077			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: 01/01/2014 Ending: 12/31/2014

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			109,174	109,174		109,174	5,008	114,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			198,748	198,748		198,748	(6,887)	191,861			32
33	Real Estate Taxes			73,223	73,223		73,223		73,223			33
34	Rent-Facility & Grounds			1,571,913	1,571,913		1,571,913	(157,826)	1,414,087			34
35	Rent-Equipment & Vehicles			148,004	148,004		148,004	4,414	152,418			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,101,062	2,101,062		2,101,062	(155,291)	1,945,771			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,949	8,949		8,949		8,949			38
39	Ancillary Service Centers		219,012	1,419,570	1,638,582		1,638,582		1,638,582			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			451,879	451,879		451,879		451,879			42
43	Other (specify):* **Non-Allowable Cos**	34,514		358,965	393,479		393,479	(393,479)				43
44	**TOTAL Special Cost Centers**	34,514	219,012	2,239,363	2,492,889		2,492,889	(393,479)	2,099,410			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,522,151	895,416	6,965,549	13,383,116		13,383,116	(735,858)	12,647,258			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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(15,488)	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	(6,887)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,587)	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	(2,441)	43		18
19	Entertainment				19
20	Contributions	(5,899)	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	(197,820)	43		24
25	Fund Raising, Advertising and Promotional	(9,367)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(193)	43		28
29	Other-Attach Schedule See Page 5A	(176,089)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (415,771)		$	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)	(320,159)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (320,159)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (735,930)		37

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

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

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

Symphony of Decatur

ID# 0051771

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (115,512)	43	1
2	Laboratory Costs	(24,231)	43	2
3	X-Ray Costs	(20,455)	43	3
4	Theft and Damage Loss	(486)	43	4
5	Lobbying Expense	(6,448)	20	5
6	Medicare and Medicare HMO ancillary	(72)	43	6
7	Nonallowable Legal	(8,885)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(176,089)		49

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 [X] 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			$			$	$ * 0	14

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	5	Utilities	$	Symphony Financial Services, LLC	100.00%	$ 791	$ 791	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	7,287	7,287	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	59,766	59,766	17
18	V	15	Other		Symphony Financial Services, LLC	100.00%	11,940	11,940	18
19	V	17	Administrative	593,453	Symphony Financial Services, LLC	100.00%		(593,453)	19
20	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	30,589	30,589	20
21	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	3,910	3,910	21
22	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	245,074	245,074	22
23	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	17,677	17,677	23
24	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	9,874	9,874	24
25	V	27	Other		Symphony Financial Services, LLC	100.00%	34,790	34,790	25
26	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	5,008	5,008	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(157,826)	(157,826)	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	4,414	4,414	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			$ 593,453			$ 273,294	$ * (320,159)	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: 01/01/2014 Ending: 12/31/2014

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 o	Crestwood	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Maple Crest, LLC D/B/A Maple Cres	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						8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7257 N. Lincoln Ave, 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	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by h			24
25			Renaissance West	Mesa, Arizona	entity, therefore no pa			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this r			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	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: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	5	Utilities	Occupied Bed Days	418,769	8	$ 5,138	$	64,501	$ 791	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313		64,501	7,287	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	418,769	8	388,030	388,030	64,501	59,766	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521		64,501	11,940	4
5	19	Professional Services-Legal	Occupied Bed Days	418,769	8	14,326		64,501	2,207	5
6	19	Professional Services-Other	Occupied Bed Days	418,769	8	184,271		64,501	28,382	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386		64,501	3,910	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276	1,490,276	64,501	229,540	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	100,854		64,501	15,534	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768		64,501	17,677	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109		64,501	9,874	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869		64,501	34,790	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512		64,501	5,008	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)		64,501	(157,826)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271		64,501	2,660	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389		64,501	1,754	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,774,356	$ 1,878,306		$ 273,294	25

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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							$	$			$	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	29,676	12/30/2017	0.0525	1,133	6
7	The Private Bank		X	Line of credit	Interest Only	12/30/2011	27,000,000	5,177,398	12/30/2015	0.0450	197,615	7
8												8
9	TOTAL Facility Related						$ 29,000,000	$ 5,207,074			$ 198,748	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(6,887)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,887)	14
15	TOTALS (line 9+line14)						$ 29,000,000	$ 5,207,074			$ 191,861	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 Symphony of Decatur **#** 0051771 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 80,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$ 74,873	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,427)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,650	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 73,223	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	77,236	8
	2010	77,477	9
	2011	76,378	10
	2012	81,700	11
	2013	74,873	12

