



Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	180	Skilled (SNF)	180	65,700	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	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	Private Pay	4 Other	Total		
8	SNF	37,546	8,110	8,191	53,847	8	
9	SNF/PED					9	
10	ICF	7,684			7,684	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	45,230	8,110	8,191	61,531	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.65%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 12/14/1994

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/25/1994 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 180 and days of care provided 6,705

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	433,380	78,105	9,034	520,519		520,519	3,706	524,225		1
2	Food Purchase		330,310		330,310	(58,619)	271,691	(1,099)	270,592		2
3	Housekeeping	345,699	31,231		376,930		376,930	6,957	383,887		3
4	Laundry	112,749	31,136		143,885		143,885		143,885		4
5	Heat and Other Utilities			227,785	227,785		227,785	2,804	230,589		5
6	Maintenance	80,433	34,078	130,092	244,603		244,603	16,694	261,297		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	972,261	504,860	366,911	1,844,032	(58,619)	1,785,413	29,062	1,814,475		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			102,931	102,931		102,931		102,931		9
10	Nursing and Medical Records	3,416,726	239,658	30,255	3,686,639		3,686,639	(7,656)	3,678,983		10
10a	Therapy	169,400	563	11,394	181,357		181,357		181,357		10a
11	Activities	147,260	17,155	2,528	166,943		166,943		166,943		11
12	Social Services	249,280		3,976	253,256		253,256		253,256		12
13	CNA Training										13
14	Program Transportation			11,783	11,783		11,783		11,783		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,982,666	257,376	162,867	4,402,909		4,402,909	(7,656)	4,395,253		16
	<b>C. General Administration</b>										
17	Administrative	115,590			115,590		115,590		115,590		17
18	Directors Fees										18
19	Professional Services			401,388	401,388		401,388	(326,012)	75,376		19
20	Dues, Fees, Subscriptions & Promotions			200,048	200,048		200,048	(97,892)	102,156		20
21	Clerical & General Office Expenses	191,273	4,995	137,297	333,565		333,565	188,088	521,653		21
22	Employee Benefits & Payroll Taxes			881,858	881,858	58,619	940,477		940,477		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,750	2,750		2,750	341	3,091		24
25	Other Admin. Staff Transportation			3,986	3,986		3,986	(800)	3,186		25
26	Insurance-Prop.Liab.Malpractice			432,238	432,238		432,238	980	433,218		26
27	Other (specify):*							71,676	71,676		27
28	<b>TOTAL General Administration</b>	306,863	4,995	2,059,565	2,371,423	58,619	2,430,042	(163,619)	2,266,423		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,261,790	767,231	2,589,343	8,618,364		8,618,364	(142,213)	8,476,151		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			173,402	173,402		173,402	376,946	550,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,925	161,925		161,925	398,077	560,002			32
33	Real Estate Taxes							272,247	272,247			33
34	Rent-Facility & Grounds			952,650	952,650		952,650	(952,650)				34
35	Rent-Equipment & Vehicles			38,294	38,294		38,294	1,848	40,142			35
36	Other (specify):*			18,640	18,640		18,640	43,487	62,127			36
37	<b>TOTAL Ownership</b>			1,344,911	1,344,911		1,344,911	139,955	1,484,866			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		489,327	588,029	1,077,356		1,077,356		1,077,356			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*	62,812			62,812		62,812	(62,812)				43
44	<b>TOTAL Special Cost Centers</b>	62,812	489,327	686,579	1,238,718		1,238,718	(62,812)	1,175,906			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,324,602	1,256,558	4,620,833	11,201,993		11,201,993	(65,070)	11,136,923			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(666)	02		4
5	Telephone, TV & Radio in Resident Rooms	(31,285)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	185,872	30		9
10	Interest and Other Investment Income	(106,534)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(433)	02		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				18
19	Entertainment				19
20	Contributions	(24,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,856)	21		24
25	Fund Raising, Advertising and Promotional	(71)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,356)	20		28
29	Other-Attach Schedule	(200,732)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (228,061)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	162,991		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 162,991		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (65,070)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

