

		FOR BHF USE					

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

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.

I. IDPH License ID Number: <u>0040535</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Harmony Nursing And Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.	
Address: <u>3919 West Foster</u> <u>Chicago</u> <u>60625</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(773) 588-9500</u> Fax # <u>(773) 588-9533</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>12/14/94</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☒ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steve Lavenda</u>		Telephone Number: <u>(847) 236-1111</u>	
Email Address: _____			

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
Paid Preparer	(Title) _____	
	(Signed) _____	
	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>	(Date) _____
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
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		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab

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

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	<u>180</u>	Skilled (SNF)	<u>180</u>	<u>65,880</u>	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	<u>180</u>	TOTALS	<u>180</u>	<u>65,880</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>40,231</u>	<u>3,350</u>	<u>10,531</u>	<u>54,112</u>	8
9	SNF/PED					9
10	ICF	<u>4,354</u>	<u>64</u>		<u>4,418</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,585</u>	<u>3,414</u>	<u>10,531</u>	<u>58,530</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.84%

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 5/25/1994 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 7,823

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/12 Ending: 12/31/12
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	435,510	68,581	12,143	516,234		516,234	3,291	519,525			1
2	Food Purchase		436,469		436,469	(80,923)	355,546	(993)	354,553			2
3	Housekeeping	384,034	33,580		417,614		417,614	6,492	424,106			3
4	Laundry	100,121	33,508		133,629		133,629		133,629			4
5	Heat and Other Utilities			182,307	182,307		182,307	2,701	185,008			5
6	Maintenance	79,783	32,616	110,675	223,074		223,074	11,051	234,125			6
7	Other (specify):*											7
8	TOTAL General Services	999,448	604,754	305,125	1,909,327	(80,923)	1,828,404	22,542	1,850,946			8
	B. Health Care and Programs											
9	Medical Director			141,900	141,900		141,900		141,900			9
10	Nursing and Medical Records	3,285,467	305,779	77,258	3,668,504		3,668,504	(41,022)	3,627,482			10
10a	Therapy	126,276			126,276		126,276		126,276			10a
11	Activities	143,421	16,175	6,506	166,102		166,102		166,102			11
12	Social Services	212,902		5,989	218,891		218,891		218,891			12
13	CNA Training											13
14	Program Transportation			18,263	18,263		18,263		18,263			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,768,066	321,954	249,916	4,339,936		4,339,936	(41,022)	4,298,914			16
	C. General Administration											
17	Administrative	126,715			126,715		126,715		126,715			17
18	Directors Fees											18
19	Professional Services			476,413	476,413		476,413	(346,208)	130,205			19
20	Dues, Fees, Subscriptions & Promotions			259,308	259,308		259,308	(174,200)	85,108			20
21	Clerical & General Office Expenses	216,630	4,991	240,639	462,260		462,260	104,279	566,539			21
22	Employee Benefits & Payroll Taxes			930,706	930,706	80,923	1,011,629		1,011,629			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,033	2,033		2,033	(722)	1,311			24
25	Other Admin. Staff Transportation			8,123	8,123		8,123	(4,550)	3,573			25
26	Insurance-Prop.Liab.Malpractice			300,466	300,466		300,466	1,222	301,688			26
27	Other (specify):*							75,651	75,651			27
28	TOTAL General Administration	343,345	4,991	2,217,688	2,566,024	80,923	2,646,947	(344,528)	2,302,419			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,110,859	931,699	2,772,729	8,815,287		8,815,287	(363,009)	8,452,278			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			163,894	163,894		163,894	356,942	520,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			166,554	166,554		166,554	309,723	476,277			32
33	Real Estate Taxes							263,009	263,009			33
34	Rent-Facility & Grounds			864,400	864,400		864,400	(864,400)				34
35	Rent-Equipment & Vehicles			42,726	42,726		42,726	852	43,578			35
36	Other (specify):*			7,519	7,519		7,519	41,427	48,946			36
37	TOTAL Ownership			1,245,093	1,245,093		1,245,093	107,553	1,352,646			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		598,444	722,752	1,321,196		1,321,196		1,321,196			39
40	Barber and Beauty Shops			4,204	4,204		4,204		4,204			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			430,480	430,480		430,480	(23,898)	406,582			42
43	Other (specify):*	75,172		33,000	108,172		108,172	(108,172)	(0)			43
44	TOTAL Special Cost Centers	75,172	598,444	1,190,436	1,864,052		1,864,052	(132,070)	1,731,982			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,186,031	1,530,143	5,208,258	11,924,432		11,924,432	(387,526)	11,536,906			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(740)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,881)	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	167,476	30		9
10	Interest and Other Investment Income	(38,319)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(253)	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	(7,964)	21		18
19	Entertainment				19
20	Contributions	(80,575)	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	(127,093)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(583,323)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (674,672)		\$	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)	287,146		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 287,146		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (387,526)		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.			\$		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	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0040535