2014 Tax Accrual = $74,873 * 1.05 = $78,617; use $78,650

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-014	Nursing Home	$ 74,872.68	$ 74,872.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,872.68	$ 74,872.68

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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	New Piston & Cylinder for Elevator			2012	64,900	3,245	20	3,245		6,392	9
10	Drill new hole for elevator			2013	50,316	2,516	20	2,516		4,346	10
11	Elevator - shut off valve/oil line			2013	20,420	1,021	20	1,021		1,269	11
12	Cabling for EMR Kiosks			2013	7,721	386	20	386		573	12
13	Line Voltage Outlets			2013	5,740	287	20	287		391	13
14	Remodeling-Painting, wall coverings, millwork, ceiling			2013	487,979	24,397	20	24,397		25,876	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	12,006	10	12,006		13,007	21
22	1st Floor - Lobby, offices/conference rooms, hallways,										22
23	laundry & dietary areas										23
24											24
25	Facility Remodeling			2014	195,750	7,327	5-20	7,327		7,328	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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	Continued from Page 12		$	$		$	$	$	37
38	-Mid rails: throughout facility								38
39	-Asphalt: previous location of trailor								39
40	-Spandrel Glass: lobby								40
41	-Stucco: front of building								41
42	-Entry								42
43	-General contractors fees								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)		$ 952,894	$ 51,185		$ 51,185	$	$ 59,182	70

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 321,211	$ 53,219	$ 53,219	$	5-7	$ 84,097	71
72	Current Year Purchases	35,889	4,770	4,770		5-7	4,770	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	27,395		5,008	5,008	5-7	7,518	74
75	TOTALS	$ 384,495	$ 57,989	$ 62,997	$ 5,008		$ 96,385	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,337,389	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 109,174	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 114,182	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,008	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 155,567	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Diana Master Landlord, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [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:	1973	195	12/31/2011	$ 1,568,426	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(157,826)			6
7	TOTAL		195		$ 1,410,600 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,487
   This amount was calculated by dividing the total amount to be amortized 34,871
   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.	/2015	$ 1,122,000
13.	/2016	$ 1,144,440
14.	/2017	$ 1,167,329

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: $ 138,964 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	Chevy Tahoe	$ 900.00	$ 11,700	17
18					18
19					19
20	Allocated from Mgmt. Co			1,754	20
21	TOTAL		$ 900.00	$ 13,454	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: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxygen Concentrator	18,446
VCA Therapy Unit	800
Annual Cylinder Lease	42
Plant Rental	6,600
Chairs & Tables	1,138
Cooler	398
Water	26
Domestic Container	1,755
Gas Carbon Dioxide	46
Computer	959
Digital Music	956
Ricoh	14,145
Mail Machine	1,101
Kyocera Copier	22,943
Low Air Loss Mattress, Air Compr	34,527
Bed Bariatric, Air Compressor	15,503
Vac ATS Therapy Unit	16,919
Allocated from Mgmt. Co.	2,660
Total - Line 16	**138,964**

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	8,621	$ 620,722	$	8,621	$ 620,722	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,633	117,601		1,633	117,601	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,168	660,079		9,168	660,079	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				212,040		212,040	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					6,972		6,972	12
13	Other (specify): See Schedule 16A	39(3)				21,168			21,168	13
14	TOTAL			$	19,422	$ 1,419,570	$ 219,012	19,422	$ 1,638,582	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: **12/31/2014**

Schedule 16A

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

Description	Units	Amount
OXYGEN - PRIVATE		215
OXYGEN - MEDICAID		2,796
OXYGEN - PENDING		236
PHYSICIANS-MEDICARE		513
PHYSICIANS-MEDICAID		86
PSYCHIATRIC		5,250
OTHER SERVICES		72
ONCOLOGIST		12,000
Total - Line 12	**-**	**21,168**

STATE OF ILLINOIS

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 56,732	$ 56,732	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 214,794)	5,614,710	5,614,710	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,877	3,877	6
7	Other Prepaid Expenses	63,279	63,279	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	164,871	164,871	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,903,469	$ 5,903,469	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	952,894	952,894	15
16	Equipment, at Historical Cost	357,100	384,495	16
17	Accumulated Depreciation (book methods)	(150,377)	(155,567)	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	24,411	24,411	22
23	Other(specify): See Schedule 17A	303,015	303,015	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,487,043	$ 1,509,248	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,390,512	$ 7,412,717	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 916,221	$ 916,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	285,624	285,624	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,650	78,650	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	1,848,902	1,848,902	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,129,397	$ 3,129,397	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,207,074	5,207,074	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)**	$ 5,207,074	$ 5,207,074	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,336,471	$ 8,336,471	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (945,959)	$ (923,754)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,390,512	$ 7,412,717	48

*(See instructions.)