**Harmony Nursing & Rehab Center**

**ID# 0040535**

**Report Period Beginning: 01/01/09**

**Ending: 12/31/09**

<b>NON-ALLOWABLE EXPENSES</b>		<b>Amount</b>	<b>Sch. V Line Reference</b>	
<b>1</b>	Miscellaneous Veterans' Expenses	\$ (5,850)	<b>10</b>	<b>1</b>
<b>2</b>	Franchise Tax	(100)	<b>21</b>	<b>2</b>
<b>3</b>	Public Relations	(72,595)	<b>20</b>	<b>3</b>
<b>4</b>	Bank Charges	(7,210)	<b>21</b>	<b>4</b>
<b>5</b>	Jury Duty Income	(120)	<b>10</b>	<b>5</b>
<b>6</b>	Miscellaneous Income	(1,016)	<b>21</b>	<b>6</b>
<b>7</b>	Marketing Travel	(800)	<b>25</b>	<b>7</b>
<b>8</b>	Non-Allowable Professional Fee	(4,400)	<b>19</b>	<b>8</b>
<b>9</b>	Capitalized R&M	(6,428)	<b>06</b>	<b>9</b>
<b>10</b>	Non-Allowable Seminars	(199)	<b>24</b>	<b>10</b>
<b>11</b>	Marketing Salary	(62,812)	<b>43</b>	<b>11</b>
<b>12</b>	Collections Salary	(24,973)	<b>21</b>	<b>12</b>
<b>13</b>	Non-Allowable Legal Expense	(14,076)	<b>19</b>	<b>13</b>
<b>14</b>	Additional R&M	16,871	<b>06</b>	<b>14</b>
<b>15</b>	Franchise Tax - Building Co.	(250)	<b>21</b>	<b>15</b>
<b>16</b>	Office Expense - Building Co.	(380)	<b>21</b>	<b>16</b>
<b>17</b>	Legal Fees - Building Co.	(250)	<b>19</b>	<b>17</b>
<b>18</b>	Accounting Fees - Building Co.	(12,600)	<b>19</b>	<b>18</b>
<b>19</b>	Amortization - Building Co.	(1,858)	<b>36</b>	<b>19</b>
<b>20</b>	Patient Purchases	(1,686)	<b>10</b>	<b>20</b>
<b>21</b>				<b>21</b>
<b>22</b>				<b>22</b>
<b>23</b>				<b>23</b>
<b>24</b>				<b>24</b>
<b>25</b>				<b>25</b>
<b>26</b>				<b>26</b>
<b>27</b>				<b>27</b>
<b>28</b>				<b>28</b>
<b>29</b>				<b>29</b>
<b>30</b>				<b>30</b>
<b>31</b>				<b>31</b>
<b>32</b>				<b>32</b>
<b>33</b>				<b>33</b>
<b>34</b>				<b>34</b>
<b>35</b>				<b>35</b>
<b>36</b>				<b>36</b>
<b>37</b>				<b>37</b>
<b>38</b>				<b>38</b>
<b>39</b>				<b>39</b>
<b>40</b>				<b>40</b>
<b>41</b>				<b>41</b>
<b>42</b>				<b>42</b>
<b>43</b>				<b>43</b>
<b>44</b>				<b>44</b>
<b>45</b>				<b>45</b>
<b>46</b>				<b>46</b>
<b>47</b>				<b>47</b>
<b>48</b>				<b>48</b>
<b>49</b>	<b>Total</b>	(200,732)		<b>49</b>