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veteran Expenses - Miscellaneous	\$ (22,854)	10	1
2	Patient Purchases	(18,031)	10	2
3	Bank Charges	(6,368)	21	3
4	Public Relations	(93,266)	20	4
5	Non-Allowable Legal	(26,823)	19	5
6	Miscellaneous Income - State of Illinois	(20)	21	6
7	Miscellaneous Income - Jury Duty	(138)	10	7
8	Miscellaneous Income - Insurance Brokerage	(11)	26	8
9	Non-Allowable Professional Fees	(4,800)	19	9
10	Non-Allowable Seminars	(739)	24	10
11	Non-Allowable Travel	(4,550)	25	11
12	Late Payment Fee	(728)	21	12
13	Collections Salary	(20,718)	43	13
14	Marketing Salary	(54,454)	43	14
15	Building Co. - Penalty	(205,479)	21	15
16	Building Co. - Office Expense	(347)	21	16
17	Building Co. - Legal Fees	(6,497)	19	17
18	Building Co. - Accounting Fees	(13,029)	19	18
19	Building Co. - Amortization	(52,414)	36	19
20	Additional R&M	9,400	06	20
21	Prior Period - IDPA Tax Assessment	(23,898)	42	21
22	Capitalized R&M	(3,650)	06	22
23	COPE Dues	(909)	20	23
24	Non-Allowable Expense	(33,000)	43	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	(583,323)		49

ID#0040535

Report Period Beginning:01/01/12

Ending:12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	32	Interest Income	\$ 746	Keiro Building LLC	100.00%	\$	\$ (746)	1
2	V	21	Miscellaneous Income	10,667	Keiro Building LLC	100.00%		(10,667)	2
3	V	34	Rental Income	864,400	Keiro Building LLC	100.00%		(864,400)	3
4	V	36	MIP Insurance		Keiro Building LLC	100.00%	41,427	41,427	4
5	V	21	Office Expense		Keiro Building LLC	100.00%	347	347	5
6	V	19	Legal Fees		Keiro Building LLC	100.00%	6,497	6,497	6
7	V	19	Accounting Fees		Keiro Building LLC	100.00%	13,029	13,029	7
8	V	32	Mortgage Interest		Keiro Building LLC	100.00%	330,557	330,557	8
9	V	33	Real Estate Taxes		Keiro Building LLC	100.00%	255,428	255,428	9
10	V	30	Depreciation		Keiro Building LLC	100.00%	180,072	180,072	10
11	V	36	Amoritization of Loan Costs		Keiro Building LLC	100.00%	52,414	52,414	11
12	V	21	Penalty		Keiro Building LLC	100.00%	205,479	205,479	12
13	V								13
14	Total			\$ 875,813			\$ 1,085,250	\$ * 209,437	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 3,291	\$	3,291 15
16	V	3	HOUSEKEEPING			100.00%	6,492		6,492 16
17	V	5	UTILITIES			100.00%	2,701		2,701 17
18	V	6	REPAIRS AND MAINT.			100.00%	5,301		5,301 18
19	V	19	PROFESSIONAL FEES			100.00%	9,415		9,415 19
20	V	20	FEES, SUBSCRIPTIONS			100.00%	550		550 20
21	V	21	CLERICAL AND GENERAL			100.00%	25,807		25,807 21
22	V	24	EDUCATION/SEMINARS			100.00%	17		17 22
23	V	26	INSURANCE			100.00%	1,233		1,233 23
24	V	30	DEPRECIATION			100.00%	9,394		9,394 24
25	V	32	INTEREST			100.00%	18,231		18,231 25
26	V	33	REAL ESTATE TAXES			100.00%	7,581		7,581 26
27	V	35	EQUIPMENT RENTAL			100.00%	852		852 27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES			100.00%	235,193		235,193 32
33	V	27	GEN ADMIN. - EMP. BEN.			100.00%	75,651		75,651 33
34	V								34
35	V								35
36	V	19	BOOKKEEPING	324,000		100.00%			(324,000) 36
37	V								37
38	V								38
39	Total			\$ 324,000			\$ 401,709	\$ *	77,709 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Total			\$			\$	\$ *	39