Facility Name: **Symphony of Decatur**
IDPH License ID Number: **0051771**
Fiscal Year End: **12/31/2014**

Schedule 17A

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

	Description	Operating	After Consolidation
1106	PATIENT PERSONAL FUNDS	27,542	27,542
1124	RENT PREPAIDS	137,329	137,329
	Total - Line 9	**164,871**	**164,871**

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

	Description	Operating	After Consolidation
1125	SECURITY DEPOSIT	146,744	146,744
1126	REAL ESTATE ESCROW DEPOSIT	156,271	156,271
	Total - Line 23	**303,015**	**303,015**

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

	Description	Operating	After Consolidation
1204	EXCHANGE FORMATION LEASEHOLDS	727,212	727,212
1206	DUE TO DPA	19,912	19,912
1209	SECURITY DEPOSIT PAYABLE	40,731	40,731
1210	OPERATING EXPENSES	134,526	134,526
1212	MANAGEMENT FEES - SYMPHONY	194,901	194,901
1214	INSURANCE ALLOWANCE - W/C & GLPL	87,050	87,050

1215	ACCRUED INTEREST	1,011	1,011
1220	ACCUMULATED AMORTIZATION DEFERRED RENT	(47,087)	(47,087)
1221	STATE UNEMPLOYMENT TAX	4,751	4,751
1222	FEDERAL UNEMPLOYMENT TAX	607	607
1223	SALES TAX	145	145
1224	PAYROLL TAXES OTHER	29,667	29,667
1226	ACCRUED EMPLOYEE BENEFITS	170,576	170,576
1232	FICA & W/H FED	54	54
1242	DUE TO IDPA - ADD'TL BED TAX	54,739	54,739
1244	DUE TO/FROM THE KENSINGTON	42,203	42,203
1252	DUE TO NUCARE	21,236	21,236
1253	DUE TO SYMPHONY	18,516	18,516
1254	DUE TO McKINLEY COURT	316,696	316,696
1257	WAGE ASSIGN & GARNISHMENTS	241	241
1258	PATIENT PERSONAL FUNDS	31,215	31,215
	Total - Line 36	**1,848,902**	**1,848,902**

Facility Name & ID Number Symphony of Decatur **#** 0051771 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (613,431)	1	
2	Restatements (describe):		2	
3	**Rounding**	(144,132)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (757,563)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(188,396)	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)**	$ (188,396)	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)**	$ (945,959)	24	*

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

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 12,524,262	1
2	Discounts and Allowances for all Levels	(2,261,708)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,262,554	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,567,719	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,567,719	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	288,143	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,516	19
20	Radiology and X-Ray	3,956	20
21	Other Medical Services	22,942	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 336,557	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,887	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,887	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare and Managed Care Rentals	21,003	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,003	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,194,720	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,676,415	31
32	Health Care	4,381,875	32
33	General Administration	2,730,875	33
	B. Capital Expense		
34	Ownership	2,101,062	34
	C. Ancillary Expense		
35	Special Cost Centers	2,041,010	35
36	Provider Participation Fee	451,879	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,383,116	40
41	**Income before Income Taxes (line 30 minus line 40)****	(188,396)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (188,396)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,461,029	44
45	Private Pay - Net Inpatient Revenue	1,014,520	45
46	Medicare - Net Inpatient Revenue	1,459,657	46
47	Other-(specify) Hospice	216,085	47
48	Other-(specify) Managed Care	111,263	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,262,554	49

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

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

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

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

^ **Tax Return prepared on cash basis.**

Facility Name: **Symphony of Decatur**
IDPH License ID Number: **0051771**
Fiscal Year End: **12/31/2014**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

	Description	Amount
4653	RENTALS - MEDICARE	18,759
4658	RENTALS - MANAGED CARE	2,244
	Total - Line 28	**21,003**