Harmony Nursing & Rehab Center

ID# 0040535

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
50				1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			3,706									3,706	1
2	Food Purchase	(1,099)											(1,099)	2
3	Housekeeping			6,957									6,957	3
4	Laundry													4
5	Heat and Other Utilities			2,804									2,804	5
6	Maintenance	10,443		6,251									16,694	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>9,344</b>		<b>19,718</b>									<b>29,062</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(7,656)											(7,656)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(7,656)</b>											<b>(7,656)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(31,326)	12,850	(307,536)									(326,012)	19
20	Fees, Subscriptions & Promotions	(100,022)		2,130									(97,892)	20
21	Clerical & General Office Expenses	(112,070)	630	299,528									188,088	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(199)		540									341	24
25	Other Admin. Staff Transportation	(800)											(800)	25
26	Insurance-Prop.Liab.Malpractice			980									980	26
27	Other (specify):*			71,676									71,676	27
28	<b>TOTAL General Administration</b>	<b>(244,417)</b>	<b>13,480</b>	<b>67,318</b>									<b>(163,619)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(242,729)</b>	<b>13,480</b>	<b>87,036</b>									<b>(142,213)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	185,872	180,072	11,002									376,946	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(106,534)	478,541	26,070									398,077	32
33	Real Estate Taxes		262,852	9,395									272,247	33
34	Rent-Facility & Grounds		(952,650)										(952,650)	34
35	Rent-Equipment & Vehicles			1,848									1,848	35
36	Other (specify):*	(1,858)	45,345										43,487	36
37	<b>TOTAL Ownership</b>	<b>77,480</b>	<b>14,160</b>	<b>48,315</b>									<b>139,955</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(62,812)											(62,812)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(62,812)</b>											<b>(62,812)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(228,061)	27,640	135,351									(65,070)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Keiro Building LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 952,650	Keiro Building LLC	100.00%	\$	\$ (952,650)	1
2	V	32 Interest Income	395	Keiro Building LLC	100.00%		(395)	2
3	V	21 Franchise Fee		Keiro Building LLC	100.00%	250	250	3
4	V	36 MIP Insurance		Keiro Building LLC	100.00%	43,487	43,487	4
5	V	21 Office Expense		Keiro Building LLC	100.00%	380	380	5
6	V	19 Legal Fees		Keiro Building LLC	100.00%	250	250	6
7	V	19 Accounting Fees		Keiro Building LLC	100.00%	12,600	12,600	7
8	V	32 Mortgage Interest		Keiro Building LLC	100.00%	478,936	478,936	8
9	V	33 Real Estate Taxes		Keiro Building LLC	100.00%	262,852	262,852	9
10	V	30 Depreciation		Keiro Building LLC	100.00%	180,072	180,072	10
11	V	36 Amortization of Loan Costs		Keiro Building LLC	100.00%	1,858	1,858	11
12	V							12
13	V							13
14	Total		\$ 953,045			\$ 980,685	\$ * 27,640	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 3,706	\$	3,706	15
16	V	3 HOUSEKEEPING				6,957		6,957	16
17	V	5 UTILITIES				2,804		2,804	17
18	V	6 REPAIRS AND MAINT.				6,251		6,251	18
19	V	19 PROFESSIONAL FEES				9,564		9,564	19
20	V	20 FEES, SUBSCRIPTIONS				2,130		2,130	20
21	V	21 CLERICAL AND GENERAL				26,665		26,665	21
22	V	24 EDUCATION/SEMINARS				540		540	22
23	V	26 INSURANCE				980		980	23
24	V	30 DEPRECIATION				11,002		11,002	24
25	V	32 INTEREST				26,070		26,070	25
26	V	33 REAL ESTATE TAXES				9,395		9,395	26
27	V	35 EQUIPMENT RENTAL				1,848		1,848	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21 CLERICAL SALARIES				272,863		272,863	32
33	V	27 GEN ADMIN. - EMP. BEN.				71,676		71,676	33
34	V								34
35	V	19 BOOKKEEPING	282,000	ITEX / AK CARE COMPANY				(282,000)	35
36	V	19 ADMINISTRATIVE CONSULTING	35,100	ITEX / AK CARE COMPANY				(35,100)	36
37	V								37
38	V								38
39	Total		\$ 317,100			\$ 452,451	\$ *	135,351	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Bernard Hollander	Owner	Administrative	28.67%	See Attached	15.00	23.08%		\$	1
2	Jack Rajchenbach	Owner	Administrative	28.67%	See Attached	4.00	6.15%			2
3	Mark Hollnader	Owner	Administrative	9.56%	See Attached	23.00	38.33%			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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ITEX / AK CARE COMPANY  
 Street Address 6633 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 679-9141  
 Fax Number ( 847) 679-1820

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	358,430	4	\$ 20,219	\$ 65,700	\$ 3,706	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	358,430	4	37,953	65,700	6,957	2
3	5	UTILITIES	AVAILABLE BED DAYS	358,430	4	15,300	65,700	2,804	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	358,430	4	34,101	65,700	6,251	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	358,430	4	52,179	65,700	9,564	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	358,430	4	11,623	65,700	2,130	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	358,430	4	145,474	65,700	26,665	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	358,430	4	2,946	65,700	540	8
9	26	INSURANCE	AVAILABLE BED DAYS	358,430	4	5,348	65,700	980	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	358,430	4	60,022	65,700	11,002	10
11	32	INTEREST	AVAILABLE BED DAYS	358,430	4	142,224	65,700	26,070	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	358,430	4	51,255	65,700	9,395	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	358,430	4	10,084	65,700	1,848	13
14									14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	859,236	859,236	272,863	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	225,704		71,676	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,673,668	\$ 859,236	\$ 452,451	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Cambridge		X	Mortgage	\$49,971.00	10/01/03	\$ 9,295,200	\$ 8,690,894	10/01/2038	5.5000	\$ 478,936	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
<b>Working Capital</b>																			
6	Citi Bank		X	Line of Credit				3,000,000			154,709	6							
7	Insurance Financing		X								7,215	7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related				\$49,971.00		\$ 9,295,200	\$ 11,690,894			\$ 640,861	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(106,534)	10							
11	Alloc. From ITEXAK Care		X								26,070	11							
12	Bldg. Co. Interest Income		X								(395)	12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ (80,859)	14							
15	TOTALS (line 9+line14)						\$ 9,295,200	\$ 11,690,894			\$ 560,002	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,487 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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

Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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 Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 64,216 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 4

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1994</u>	<u>\$ 600,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 600,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1994	11,156		20	537	537	9,198	9
10	Various		1996	9,553		20	477	477	6,581	10
11	Various		1997	8,612		20	431	431	5,505	11
12	Various		1998	12,911		20	646	646	7,493	12
13	Various		1999	61,368		20	3,068	3,068	32,937	13
14	Various		2000	36,671		20	1,833	1,833	16,902	14
15	Various		2001	21,772		20	1,089	1,089	9,090	15
16	Various		2002	28,919		20	1,070	1,070	17,936	16
17	Various		2003	24,492		20	2,154	2,154	15,733	17
18	Various		2004	14,195		20	751	751	4,128	18
19	Various		2005	65,521		20	8,235	8,235	37,342	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F &amp; 12G)</u>		<u>7,039,152</u>	<u>180,072</u>		<u>351,957</u>	<u>171,885</u>	<u>4,970,169</u>	67
68	<u>Related Party Allocations (Pages 12H &amp; 12I)</u>		<u>380,855</u>	<u>9,602</u>		<u>13,019</u>	<u>3,417</u>	<u>195,296</u>	68
69	<u>Financial Statement Depreciation</u>			<u>173,402</u>			<u>(173,402)</u>		69
70	<b>TOTAL (lines 4 thru 69)</b>		<b>\$ 7,715,177</b>	<b>\$ 363,076</b>		<b>\$ 385,267</b>	<b>\$ 22,191</b>	<b>\$ 5,328,310</b>	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,715,177	\$ 363,076		\$ 385,267	\$ 22,191	\$ 5,328,310	1
2	Repairs To Driveway And Parking	2006	9,750		20	975	975	3,494	2
3	Air Damper Motor	2006	827		20	165	165	537	3
4	Heat Exchanger	2006	4,051		20	810	810	2,633	4
5	Water Heater Parts	2006	585		20	117	117	380	5
6	Window Replacements	2006	6,747		20	675	675	2,080	6
7	Concrete To Main Entrance	2007	3,050		20	203	203	441	7
8	Japanese Garden Design In Lobby	2007	3,200		20	213	213	462	8
9	Landscaping For Tree Planting	2007	6,550		20	437	437	1,055	9
10	Wallpaper	2007	3,200		20	320	320	827	10
11	Wallpaper	2007	3,000		20	300	300	650	11
12	Additional Outlets, Wiring For Cable Tv	2007	7,500		20	750	750	2,188	12
13	Cameras/Monitors/Drive/Labor	2007	7,085		20	1,417	1,417	4,133	13
14	Wallcoverings	2007	6,620		20	1,324	1,324	3,420	14
15	Borders	2007	7,858		20	1,572	1,572	3,798	15
16	Curtains, Draperies, Cubicle Curtains (Resident Rooms)	2007	65,996		20	13,199	13,199	30,798	16
17	Draperies	2007	6,892		20	1,378	1,378	3,216	17
18	Cornice Boards	2007	28,717		20	2,872	2,872	6,461	18
19	Spool Borders, Swag Sets Sanboxs	2007	23,405		20	2,341	2,341	4,876	19
20	Drywall Repairs Post Wiring	2007	2,500		20	250	250	729	20
21	Lobby And Corridor Remodeling	2007	20,767		20	2,077	2,077	5,019	21
22	Lobby And Corridor Remodeling	2007	24,099		20	2,410	2,410	5,623	22
23	Lobby And Corridor Remodeling	2007	43,378		20	4,338	4,338	9,760	23
24	Down Payment- Lobby And Corridor Remodeling	2007	31,503		20	3,150	3,150	8,926	24
25	Pedimat Floor System And Delivery	2007	3,450		20	345	345	805	25
26	Nurses Station & Reception Station & Installation	2007	45,000		20	9,000	9,000	22,500	26
27	Refinish Elevators	2007	5,500		20	550	550	1,238	27
28	Lobby Wallpaper	2007	1,710		20	171	171	413	28
29	New Valve & Gasket	2007	2,689		20	134	134	325	29
30	Wallpaper Borders	2008	3,814		20	763	763	1,462	30
31	Wallpaper Borders	2008	1,250		20	250	250	479	31
32	Roman Shades Lounge	2008	868		20	174	174	289	32
33	Electrical Wiring	2008	10,000		20	2,000	2,000	3,500	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,106,738	\$ 363,076		\$ 439,947	\$ 76,871	\$ 5,460,827	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 8,106,738	\$ 363,076		\$ 439,947	\$ 76,871	\$ 5,460,827	1
2	Lighting	2008	1,900		20	380	380	633	2
3	Pt Room Cabinets	2008	12,700		20	2,540	2,540	4,868	3
4	Replacement Of Hot Water Heater (Downpayment)	2008	7,250		20	1,450	1,450	2,417	4
5	Service On Broken Pump	2008	2,303		20	461	461	883	5
6	Lobby Work	2008	17,824		20	1,782	1,782	3,565	6
7	Relocate 9 Sprinkler Heads	2008	2,781		20	556	556	1,113	7
8	Ceilings & Walls Therapy, Office & Beauty Shop	2008	8,540		20	854	854	1,637	8
9	Ceilings Activity Room	2008	4,738		20	474	474	908	9
10	Ceilings Therapy Room	2008	6,290		20	629	629	1,206	10
11	Therapy & Activity Room Lighting	2008	8,285		20	829	829	1,588	11
12	Vending Room Flooring	2008	6,343		20	634	634	1,216	12
13	Activity Room Flooring	2008	7,446		20	745	745	1,427	13
14	Therapy Room Flooring	2008	7,843		20	784	784	1,503	14
15	Floors In New Rooms	2008	7,756		20	776	776	1,487	15
16	Remove Elevator & Sub Flooring	2008	1,950		20	195	195	374	16
17	New Faucet & Sink	2008	340		20	68	68	130	17
18	New Beauty Shop	2008	4,430		20	443	443	849	18
19	Dietary Entry Service Doors	2008	1,530		20	153	153	255	19
20	Doors & Frame Therapy Room	2008	4,900		20	490	490	817	20
21	Lobby Ceiling	2008	290		20	29	29	56	21
22	Roof Patching	2008	2,700		20	270	270	360	22
23	Repair Stucco Overhang	2008	2,000		20	200	200	233	23
24	Alarm Lighting & Sound	2008	2,627		20	263	263	438	24
25	Roofing	2009	45,683		20	666	666	666	25
26	Door Work, Flooring, Wiring	2009	15,782		20	164	164	164	26
27	Bedrooms And Bathrooms - Remove And Replace Flooring	2009	14,505		20	151	151	151	27
28	Roofing	2009	13,400		20	140	140	140	28
29	Entry And Lobby-New Slide Door, Electrical, Repair Floor	2009	15,782		20	99	99	99	29
30	Bedrooms & Bathrooms-Remove And Replace Flooring	2009	44,217		20	276	276	276	30
31	Wall Lavatories	2009	3,548		20	177	177	177	31
32	New Telephone Hub	2009	3,988		20	665	665	665	32
33	New Telephone Hub	2009	3,043		20	507	507	507	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,389,452	\$ 363,076		\$ 457,797	\$ 94,721	\$ 5,491,635	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Harmony Nursing & Rehab Center

# 0040535

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,414,447	\$ 363,076		\$ 459,210	\$ 96,134	\$ 5,493,048	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,414,447	\$ 363,076		\$ 459,210	\$ 96,134	\$ 5,493,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,389,452	\$ 363,076		\$ 457,797	\$ 94,721	\$ 5,491,635	1
2	2009	7,845		20	915	915	915	2
3	2009	6,532		20	311	311	311	3
4	2009	4,190		20	70	70	70	4
5	2009	2,550		20	85	85	85	5
6	2009	3,878		20	32	32	32	6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,414,447	\$ 363,076		\$ 459,210	\$ 96,134	\$ 5,493,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	<b>Keiro Building LLC</b>	1993	7,019,409	180,072	20	350,970	170,898	4,955,785	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Keiro Building LLC</b>	1995	19,743		20	987	987	14,384	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>	\$ <b>7,039,152</b>	\$ <b>180,072</b>		\$ <b>351,957</b>	\$ <b>171,885</b>	\$ <b>4,970,169</b>	<b>34</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<u>Allocated from ITEX/AK Care</u>	1993	294,022	7,539	35	8,401	862	139,310	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<u>Allocated from ITEX/AK Care</u>	1993	36,996	218	20	1,850	1,632	30,904	9
10	<u>Allocated from ITEX/AK Care</u>	1993	19,872	517	20	994	477	15,183	10
11	<u>Allocated from ITEX/AK Care</u>	1995	3,387	9	20	169	160	2,404	11
12	<u>Allocated from ITEX/AK Care</u>	1996	192		20	10	10	135	12
13	<u>Allocated from ITEX/AK Care</u>	1997	5,713	146	20	286	140	3,571	13
14	<u>Allocated from ITEX/AK Care</u>	1999	634	16	20	32	16	349	14
15	<u>Allocated from ITEX/AK Care</u>	2005	2,778	320	20	451	131	1,910	15
16	<u>Allocated from ITEX/AK Care</u>	2007	3,439	140	20	357	217	809	16
17	<u>Allocated from ITEX/AK Care</u>	2008	13,108	336	20	433	97	685	17
18	<u>Allocated from ITEX/AK Care</u>	2009	714	361	20	36	(325)	36	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 380,855	\$ 9,602		\$ 13,019	\$ 3,417	\$ 195,296	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Harmony Nursing & Rehab Center**

# **0040535**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-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	\$ 502,334	\$ 1,399	\$ 83,215	\$ 81,816	10	\$ 321,613	71
72	Current Year Purchases	50,677		5,966	5,966	10	5,966	72
73	Fully Depreciated Assets	1,137,054		1,956	1,956	10	1,137,054	73
74								74
75	<b>TOTALS</b>	\$ 1,690,065	\$ 1,399	\$ 91,137	\$ 89,738		\$ 1,464,633	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$			\$	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)	\$ 10,704,512	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 364,475	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 550,347	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 185,872	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,957,681	85

\*\*

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

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

**G. Construction-in-Progress**

	Description	Cost	
92		\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 27,780 Description: See Attached Schedule

(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	Facility	2007 Accura	\$ 895.00	\$ 5,370	17
18	Facility	Lexus	779.00	5,845	18
19	Facility	Volvo	652.52	1,147	19
20					20
21	TOTAL		\$ #####	\$ 12,362	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 255,233				\$ 255,233	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				41,438				41,438	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				287,562				287,562	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					357,033			357,033	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <b>See Supplemental</b>						3,796	132,294			136,090	13
14	<b>TOTAL</b>				\$		\$ 588,029	\$ 489,327			\$ 1,077,356	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Harmony Nursing & Rehab Center**# **0040535**Report Period Beginning: **01/01/09**Ending: **12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,020,594	\$ 1,176,850	1
2	Cash-Patient Deposits	55,598	55,598	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,071,127	1,071,127	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	159,065	191,337	6
7	Other Prepaid Expenses	66,054	66,054	7
8	Accounts Receivable (owners or related parties)	978,196	978,196	8
9	Other(specify): <a href="#">See Attached Schedule</a>	468,731	1,038,443	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,819,365	\$ 4,577,605	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		7,019,409	14
15	Leasehold Improvements, at Historical Cost	650,747	654,147	15
16	Equipment, at Historical Cost	895,617	1,819,100	16
17	Accumulated Depreciation (book methods)	(755,357)	(4,386,432)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	20,221	85,253	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(18,535)	(30,148)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 792,693	\$ 5,761,329	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,612,058	\$ 10,338,934	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 375,771	\$ 386,770	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,587	53,587	28
29	Short-Term Notes Payable	3,000,000	3,038,277	29
30	Accrued Salaries Payable	451,993	451,993	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,792	31,792	31
32	Accrued Real Estate Taxes(Sch.IX-B)		273,146	32
33	Accrued Interest Payable	1,133	40,791	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<a href="#">See Attached Schedule</a>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,914,276	\$ 4,276,356	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,652,617	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 8,652,617	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,914,276	\$ 12,928,973	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 697,782	\$ (2,590,039)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,612,058	\$ 10,338,934	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>549,976</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>549,979</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>180,886</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>180,886</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Treasury Stock</b>	<b>(33,083)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(33,083)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>697,782</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Harmony Nursing & Rehab Center**# **0040535**Report Period Beginning: **01/01/09**Ending: **12/31/09**

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,847,881	1
2	Discounts and Allowances for all Levels	(672,322)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,175,559</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,246,415	6
7	Oxygen	58,476	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,304,891</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	729	13
14	Non-Patient Meals	666	14
15	Telephone, Television and Radio	31,285	15
16	Rental of Facility Space		16
17	Sale of Drugs	505,975	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,227	19
20	Radiology and X-Ray		20
21	Other Medical Services	168,797	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 794,679</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	106,534	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 106,534</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,216	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,216</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 11,382,879</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,844,032	31
32	Health Care	4,402,909	32
33	General Administration	2,371,423	33
<b>B. Capital Expense</b>			
34	Ownership	1,344,911	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,140,168	35
36	Provider Participation Fee	98,550	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,201,993</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>180,886</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 180,886</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. **SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number **Harmony Nursing & Rehab Center**

# **0040535**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**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	1,988	2,248	\$ 103,993	\$ 46.26	1
2	Assistant Director of Nursing	1,880	1,960	74,065	37.79	2
3	Registered Nurses	37,476	42,541	1,137,525	26.74	3
4	Licensed Practical Nurses	29,294	31,302	768,502	24.55	4
5	CNAs & Orderlies	94,086	112,077	1,295,707	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,402	11,859	169,400	14.28	8
9	Activity Director	3,745	4,113	65,330	15.88	9
10	Activity Assistants	7,537	7,884	81,930	10.39	10
11	Social Service Workers	11,548	13,068	249,280	19.08	11
12	Dietician					12
13	Food Service Supervisor	4,369	5,072	84,831	16.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,182	36,013	348,549	9.68	15
16	Dishwashers					16
17	Maintenance Workers	4,110	4,300	80,433	18.71	17
18	Housekeepers	29,746	33,322	345,699	10.37	18
19	Laundry	9,642	10,858	112,749	10.38	19
20	Administrator	1,656	1,944	79,228	40.76	20
21	Assistant Administrator					21
22	Other Administrative	985	1,030	36,362	35.30	22
23	Office Manager	1,980	2,084	29,855	14.33	23
24	Clerical	8,741	10,325	161,418	15.63	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	1,943	2,403	36,934	15.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,103	2,336	62,812	26.89	33
34	TOTAL (lines 1 - 33)	296,413	336,739	\$ 5,324,602 *	\$ 15.81	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	\$ 9,034	01-03	35
36	Medical Director	Monthly	102,931	09-03	36
37	Medical Records Consultant	Monthly	4,328	10-03	37
38	Nurse Consultant	Monthly	16,807	10-03	38
39	Pharmacist Consultant	Monthly	9,120	10-03	39
40	Physical Therapy Consultant	Monthly	806	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	10,588	10a-03	43
44	Activity Consultant	Monthly	2,528	11-03	44
45	Social Service Consultant	Monthly	3,976	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 160,118		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



**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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535Report Period Beginning: 01/01/09Ending: 12/31/09**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 Assoc. of HC \$2,160; ICLTC \$14,580
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,899 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. \$ 98,550  
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. \$ 58,619 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 666
- (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? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
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? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.