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	Total			\$			\$	\$ *	39

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	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	THE RAJCHENBACH FAMILY TRUST	30.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	KEIRO BUILDING LLC	CHICAGO	BUILDING CO.	1
2	MARK HOLLANDER	10.000%	GLENVIEW TERRACE N. C.	GLENVIEW	ITEX / A.K. CARE	LINCOLNWOOD	BOOKEEPING CO./MAN/	2
3	MARK HOLLANDER DISCRETIONARY TRUST	20.000%	THE CARLTON AT THE LAKE, INC.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	SHARON HOLLANDER DISCRETIONARY TRUST	20.000%	WHITEHALL NORTH	DEERFIELD				4
5	FEIGE KNOBEL DISCRETIONARY TRUST	20.000%						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

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								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

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	Jack Rajchenbach	Relative	Administrative	N/A	See Attached	4.00	6.67%		\$		1
2	Mark Hollander	Owner	Administrative	10.00%	See Attached	20.00	33.33%				2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										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 Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	TOTALS					\$	\$		\$	25

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

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	360,876	4	\$ 18,028	\$	65,880	\$ 3,291	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	360,876	4	35,563		65,880	6,492	2
3	5	UTILITIES	AVAILABLE BED DAYS	360,876	4	14,796		65,880	2,701	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	360,876	4	29,040		65,880	5,301	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	360,876	4	51,572		65,880	9,415	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	360,876	4	3,012		65,880	550	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	360,876	4	141,365		65,880	25,807	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	360,876	4	95		65,880	17	8
9	26	INSURANCE	AVAILABLE BED DAYS	360,876	4	6,754		65,880	1,233	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	360,876	4	51,459		65,880	9,394	10
11	32	INTEREST	AVAILABLE BED DAYS	360,876	4	99,865		65,880	18,231	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	360,876	4	41,525		65,880	7,581	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	360,876	4	4,669		65,880	852	13
14										14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	782,540	782,540		235,193	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	251,708			75,651	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,531,991	\$ 782,540		\$ 401,709	25

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

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	TOTALS					\$	\$		\$	25

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

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	TOTALS					\$	\$		\$	25

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

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	TOTALS					\$	\$		\$	25

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

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
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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	TOTALS					\$	\$		\$	25

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

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	TOTALS					\$	\$		\$	25

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

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	TOTALS					\$	\$		\$	25

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

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	TOTALS					\$	\$		\$	25

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

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	TOTALS					\$	\$		\$	25

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	Cambridge		X	Mortgage	\$49,971.00	10/01/03	\$ 9,295,200	\$ 9,184,396	10/01/2038	5.5000	\$ 330,557	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Citi Bank		X	Line of Credit				3,000,000			166,554	6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$49,971.00		\$ 9,295,200	\$ 12,184,396			\$ 497,111	9	
	B. Non-Facility Related*												
10	Interest Income		X								(38,319)	10	
11	Interest Income - Bldg Co		X								(746)	11	
12	Allocated from ITEX		X								18,231	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (20,834)	14	
15	TOTALS (line 9+line14)						\$ 9,295,200	\$ 12,184,396			\$ 476,276	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,427 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.)

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	270,506	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.)		\$	264,134	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(6,372)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	269,381	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.		\$	263,009	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	257,554	8	
		2008	260,139	9	
		2009	246,877	10	
		2010	257,624	11	
		2011	256,553	12	
Beginning Accrual Adjusted					
2012 Accrual = \$256,553 x 1.05 = \$269,381					
Allocated from ITEX = \$7,581					

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

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing And Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX#: ()

A. Summary of Real Estate Tax Cost

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

(A)		(B)		(C)		(D)	
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>	
1.	<u>13-11-300-007-0000</u>	<u>Long Term Care Property</u>		\$	<u>256,552.90</u>	\$	<u>256,552.90</u>
2.	<u>10-35-312-022-0000</u>	<u>Allocated from ITEX</u>		\$	<u>50,627.24</u>	\$	<u>8,835.63</u>
3.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
4.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
5.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
6.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
7.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
8.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
9.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
10.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
TOTALS				\$	<u><u>307,180.14</u></u>	\$	<u><u>265,388.53</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEHarmony Nursing And RehabCOUNTYCook

