		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: 0051789

Facility Name: Symphony of Lincoln

Address: 2202 N Kickapoo St (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

Telephone Number: (217) 735-1538 Fax # (217) 732-4848

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
			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

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 01/01/14 to 12/31/14 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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,955		5,202	8,157	8
9	SNF/PED	16,896	4,826	866	22,588	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,851	4,826	6,068	30,745	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.85%

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 99 and days of care provided 4,312

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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,168	20,956	12,374	236,498		236,498		236,498			1
2	Food Purchase		213,832		213,832		213,832		213,832			2
3	Housekeeping	145,535	25,512		171,047		171,047		171,047			3
4	Laundry	46,882	11,463	572	58,917		58,917		58,917			4
5	Heat and Other Utilities			213,027	213,027		213,027	377	213,404			5
6	Maintenance	51,874		110,013	161,887		161,887	3,474	165,361			6
7	Other (specify):*											7
8	TOTAL General Services	447,459	271,763	335,986	1,055,208		1,055,208	3,851	1,059,059			8
	B. Health Care and Programs											
9	Medical Director			86,940	86,940		86,940		86,940			9
10	Nursing and Medical Records	2,221,563	187,709	6,079	2,415,351		2,415,351	28,488	2,443,839			10
10a	Therapy	49,809			49,809		49,809		49,809			10a
11	Activities	56,802		19,513	76,315		76,315		76,315			11
12	Social Services	38,663		3,296	41,959		41,959		41,959			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							5,691	5,691			15
16	TOTAL Health Care and Programs	2,366,837	187,709	115,828	2,670,374		2,670,374	34,179	2,704,553			16
	C. General Administration											
17	Administrative	77,079		352,532	429,611		429,611	(352,532)	77,079			17
18	Directors Fees											18
19	Professional Services			278,420	278,420		278,420	(15,693)	262,727			19
20	Dues, Fees, Subscriptions & Promotions			46,474	46,474		46,474	(2,302)	44,172			20
21	Clerical & General Office Expenses	153,140	27,769	57,971	238,880		238,880	116,816	355,696			21
22	Employee Benefits & Payroll Taxes			455,119	455,119		455,119		455,119			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,341	7,341		7,341	8,426	15,767			24
25	Other Admin. Staff Transportation			21,780	21,780		21,780	(2,373)	19,407			25
26	Insurance-Prop.Liab.Malpractice			213,059	213,059		213,059	4,707	217,766			26
27	Other (specify):* Mgmt alloc of benef							16,583	16,583			27
28	TOTAL General Administration	230,219	27,769	1,432,696	1,690,684		1,690,684	(226,368)	1,464,316			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,044,515	487,241	1,884,510	5,416,266		5,416,266	(188,338)	5,227,928			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 Lincoln #0051789 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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			54,074	54,074		54,074	2,387	56,461			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			117,884	117,884		117,884	(9,700)	108,184			32
33	Real Estate Taxes			71,999	71,999		71,999		71,999			33
34	Rent-Facility & Grounds			466,452	466,452		466,452	(75,229)	391,223			34
35	Rent-Equipment & Vehicles			220,121	220,121		220,121	2,104	222,225			35
36	Other (specify):*											36
37	TOTAL Ownership			930,530	930,530		930,530	(80,438)	850,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			14,047	14,047		14,047		14,047			38
39	Ancillary Service Centers		176,654	798,644	975,298		975,298		975,298			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,433	229,433		229,433		229,433			42
43	Other (specify):* Non-Allowable Cos	73,696		251,609	325,305		325,305	(325,305)				43
44	TOTAL Special Cost Centers	73,696	176,654	1,293,733	1,544,083		1,544,083	(325,305)	1,218,778			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,118,211	663,895	4,108,773	7,890,879		7,890,879	(594,081)	7,296,798			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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Reference	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	(23,715)	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	(9,700)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,623)	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	(906)	43		18
19	Entertainment				19
20	Contributions	(5,674)	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	(117,510)	43		24
25	Fund Raising, Advertising and Promotional	(9,123)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,541)	43		28
29	Other-Attach Schedule See Page 5A	(201,026)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (371,818)		$	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)	(222,263)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (222,263)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (594,081)		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

STATE OF ILLINOIS

Symphony of Lincoln

ID# 0051789

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (57,037)	43	1
2	Laboratory Costs	(18,776)	43	2
3	X-Ray Costs	(9,555)	43	3
4	Marketing Salaries	(73,696)	43	4
5	Lobbying offset	(4,166)	20	5
6	EKG	(5,149)	43	6
7	Legal Expense	(30,274)	19	7
8	Marketing Travel	(2,373)	25	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**	(201,026)		49

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V	N/A							3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 377	$ 377	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	3,474	3,474	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	28,488	28,488	17
18	V	15	Other		Symphony Financial Services, LLC	100.00%	5,691	5,691	18
19	V	17	Administrative	352,532	Symphony Financial Services, LLC	100.00%		(352,532)	19
20	V	19	Professional Services-Other		Symphony Financial Services, LLC	100.00%	14,581	14,581	20
21	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	1,864	1,864	21
22	V	21	Clerical & General Office Exp-Salaries		Symphony Financial Services, LLC	100.00%	116,816	116,816	22
23	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	8,426	8,426	23
24	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	4,707	4,707	24
25	V	27	Other		Symphony Financial Services, LLC	100.00%	16,583	16,583	25
26	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	2,387	2,387	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(75,229)	(75,229)	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	2,104	2,104	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			$ 352,532			$ 130,269	$ * (222,263)	39

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

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple 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	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, Wisconsin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			24
25			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	No owners receive compensation from this facility.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [ ]

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

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

	1 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	$	30,745	$ 377	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313		30,745	3,474	2
3	10	Nursing & Med. Records Salary	Occupied Bed Days	418,769	8	388,030	388,030	30,745	28,488	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521		30,745	5,691	4
5	19	Professional Service Legal	Occupied Bed Days	418,769	8	14,326		30,745	1,052	5
6	19	Professional Service Other	Occupied Bed Days	418,769	8	184,271		30,745	13,529	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386		30,745	1,864	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276		30,745	109,412	8
9	21	Clerical & Gen ofc expenses	Occupied Bed Days	418,769	8	100,854		30,745	7,404	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768		30,745	8,426	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109		30,745	4,707	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869		30,745	16,583	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512		30,745	2,387	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)		30,745	(75,229)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271		30,745	1,268	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389		30,745	836	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,774,356	$ 388,030		$ 130,269	25

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Capital Improvements	Interest Only	12/30/2011	2,000,000	22,578	12/30/2015	0.0550	878	6
7	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	17,520,000	3,007,883	12/30/2017	0.0550	117,006	7
8												8
9	TOTAL Facility Related						$ 19,520,000	$ 3,030,461			$ 117,884	9
	B. Non-Facility Related*											
10												10
11												11
12							Interest Income Offset				(9,700)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,700)	14
15	TOTALS (line 9+line14)						$ 19,520,000	$ 3,030,461			$ 108,184	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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2013 report.		$ 73,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013	$ 70,799	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,401)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 74,400	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.		$ 71,999	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2009	42,890	8
	2010	42,738	9
	2011	42,870	10
	2012	69,751	11
	2013	70,799	12

2014 Tax Accrual = $70,799 * 1.05 = $74,339; use $74,400

Line	FOR BHF USE ONLY		Line
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 Lincoln COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0051789

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.	08-029-019-00	Nursing Home	$ 43,945.30	$ 43,945.30
2.	08-029-019-50	Nursing Home	$ 26,854.16	$ 26,854.16
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,799.46	$ 70,799.46

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,852 B. General Construction Type: Exterior Masonry Frame Steel/Wood Number of Stories 1

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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Wiring for EMR 24 Port Pan, Wire Mold, Cable Ties			2012	6,545	328	20	328		566	9
10	Exterior Sign			2013	21,718	1,086	20	1,086		1,810	10
11	General Contractor - Hallway, Lobby, Therapy, Vestibule			2013	67,885	3,394	20	3,394		3,600	11
12	Dining Room, Willow Lane, Redwood Lane & Nurse's Station										12
13											13
14	Remodeling - Painting, Wall covering, Wallpaper			2013	85,662	8,566	10	8,566		9,280	14
15	- Hallway, Dining Room, Willow Lane Resident Rooms & Offices										15
16											16
17	Remodeling - Flooring			2013	67,014	3,351	20	3,351		3,554	17
18	- Hallway, Lobby, Dining Room & Willow Lane Resident Rooms										18
19											19
20	Remodeling - Structural, Iron work, Bond beam			2013	33,520	1,676	20	1,676		1,777	20
21	-Lobby, Entrance and Vestibule										21
22											22
23	Remodeling - Electrical			2013	25,461	1,273	20	1,273		1,350	23
24	-Respirator Receptacles, Lobby, Entrance & Willow Lane										24
25											25
26	Remodeling - Custom millwork - Lobby, Dining Room,			2013	21,400	1,070	20	1,070		1,135	26
27	Hallway, Nurse's Station and Willow Lane Wing										27
28											28
29	Remodeling - Drywall - Hallway, Lobby & Willow Lane			2013	74,126	3,706	20	3,706		3,931	29
30	Resident Rooms										30
31											31
32	Remodeling - Ceiling Panel - front/back nurse's station			2013	21,400	1,070	20	1,070		1,135	32
33	Dining Room, Activity Room & Entryway										33
34											34
35	Remodeling - Roof Fire proofing, Fire sprinklers			2013	14,297	715	20	715		759	35
36	-Lobby, Main Entrance & Roof										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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Remodeling - Nursing station counters & cabinetry	2013	$ 6,900	$ 345	20	$ 345	$	$ 366	37
38	- Redwood Lane and Lobby								38
39									39
40									40
41	Facility Remodeling	2014	37,742	1,573	20	1,573		1,573	41
42	-Ceramic flooring, front entrance								42
43	-Electrical:Repair broken pipe on patio, wiremold in								43
44	hallway, activity room, change wiring in ceiling and								44
45	emergency light panel to put front door on emer panel.								45
46	electrical in vestibule, elec for flag light								46
47	-Faucet & drain at nurse station								47
48	-Glass installation, front entrance								48
49	-Stucco application on front entrance								49
50	-General contracting fee								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)		$ 483,670	$ 28,153		$ 28,153	$	$ 30,836	70

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

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 132,974	$ 23,089	$ 23,089	$	5-20	$ 37,802	71
72	Current Year Purchases	23,768	2,832	2,832		5-20	2,832	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	13,058		2,387	2,387	5-7	3,583	74
75	TOTALS	$ 169,800	$ 25,921	$ 28,308	$ 2,387		$ 44,217	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)	$ 653,470	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,074	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,461	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,387	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 75,053	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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	126	12/31/2011	$ 465,697	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(75,229)			6
7	TOTAL		126		$ 390,468 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 755
   This amount was calculated by dividing the total amount to be amortized 7,545
   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	$ 255,000
13.	/2016	$ 260,100
14.	/2017	$ 265,302

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: $ 217,912 Description: See Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Toyota Corolla	$ 359.40	$ 4,313	17
18					18
19					19
20					20
21	TOTAL		$ 359.40	$ 4,313	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 Lincoln**
IDPH License ID Number: **0051789**
Fiscal Year End: **12/31/14**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Mattress/Bed	79,185
Broda Chair	1,870
Vac Freedom	8,260
Bipap Auto, Heated Humidifier	1,083
Oxygen	94,838
Computer Lease	959
Copier	22,167
Digital Music	1,189
Mailing System	636
Innerspring Hospital L80' Stand	15
Security Container	3,045
Dish Machine	1,035
Culligan Water	195
Cooler Infinity	1,334
Home Office Allocation	2,101
Total - Line 16	**217,912**

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	4,341	$ 312,535	$	4,341	$ 312,535	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,212	87,240		1,212	87,240	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,540	398,869		5,540	398,869	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				164,153		164,153	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(3)					12,501		12,501	12
13	Other (specify):									13
14	TOTAL			$	11,093	$ 798,644	$ 176,654	11,093	$ 975,298	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 & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 136,101	$ 136,101	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 113,128)	3,464,973	3,464,973	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,613	2,613	6
7	Other Prepaid Expenses	80,279	80,279	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	21,369	21,369	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,705,335	$ 3,705,335	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	483,670	483,670	15
16	Equipment, at Historical Cost	156,742	169,800	16
17	Accumulated Depreciation (book methods)	(72,224)	(75,053)	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 Costs	5,281	5,281	22
23	Other(specify): Deposits	129,304	129,304	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 702,773	$ 713,002	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,408,108	$ 4,418,337	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 609,163	$ 609,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,995	101,995	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,400	74,400	32
33	Accrued Interest Payable	583	583	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	864,651	864,651	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,650,792	$ 1,650,792	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,030,461	3,030,461	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)**	$ 3,030,461	$ 3,030,461	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,681,253	$ 4,681,253	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (273,145)	$ (262,916)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,408,108	$ 4,418,337	48

*(See instructions.)

Facility Name: Symphony of Lincoln
IDPH License ID Number: 0051789
Fiscal Year End: 12/31/14

Schedule 17A

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

Description	Operating	After Consolidation
Trust Fund	21,369	21,369
Total - Line 9	**21,369**	**21,369**

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

Description	Operating	After Consolidation
Exchange Formation Leasehold	301,143	301,143
Security Deposit Payable	31,016	31,016
Operating Expenses	112,774	112,774
Management Fees - Symphony	146,390	146,390
Clm.Wrkns Comp. Deduct./Settle	82,758	82,758
Accumulated Amortization Def	(20,076)	(20,076)
State Unemployment Tax	12,314	12,314
Federal Unemployment Tax	908	908
Sales Tax	161	161
Payroll Taxes Other	13,138	13,138
Accrued Employee Benefits	116,012	116,012
FICA & W/H FED	92	92
Due to IDPA - Bed Tax	27,491	27,491
Due to/from Kensington	7,355	7,355
Exchange	10,042	10,042
Due to NuCare	4,935	4,935
Due to Symphony	-	-

Wage Assign & Garnishments	1,341	1,341
Patient Personal Funds	16,857	16,857
Total - Line 36	**864,651**	**864,651**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (189,349)	1
2	Restatements (describe):		2
3	Prior Year Adjustment	5,016	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (184,333)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(88,812)	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)**	$ (88,812)	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)**	$ (273,145)	24 *

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

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 7,436,885	1
2	Discounts and Allowances for all Levels	(1,481,097)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,955,788	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,583,346	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,583,346	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	187,724	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,007	19
20	Radiology and X-Ray	9,938	20
21	Other Medical Services	(26,284)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 246,385	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,700	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,700	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Medicare and Managed Care Rentals	6,848	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,848	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,802,067	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,055,208	31
32	Health Care	2,670,374	32
33	General Administration	1,690,684	33
	B. Capital Expense		
34	Ownership	930,530	34
	C. Ancillary Expense		
35	Special Cost Centers	1,314,650	35
36	Provider Participation Fee	229,433	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,890,879	40
41	**Income before Income Taxes (line 30 minus line 40)****	(88,812)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (88,812)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,960,252	44
45	Private Pay - Net Inpatient Revenue	849,455	45
46	Medicare - Net Inpatient Revenue	804,209	46
47	Other-(specify) Hospice	239,930	47
48	Other-(specify) Managed Care, Veteran & ALF	101,942	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,955,788	49

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

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

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

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

^ Tax Return prepared on cash basis

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,944	2,130	$ 93,047	$ 43.68	1
2	Assistant Director of Nursing	1,440	1,585	46,069	29.07	2
3	Registered Nurses	20,055	22,185	619,560	27.93	3
4	Licensed Practical Nurses	30,693	33,230	789,756	23.77	4
5	CNAs & Orderlies	54,668	57,611	673,131	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,364	3,827	49,809	13.02	8
9	Activity Director	3,719	3,953	56,802	14.37	9
10	Activity Assistants					10
11	Social Service Workers	2,189	2,296	38,663	16.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,818	24,403	203,168	8.33	15
16	Dishwashers					16
17	Maintenance Workers	2,062	2,337	51,874	22.20	17
18	Housekeepers	13,655	14,521	145,535	10.02	18
19	Laundry	4,892	5,368	46,882	8.73	19
20	Administrator	1,627	1,685	77,079	45.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,644	14,779	153,140	10.36	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:					32
33	Other(specify) Marketing	2,845	3,275	73,696	22.50	33
34	TOTAL (lines 1 - 33)	180,615	193,185	$ 3,118,211 *	$ 16.14	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,374	1(3)	35
36	Medical Director	Monthly	86,940	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,079	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	3,252	11(3)	44
45	Social Service Consultant	Monthly	3,296	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 111,941		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephanie Williams	Administrator	0	$ 77,079
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,079

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	$ 352,532
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 352,532

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 278,420
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 278,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 150
Unemployment Compensation Insurance	95,235
FICA Taxes	229,025
Employee Health Insurance	83,107
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	17,708
Employee Benefits - Other	17,912
Employees' Physical Exams	11,982
TOTAL (agree to Schedule V, line 22, col.8)	$ 455,119

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	7,248
Health Care Worker Background Check (Indicate # of checks performed 611)	7,330
Patient Background Checks 490	5,879
Miscellaneous Licenses & Fees	2,472
Illinois Council on Long Term Care	12,625
Miscellaneous Dues & Subscriptions	10,920
Lobbying offset	(4,166)
Allocated from Mgmt. Co.	1,864
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,172

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,341
Allocated from Mgmt. Co.	8,426
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,767

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Symphony of Lincoln**
IDPH License ID Number: **0051789**
Fiscal Year End: **12/31/14**

Schedule 21A

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Stone, Podgrund, & Korey	Legal Fees	781
Hipp Law Office	Legal Fees	30,274
Much Shelist	Legal Fees	1,245
Stone, McGuire & Siegel	Legal Fees	15,219
Ability Network	Payer Transactions	1,938
Achieve Accreditation	Accreditation Mntnc.	20,807
Adobe	Web Hosting	23
Aon E Solutions Inc	Riskmgmt Sftwr/Maint	1,716
Comcast	Internet	29,628
Creative Technology	Email Protection	10,398
Curaspan Health Group	Referrel Center Network	2,400
E-Health Data Solutions	Carewatch	5,112
Evault	Protect-one-server2k	9,239
HDSI	Data Retrieval	3,885
Healthlink	Billing	3,884
IIT/Sourcetech	Monthly Suport Fee	1,380
HK Payroll Services	Work Tax Credit	2,451
Jeremy Pierson	SEO Improvements	71
Market Matrix	Surveys	280
Personnel Planners	Quarterly U.l. Claims Mgt Fees	2,835
Pinnacle Quality Insight	Customer Sutisfaction	2,115
Point B Communication	Yrly Web Hosting	1,595
Provinent Solutions	Outsourced IT Services	1,345
Symphony Financial	Consultants	62,904
Telemedicine Solutions	Wound Rounds Care	10,974
The Joint Commission	Subacute Care	815

Wescom Solutions	Data Processing	6,575
Zirmed	Eligibility Verification	339
Administrative Consultant	Consultants	756
McGladrey LLP	Accounting Fees	47,435
	Total (agree to Schedule V, line 19, column 3)	278,420
Allocated from Management Company Professional Services		13,529
Less: Non-Allowable Legal Fees		(29,222)
	Total (agree to Schedule V, line 19, column 8)	262,727

Facility Name & ID Number Symphony of Lincoln # 0051789 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Lincoln** **# 0051789** **Report Period Beginning: 01/01/14 Ending: 12/31/14**

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 - $8,459**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-20 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **229,433**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **5**

d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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 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.