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,012	2,102	$ 93,075	$ 44.28	1
2	Assistant Director of Nursing	1,969	2,264	67,189	29.68	2
3	Registered Nurses	10,230	11,281	386,484	34.26	3
4	Licensed Practical Nurses	54,753	60,603	1,513,913	24.98	4
5	CNAs & Orderlies	116,512	126,471	1,648,664	13.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	756	829	10,690	12.90	8
9	Activity Director	1,981	2,174	42,589	19.59	9
10	Activity Assistants	10,556	12,092	185,829	15.37	10
11	Social Service Workers	3,152	3,387	76,815	22.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,374	33,562	317,851	9.47	15
16	Dishwashers					16
17	Maintenance Workers	2,503	2,980	63,726	21.39	17
18	Housekeepers	22,240	24,063	293,266	12.19	18
19	Laundry	10,571	11,813	114,467	9.69	19
20	Administrator	2,061	2,316	225,691	97.47	20
21	Assistant Administrator	3,913	4,229	150,598	35.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,832	10,877	205,342	18.88	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	1,963	2,327	36,172	15.55	31
32	Other Health C: Ward Clerk	2,984	3,583	55,276	15.43	32
33	Other(specify) Marketing Bonus	1,808	2,141	34,514	16.12	33
34	TOTAL (lines 1 - 33)	290,168	319,093	$ 5,522,151 *	$ 17.31	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	$ 17,494	1(3)	35
36	Medical Director	Monthly	48,840	9(3)	36
37	Medical Records Consultant	Monthly	681	10(3)	37
38	Nurse Consultant	Monthly	358	11(3)	38
39	Pharmacist Consultant	Monthly	12,614	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,298	11(3)	44
45	Social Service Consultant	Monthly	3,515	12(3)	45
46	Other(specify) Wound Care	Monthly	24,163	10(3)	46
47	Alzheimers	Monthly	13,197	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 123,160		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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Trudeau	Administrator	0	$ 225,691
Paula J. Pepple	Assistant Administrator	0	150,598
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 376,289

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	$ 593,453
TOTAL (agree to Schedule V, line 17, col. 3)	$ 593,453
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 267,346
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 267,346

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,053
Unemployment Compensation Insurance	67,520
FICA Taxes	402,739
Employee Health Insurance	125,679
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	27,290
Employee Benefits - Other	32,836
Employees' Physical Exams	1,393
TOTAL (agree to Schedule V, line 22, col.8)	$ 729,510

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	367
Health Care Worker Background Check	1,593
(Indicate # of checks performed 133)	
Patient Background Checks 85	1,025
Miscellaneous Licenses & Fees	1,539
Illinois Council on Long Term Care	19,539
Miscellaneous Dues & Subscriptions	6,001
Lobbying Expense Offset	(6,448)
Allocated from Mgmt. Co.	3,910
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,526

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,486
Allocated from Mgmt. Co.	17,677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,163

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Symphony of Decatur**
IDPH License ID Number: **0051771**
Fiscal Year End: **12/31/2014**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ZIRMED	IMPLEMENTATION FEE	525
WESCOM SOLUTIONS	DATA PROCESSING BILLING	29,096
ABILITY NETWORK	DATA PROCESSING	1,938
ADOBE SYSTEMS	WEB HOSTING	17
COMCAST	CABLE & INTERNET	28,076
CREATIVE TECHNOLOGY	OUTSOURCING IT SERVICES	16,053
EHEALTH DATA SOLUTIONS	CARE WATCH BILLING	5,112
EVAULT	PROTECT ON 36 MO SERVER	1,728
HDSI	DATA PROCESSING	4,366
IIT/SOURCETECH	OPERATOR MONTHLY SUPPORT FEE	1,380
JEREMY PIERSON	SOE IMPROVEMENTS	111
MOEO	CNS AND API	1,130
POINT B COMMUNICATION	WEB HOSTING	1,556
PROVINET SOLUTIONS	OUTSOURCING IT SERVICES	3,113
SYMPHONY FINANCIAL	CONSULTANTS	97,451
TELEMEDICINE	WOUNDROUND MANAGED CARE SYS	15,382
MCGLADREY LLP	ACCOUNTING	24,887
STONE, MCGUIRE & SIGEL	LEGAL - COMPLIANCE	16,138
HIPP LAW OFFICES	COLLECTIONS	8,885
MUCH SHELIST	STATUTORY REGISTED AGENT	1,331
HK PAYROLL SERVICES	WOTC PROGRAM	1,854
PERSONNEL PLANNERS INC	UI CLAIMS	2,169
PINNACLE QUALITY INSIGHT	CUSTOMER SATISFACTION	2,160
AON ESOLUTIONS	RISK CONSOLE	1,717
ADMINISTRATIVE CONSULTANTS	ADMINISTRATIVE CONSULTANTS	1,170

Total (agree to Schedule V, line 19, column 3)	267,346
Allocated from Management Company Legal Fees	2,207
Allocated from Management Company Professional Services	28,382
Less: Non-Allowable Legal Fees	(8,885)
Total (agree to Schedule V, line 19, column 8)	289,050

Facility Name & ID Number Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Symphony of Decatur # 0051771 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC - $13,091**

(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? **6**

(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. $ **451,879**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
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) 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.