FACILITY IDPH LICENSE NUMBER0040535

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

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	TOTALS			<u>\$ 600,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	180			1993	\$ 7,019,409	\$ 180,072	20	\$ 350,970	\$ 170,898	\$ 6,008,695	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1995	11,156		20			11,156	9	
10	Various			1996	9,553		20	478	478	8,015	10	
11	Various			1997	8,612		20	431	431	6,797	11	
12	Various			1998	12,911		20	646	646	9,429	12	
13	Various			1999	61,368		20	3,068	3,068	42,142	13	
14	Various			2000	36,671		20	1,834	1,834	22,404	14	
15	Various			2001	19,752		20	988	988	11,682	15	
16	Various			2002	23,793		20	777	777	18,100	16	
17	Various			2003	19,176		20	1,721	1,721	17,365	17	
18	Various			2004	5,922		20	337	337	2,884	18	
19	Various			2005	60,851		20	4,246	4,246	50,376	19	
20	Various			2006	20,548		20	1,650	1,650	14,575	20	
21	Various			2007	369,784		20	38,277	38,277	259,965	21	
22	Various			2008	109,693		20	14,749	14,749	71,520	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
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	Related Building Company (Pages 12F & 12G)		19,743			987	987	17,345	67
68	Related Party Allocations (Pages 12H & 12I)		380,828	8,969		12,579	3,610	230,480	68
69	Financial Statement Depreciation			163,894			(163,894)		69
70	TOTAL (lines 4 thru 69)		\$ 8,189,771	\$ 352,935		\$ 433,735	\$ 80,800	\$ 6,802,928	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 And Rehab

0040535

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,189,771	\$ 352,935		\$ 433,735	\$ 80,800	\$ 6,802,928	1
2	Roofing	2009	45,683		20	4,568	4,568	16,370	2
3	Door Work, Flooring, Wiring	2009	15,782		20	395	395	1,348	3
4	Bedrooms And Bathrooms- Remove And Replace Flooring	2009	14,505		20	363	363	1,239	4
5	Roofing	2009	13,400		20	1,340	1,340	4,578	5
6	Entry And Lobby - New Slide Door , Electrical, Repair Roof	2009	15,782		20	395	395	1,282	6
7	Bedrooms & Bathrooms- Remove And Replace Flooring	2009	44,217		20	1,105	1,105	3,593	7
8	Wall Lavatories	2009	3,548		20	710	710	2,306	8
9	New Telephone Hub	2009	3,988		20	798	798	3,057	9
10	New Telephone Hub	2009	3,043		20	609	609	2,333	10
11	Voicemail System	2009	7,845		20	1,569	1,569	5,623	11
12	Office Carpeting	2009	6,532		20	933	933	3,110	12
13	Elevator Work	2009	4,190		20	105	105	384	13
14	Parking Lot Sealcoat	2009	2,550		20	128	128	468	14
15	Wall Signs	2009	3,878		20	194	194	614	15
16	Pedestal Sinks	2010	7,715		20	1,543	1,543	3,729	16
17	Radiator Assembly	2010	3,125		20	625	625	1,823	17
18	Cameras And Cctv Equipment	2010	2,590		20	518	518	1,252	18
19	Resident Room Improvements- Vinyl Tile Flooring - 17 Bedrooms	2010	29,798		20	2,980	2,980	7,201	19
20	Resident Rooms - Install New Wood Railing, 3Rd Floor Windows	2010	4,350		20	435	435	906	20
21	Telephone System	2010	38,594		20	7,719	7,719	18,654	21
22	Insulated Glass	2010	3,610		20	361	361	782	22
23	Built In Cabinets & Wardrobes	2010	34,640		20	3,464	3,464	9,526	23
24	Parking Lot Paving	2011	8,250		20	550	550	733	24
25	A & J Paving - Sewer & Concrete	2012	3,200		20	178	178	178	25
26	Water Heater For Kitchen/ Laundry	2012	7,474		20	1,370	1,370	1,370	26
27	Installed New Pump Motor On Elevator	2012	3,650		20	183	183	183	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,521,711	\$ 352,935		\$ 466,870	\$ 113,935	\$ 6,895,570	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 and Improvement Costs-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 Totals from Page 12B, Carried Forward		\$ 8,521,711	\$ 352,935		\$ 466,870	\$ 113,935	\$ 6,895,570	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)		\$ 8,521,711	\$ 352,935		\$ 466,870	\$ 113,935	\$ 6,895,570	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 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	
1	Totals from Page 12C, Carried Forward		\$ 8,521,711	\$ 352,935		\$ 466,870	\$ 113,935	\$ 6,895,570	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)		\$ 8,521,711	\$ 352,935		\$ 466,870	\$ 113,935	\$ 6,895,570	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 and Improvement Costs-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	Totals from Page 12D, Carried Forward		\$8,521,711	\$352,935		\$466,870	\$113,935	\$6,895,570	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)		\$8,521,711	\$352,935		\$466,870	\$113,935	\$6,895,570	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 and Improvement Costs-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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Keiro Building LLC	1995	19,743		20	987	987	17,345	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 and Improvement Costs-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	Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$19,743	\$		\$987	\$987	\$17,345	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 And Rehab

0040535

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from ITEX/AK Care	1993	292,829	7,509	35	8,366	857	163,844	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ITEX/AK Care	1993	36,846	217	20	1,841	1,624	36,305	9
10	Allocated from ITEX/AK Care	1994	19,791	515	20	990	475	18,090	10
11	Allocated from ITEX/AK Care	1995	3,373	9	20	169	160	2,900	11
12	Allocated from ITEX/AK Care	1996	191		20	10	10	163	12
13	Allocated from ITEX/AK Care	1997	5,690	146	20	284	138	4,410	13
14	Allocated from ITEX/AK Care	1999	632	16	20	32	16	442	14
15	Allocated from ITEX/AK Care	2005	2,767		20	138	138	1,020	15
16	Allocated from ITEX/AK Care	2007	3,425	98	20	171	73	901	16
17	Allocated from ITEX/AK Care	2008	13,054	335	20	431	96	1,976	17
18	Allocated from ITEX/AK Care	2009	711	18	20	71	53	249	18
19	Allocated from ITEX/AK Care	2010	1,519	106	20	76	(30)	180	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 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	
1	Related Party Information Continued								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
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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)		\$ 380,828	\$ 8,969		\$ 12,579	\$ 3,610	\$ 230,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$386,996	\$427	\$52,676	\$52,249	10	\$324,366	71
72	Current Year Purchases	6,338		993	993	10	993	72
73	Fully Depreciated Assets	1,355,797		298	298	10	1,356,393	73
74								74
75	TOTALS	\$1,749,131	\$427	\$53,968	\$53,541		\$1,681,752	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$10,870,842	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$353,362	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$520,838	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$167,476	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$8,577,322	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

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.

		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?
16. Rental Amount for movable equipment: \$ 43,578
- 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ NO

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 - 03	hrs	\$		\$ 294,565	\$		\$ 294,565	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			67,972			67,972	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			344,545			344,545	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				476,182		476,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					15,670	122,262		137,932	13
14	TOTAL			\$		\$ 722,752	\$ 598,444		\$ 1,321,196	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 359,539	\$ 598,253	1
2	Cash-Patient Deposits	59,219	59,219	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,119,247	4,119,247	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	241,017	256,470	6
7	Other Prepaid Expenses	418,930	418,930	7
8	Accounts Receivable (owners or related parties)	2,177,648	2,177,648	8
9	Other(specify): See Attached Schedule	697,640	2,000,747	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,073,240	\$ 9,630,514	10
	B. Long-Term Assets			
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	699,956	703,356	15
16	Equipment, at Historical Cost	1,096,551	2,020,034	16
17	Accumulated Depreciation (book methods)	(1,311,395)	(5,482,685)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,470	133,995	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(246)	(2,957)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	4,834	4,834	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 497,170	\$ 4,995,986	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,570,410	\$ 14,626,500	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,415,503	\$ 1,427,504	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,208	57,208	28
29	Short-Term Notes Payable	3,000,000	3,001,677	29
30	Accrued Salaries Payable	300,764	300,764	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,936	13,936	31
32	Accrued Real Estate Taxes(Sch.IX-B)		269,381	32
33	Accrued Interest Payable	3,288	30,836	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,000	1,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,095,501	2,223,945	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,887,200	\$ 7,326,251	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,182,719	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,182,719	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,887,200	\$ 16,508,970	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,683,210	\$ (1,882,470)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,570,410	\$ 14,626,500	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,385,962	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,385,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	297,249	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)	\$297,249	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$1,683,210	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,380,517	1
2	Discounts and Allowances for all Levels	(2,557,464)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,823,053	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,498,607	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,498,607	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	4,461	13
14	Non-Patient Meals	740	14
15	Telephone, Television and Radio	3,881	15
16	Rental of Facility Space		16
17	Sale of Drugs	636,979	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,691	19
20	Radiology and X-Ray		20
21	Other Medical Services	161,053	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 860,805	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38,319	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,319	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	897	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 897	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,221,681	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,909,327	31
32	Health Care	4,339,936	32
33	General Administration	2,566,024	33
	B. Capital Expense		
34	Ownership	1,245,093	34
	C. Ancillary Expense		
35	Special Cost Centers	1,433,572	35
36	Provider Participation Fee	430,480	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,924,432	40
41	Income before Income Taxes (line 30 minus line 40)**	297,249	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 297,249	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,230,234	44
45	Private Pay - Net Inpatient Revenue	623,636	45
46	Medicare - Net Inpatient Revenue	1,686,806	46
47	Other-(specify) Insurance	163,480	47
48	Other-(specify) Veterans	118,897	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,823,053	49

* 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.

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

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	1,392	1,473	\$ 61,533	\$ 41.77	1
2	Assistant Director of Nursing	1,920	2,160	76,678	35.50	2
3	Registered Nurses	40,804	47,764	1,195,523	25.03	3
4	Licensed Practical Nurses	27,755	31,119	645,087	20.73	4
5	CNAs & Orderlies	36,604	108,744	1,281,214	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,664	10,795	126,276	11.70	8
9	Activity Director	3,760	4,320	66,096	15.30	9
10	Activity Assistants	6,899	7,652	77,325	10.11	10
11	Social Service Workers	9,724	11,276	212,902	18.88	11
12	Dietician					12
13	Food Service Supervisor	4,675	5,298	87,668	16.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,171	36,170	347,842	9.62	15
16	Dishwashers					16
17	Maintenance Workers	6,076	6,520	79,783	12.24	17
18	Housekeepers	32,275	35,795	384,034	10.73	18
19	Laundry	8,081	9,302	100,121	10.76	19
20	Administrator	1,984	2,160	91,554	42.39	20
21	Assistant Administrator					21
22	Other Administrative	1,434	1,331	35,161	26.42	22
23	Office Manager	2,830	3,144	38,703	12.31	23
24	Clerical	12,227	13,174	177,927	13.51	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	2,072	2,504	25,432	10.16	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,299	2,555	75,172	29.42	33
34	TOTAL (lines 1 - 33)	245,646	343,256	\$ 5,186,031 *	\$ 15.11	34

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	\$ 12,143	01-03	35
36	Medical Director	Monthly	141,900	09-03	36
37	Medical Records Consultant	Monthly	5,640	10-03	37
38	Nurse Consultant	Monthly	63,698	10-03	38
39	Pharmacist Consultant	Monthly	7,920	10-03	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	6,506	11-03	44
45	Social Service Consultant	Monthly	5,989	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 243,796		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHarmony Nursing And Rehab# 0040535Report Period Beginning:01/01/12Ending:12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Christopher Kropp	Administrator	0.00%	\$ 91,554
Ian Crook	VP Operations	0.00%	35,161
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 126,715

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	\$ 48,313
Personnel Planners	Unemployment Consulting	2,084
AK Care	Centralized Bookkeeping	324,000
See Attached	Legal	54,109
Singer Networks	Data Processing	7,347
ADL Data Systems	Data Processing	8,969
E-Health Data Solutions	Data Processing	5,940
Health Medx	Data Processing	11,981
Provinet Solutions	Data Processing	1,100
M L Enterprises	Purchasing Consultant	3,000
Healthcare Horizons	Admin. Consult (Adj. P. 5A)	4,800
See Supplemental Schedule		4,770
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 476,413

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 149,416
Unemployment Compensation Insurance	57,835
FICA Taxes	390,922
Employee Health Insurance	264,680
Employee Meals	80,923
Illinois Municipal Retirement Fund (IMRF)*	
Christmas Expense	4,458
Pension Expense	45,663
Chicago Head Tax	8,450
401K Expense	7,295
Other Employee Benefits	1,987
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	45,813
Health Care Worker Background Check (Indicate # of checks performed 577)	5,765
Patient Background Checks	
Dues and Subscriptions	11,225
Association Dues	17,820
Licenses	3,090
Inspections	845
See Supplemental Schedule	93,816
Less: Public Relations Expense	(93,266)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,294
Allocated from ITEX	17
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,311

* Attach copy of IMRF notifications

**See instructions.

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 on LTC \$17,820
- (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. \$ 45,553 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. \$ 406,582
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. \$ 80,923 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 740
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT