		FOR BHF USE					

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0040535

Facility Name: Harmony Nursing & Rehab Center

Address: 3919 West Foster Avenue (Number) Chicago (City) 60625 (Zip Code)

County: Cook

Telephone Number: (773) 588-9500 **Fax #** (773) 588-9533

HFS ID Number:

Date of Initial License for Current Owners: 12/14/1994

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Noshir R. Daruwalla, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	39,442	7,077	8,663	55,182	8
9	SNF/PED					9
10	ICF	5,690			5,690	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,132	7,077	8,663	60,872	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.65%

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 [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 180 and days of care provided 7,295

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	440,402	84,948	11,318	536,668		536,668	3,934	540,602			1
2	Food Purchase		326,563		326,563	(58,619)	267,944	(936)	267,008			2
3	Housekeeping	355,497	35,253		390,750		390,750	7,062	397,812			3
4	Laundry	114,095	31,574		145,669		145,669		145,669			4
5	Heat and Other Utilities			209,725	209,725		209,725	3,521	213,246			5
6	Maintenance	80,055	35,312	137,316	252,683		252,683	32,705	285,388			6
7	Other (specify):*											7
8	**TOTAL General Services**	990,049	513,650	358,359	1,862,058	(58,619)	1,803,439	46,286	1,849,725			8
	B. Health Care and Programs											
9	Medical Director			122,139	122,139		122,139		122,139			9
10	Nursing and Medical Records	3,494,850	210,200	21,039	3,726,089		3,726,089	(19,645)	3,706,444			10
10a	Therapy	137,979	212	6,956	145,147		145,147		145,147			10a
11	Activities	142,113	17,909	2,544	162,566		162,566		162,566			11
12	Social Services	283,390		4,990	288,380		288,380		288,380			12
13	CNA Training											13
14	Program Transportation			11,143	11,143		11,143		11,143			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,058,332	228,321	168,811	4,455,464		4,455,464	(19,645)	4,435,819			16
	C. General Administration											
17	Administrative	115,570			115,570		115,570		115,570			17
18	Directors Fees											18
19	Professional Services			270,565	270,565	(16,861)	253,704	(157,187)	96,517			19
20	Dues, Fees, Subscriptions & Promotions			233,916	233,916		233,916	(148,375)	85,541			20
21	Clerical & General Office Expenses	194,877	4,832	187,612	387,321		387,321	156,532	543,853			21
22	Employee Benefits & Payroll Taxes			978,213	978,213	58,619	1,036,832		1,036,832			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,611	3,611		3,611	(210)	3,401			24
25	Other Admin. Staff Transportation			9,330	9,330		9,330	(4,200)	5,130			25
26	Insurance-Prop.Liab.Malpractice			301,011	301,011		301,011	1,144	302,155			26
27	Other (specify):*							78,590	78,590			27
28	**TOTAL General Administration**	310,447	4,832	1,984,258	2,299,537	41,758	2,341,295	(73,706)	2,267,589			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,358,828	746,803	2,511,428	8,617,059	(16,861)	8,600,198	(47,065)	8,553,133			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.

Facility Name & ID Number Harmony Nursing & Rehab Center #0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			194,222	194,222		194,222	362,149	556,371			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			212,598	212,598		212,598	401,128	613,726			32
33	Real Estate Taxes			49,155	49,155	16,861	66,016	190,524	256,540			33
34	Rent-Facility & Grounds			961,263	961,263		961,263	(961,263)				34
35	Rent-Equipment & Vehicles			37,437	37,437		37,437	1,896	39,333			35
36	Other (specify):*			1,685	1,685		1,685	42,868	44,553			36
37	TOTAL Ownership			1,456,360	1,456,360	16,861	1,473,221	37,302	1,510,523			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		484,561	585,758	1,070,319		1,070,319		1,070,319			39
40	Barber and Beauty Shops			4,091	4,091		4,091		4,091			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*	63,274			63,274		63,274	(63,274)	(0)			43
44	TOTAL Special Cost Centers	63,274	484,561	688,399	1,236,234		1,236,234	(63,274)	1,172,960			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,422,102	1,231,364	4,656,187	11,309,653		11,309,653	(73,037)	11,236,616			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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(558)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,423)	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	169,182	30		9
10	Interest and Other Investment Income	(95,715)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(378)	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	(26,920)	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	(79,788)	21		24
25	Fund Raising, Advertising and Promotional	(2,682)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(554)	20		28
29	Other-Attach Schedule	(260,089)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (316,925)		$	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)	243,888		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 243,888		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (73,037)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Harmony Nursing & Rehab Center

ID# 0040535

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income - State of Illinois	$ (60)	21	1
2	Jury Duty Income	(103)	10	2
3	Miscellaneous Income	(396)	21	3
4	Veteran Expenses - Miscellaneous	(13,714)	10	4
5	Patient Purchases	(5,828)	10	5
6	Bank Charges	(7,320)	21	6
7	Franchise Tax	(100)	21	7
8	Public Relations	(120,531)	20	8
9	2011 Seminar	(210)	24	9
10	Additional R&M	25,301	06	10
11	Non-Allowable Legal	(24,341)	19	11
12	Building Co. - Franchise Tax	(400)	21	12
13	Building Co. - Office Expense	(170)	21	13
14	Building Co. - Legal Fees	(3,528)	19	14
15	Building Co. - Accounting Fees	(14,381)	19	15
16	Building Co. - Amortization	(1,858)	36	16
17	Non-Allowable Professional Fee	(4,400)	19	17
18	Marketing Salary	(63,274)	43	18
19	Collections Salary	(20,434)	21	19
20	Non-Allowable Travel	(4,200)	25	20
21	Late Payment Fee	(142)	21	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(260,089)		49

Harmony Nursing & Rehab Center

ID# 0040535

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Harmony Nursing & Rehab Center **#** 0040535 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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			3,934									3,934	1
2	Food Purchase	(936)											(936)	2
3	Housekeeping			7,062									7,062	3
4	Laundry													4
5	Heat and Other Utilities			3,521									3,521	5
6	Maintenance	25,301		7,404									32,705	6
7	Other (specify):*													7
8	**TOTAL General Services**	24,365		21,921									46,286	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(19,645)											(19,645)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(19,645)											(19,645)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(46,650)	34,770	(145,307)									(157,187)	19
20	Fees, Subscriptions & Promotions	(150,687)		2,312									(148,375)	20
21	Clerical & General Office Expenses	(128,233)	(9,652)	294,417									156,532	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(210)											(210)	24
25	Other Admin. Staff Transportation	(4,200)											(4,200)	25
26	Insurance-Prop.Liab.Malpractice			1,144									1,144	26
27	Other (specify):*			78,590									78,590	27
28	**TOTAL General Administration**	(329,980)	25,118	231,156									(73,706)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(325,260)	25,118	253,077									(47,065)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	169,182	180,072	12,895									362,149	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(95,715)	470,528	26,315									401,128	32
33	Real Estate Taxes		183,796	6,728									190,524	33
34	Rent-Facility & Grounds		(961,263)										(961,263)	34
35	Rent-Equipment & Vehicles			1,896									1,896	35
36	Other (specify):*	(1,858)	44,726										42,868	36
37	**TOTAL Ownership**	71,609	(82,141)	47,834									37,302	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(63,274)											(63,274)	43
44	**TOTAL Special Cost Centers**	(63,274)											(63,274)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(316,925)	(57,023)	300,911									(73,037)	45

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 961,263	Keiro Building LLC	100.00%	$	$ (961,263)	1
2	V	21	Miscellaneous Income	10,222	Keiro Building LLC	100.00%		(10,222)	2
3	V	32	Interest Income	1,636	Keiro Building LLC	100.00%		(1,636)	3
4	V	21	Franchise Fee		Keiro Building LLC	100.00%	400	400	4
5	V	36	MIP Insurance		Keiro Building LLC	100.00%	42,868	42,868	5
6	V	21	Office Expense		Keiro Building LLC	100.00%	170	170	6
7	V	19	Legal Fees		Keiro Building LLC	100.00%	20,389	20,389	7
8	V	19	Accounting Fees		Keiro Building LLC	100.00%	14,381	14,381	8
9	V	32	Mortgage Interest		Keiro Building LLC	100.00%	472,164	472,164	9
10	V	33	Real Estate Taxes		Keiro Building LLC	100.00%	183,796	183,796	10
11	V	30	Depreciation		Keiro Building LLC	100.00%	180,072	180,072	11
12	V	36	Amortization of Loan Costs		Keiro Building LLC	100.00%	1,858	1,858	12
13	V								13
14	Total			$ 973,121			$ 916,098	$ * (57,023)	14

*** 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: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	ITEX / AK CARE COMPANY	100.00%	$ 3,934	$ 3,934	15
16	V	3	HOUSEKEEPING				7,062	7,062	16
17	V	5	UTILITIES				3,521	3,521	17
18	V	6	REPAIRS AND MAINT.				7,404	7,404	18
19	V	19	PROFESSIONAL FEES				6,742	6,742	19
20	V	20	FEES, SUBSCRIPTIONS				2,312	2,312	20
21	V	21	CLERICAL AND GENERAL				29,397	29,397	21
22	V	26	INSURANCE				1,144	1,144	22
23	V	30	DEPRECIATION				12,895	12,895	23
24	V	32	INTEREST				26,315	26,315	24
25	V	33	REAL ESTATE TAXES				6,728	6,728	25
26	V	35	EQUIPMENT RENTAL				1,896	1,896	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES				265,020	265,020	32
33	V	27	GEN ADMIN. - EMP. BEN.				78,590	78,590	33
34	V								34
35	V	19	HOME OFFICE						35
36	V	19	BOOKKEEPING	149,000				(149,000)	36
37	V	19	DATA PROCESSING	3,049				(3,049)	37
38	V								38
39	Total			$ 152,049			$ 452,960	$ * 300,911	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Rajchenbach	Owner	Administrative	30.00%	See Attached	4.00	6.15%		$		1
2	Mark Hollander	Owner	Administrative	9.99%	See Attached	23.00	38.33%				2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	358,430	4	$ 21,460	$	65,700	$ 3,934	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	358,430	4	38,527		65,700	7,062	2
3	5	UTILITIES	AVAILABLE BED DAYS	358,430	4	19,208		65,700	3,521	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	358,430	4	40,392		65,700	7,404	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	358,430	4	36,782		65,700	6,742	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	358,430	4	12,612		65,700	2,312	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	358,430	4	160,377		65,700	29,397	7
8	26	INSURANCE	AVAILABLE BED DAYS	358,430	4	6,239		65,700	1,144	8
9	30	DEPRECIATION	AVAILABLE BED DAYS	358,430	4	70,348		65,700	12,895	9
10	32	INTEREST	AVAILABLE BED DAYS	358,430	4	143,562		65,700	26,315	10
11	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	358,430	4	36,706		65,700	6,728	11
12	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	358,430	4	10,346		65,700	1,896	12
13										13
14										14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	887,210	887,210		265,020	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	263,098			78,590	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,746,867	$ 887,210		$ 452,960	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge		X	Mortgage	$49,971.00	10/01/03	$ 9,295,200	$ 8,527,913	10/01/2038	5.5000	$ 472,164	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Citi Bank		X	Line of Credit				3,000,000			212,598	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$49,971.00		$ 9,295,200	$ 11,527,913			$ 684,762	9
	B. Non-Facility Related*											
10	Interest Income		X								(95,715)	10
11	Allocated from ITEX		X								26,315	11
12	Interest Income - Bldg. Co.		X								(1,636)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (71,036)	14
15	TOTALS (line 9+line14)						$ 9,295,200	$ 11,527,913			$ 613,726	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 42,868 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: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
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.)

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	273,146	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.)	$	253,605	2
3. Under or (over) accrual (line 2 minus line 1).	$	(19,541)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	259,221	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.**	$	16,861	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** $ 49,155 **For** 2003 **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.	$	256,541	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	251,098	8
2006	260,333	9
2007	257,554	10
2008	260,139	11
2009	246,877	12

2010 Accrual =$246,877 x 1.05 = $259,221

Allocated from ITEX = $6,728

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-007-0000	Long Term Care Property	$ 246,876.78	$ 246,876.78
2.	10-35-312-022-0000	Allocated From ITEX	$ 41,334.65	$ 7,243.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 288,211.43	$ 254,120.02

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 & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 600,000	1
2					2
3	TOTALS			$ 600,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	11,156		20			11,156	9
10	Various			1996	9,553		20	478	478	7,059	10
11	Various			1997	8,612		20	431	431	5,936	11
12	Various			1998	12,911		20	646	646	8,137	12
13	Various			1999	61,368		20	3,068	3,068	36,005	13
14	Various			2000	36,671		20	1,834	1,834	18,737	14
15	Various			2001	19,752		20	988	988	9,706	15
16	Various			2002	23,793		20	777	777	16,547	16
17	Various			2003	19,176		20	1,721	1,721	13,923	17
18	Various			2004	5,922		20	337	337	2,210	18
19	Various			2005	60,851		20	6,511	6,511	40,366	19
20	Various			2006	20,548		20	2,460	2,460	10,667	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Building Company (Pages 12F & 12G)		7,039,152	180,072		351,957	171,885	5,322,126	67
68	Related Party Allocations (Pages 12H & 12I)		382,381	9,966		10,862	896	206,154	68
69	Financial Statement Depreciation			194,222			(194,222)		69
70	TOTAL (lines 4 thru 69)		$ 7,711,847	$ 384,260		$ 382,068	$ (2,192)	$ 5,708,730	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: 01/01/10 Ending: 12/31/10

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	Totals from Page 12A, Carried Forward		$ 7,711,847	$ 384,260		$ 382,068	$ (2,192)	$ 5,708,730	1
2	Concrete To Main Entrance	2007	3,050		20	203	203	644	2
3	Japanese Garden Design In Lobby	2007	3,200		20	213	213	676	3
4	Landscaping For Tree Planting	2007	6,550		20	437	437	1,492	4
5	Wallpaper	2007	3,200		20	320	320	1,147	5
6	Wallpaper	2007	3,000		20	300	300	950	6
7	Additional Outlets, Wiring For Cable Tv	2007	7,500		20	750	750	2,938	7
8	Cameras/Monitors/Drive/Labor	2007	7,085		20	1,417	1,417	5,550	8
9	Wallcoverings	2007	6,620		20	1,324	1,324	4,744	9
10	Borders	2007	7,858		20	1,572	1,572	5,370	10
11	Curtains, Draperies, Cubicle Curtains (Resident Rooms)	2007	65,996		20	13,199	13,199	43,997	11
12	Draperies	2007	6,892		20	1,378	1,378	4,595	12
13	Cornice Boards	2007	28,717		20	2,872	2,872	9,333	13
14	Spool Borders, Swag Sets Sanboxs	2007	23,405		20	2,341	2,341	7,217	14
15	Drywall Repairs Post Wiring	2007	2,500		20	250	250	979	15
16	Lobby And Corridor Remodeling	2007	20,767		20	2,077	2,077	7,095	16
17	Lobby And Corridor Remodeling	2007	24,099		20	2,410	2,410	8,033	17
18	Lobby And Corridor Remodeling	2007	43,378		20	4,338	4,338	14,098	18
19	Down Payment- Lobby And Corridor Remodeling	2007	31,503		20	3,150	3,150	12,076	19
20	Pedimat Floor System And Delivery	2007	3,450		20	345	345	1,150	20
21	Nurses Station & Reception Station & Installation	2007	45,000		20	9,000	9,000	31,500	21
22	Refinish Elevators	2007	5,500		20	550	550	1,788	22
23	New Valve & Gasket	2007	2,689		20	134	134	459	23
24	Lobby Work	2007	17,824		20	1,782	1,782	5,496	24
25	Wallpaper Borders	2008	3,814		20	763	763	2,225	25
26	Wallpaper Borders	2008	1,250		20	250	250	729	26
27	Electrical Wiring	2008	10,000		20	2,000	2,000	5,500	27
28	Pt Room Cabinets	2008	12,700		20	2,540	2,540	7,408	28
29	Replacement Of Hot Water Heater (Downpayment)	2008	7,250		20	1,450	1,450	3,867	29
30	Relocate 9 Sprinkler Heads	2008	2,781		20	556	556	1,669	30
31	Ceilings & Walls Therapy, Office & Beauty Shop	2008	8,540		20	854	854	2,491	31
32	Ceilings Activity Room	2008	4,738		20	474	474	1,382	32
33	Ceilings Therapy Room	2008	6,290		20	629	629	1,835	33
34	TOTAL (lines 1 thru 33)		$ 8,138,994	$ 384,260		$ 441,946	$ 57,686	$ 5,907,161	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: 01/01/10 Ending: 12/31/10

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	Totals from Page 12B, Carried Forward		$ 8,138,994	$ 384,260		$ 441,946	$ 57,686	$ 5,907,161	1
2	Therapy & Activity Room Lighting	2008	8,285		20	829	829	2,416	2
3	Vending Room Flooring	2008	6,343		20	634	634	1,850	3
4	Activity Room Flooring	2008	7,446		20	745	745	2,172	4
5	Therapy Room Flooring	2008	7,843		20	784	784	2,287	5
6	Floors In New Rooms	2008	7,756		20	776	776	2,262	6
7	New Beauty Shop	2008	4,430		20	443	443	1,292	7
8	Doors & Frame Therapy Room	2008	4,900		20	490	490	1,307	8
9	Roof Patching	2008	2,700		20	270	270	630	9
10	Alarm Lighting & Sound	2008	2,627		20	263	263	701	10
11	Roofing	2009	45,683		20	4,568	4,568	7,233	11
12	Door Work, Flooring, Wiring	2009	15,782		20	395	395	559	12
13	Bedrooms And Bathrooms- Remove And Replace Flooring	2009	14,505		20	363	363	514	13
14	Roofing	2009	13,400		20	1,340	1,340	1,898	14
15	Entry And Lobby - New Slide Door , Electrical, Repair Roof	2009	15,782		20	395	395	493	15
16	Bedrooms & Bathrooms- Remove And Replace Flooring	2009	44,217		20	1,105	1,105	1,382	16
17	Wall Lavatories	2009	3,548		20	710	710	887	17
18	New Telephone Hub	2009	3,988		20	798	798	1,462	18
19	New Telephone Hub	2009	3,043		20	609	609	1,116	19
20	Voicemail System	2009	7,845		20	1,569	1,569	2,484	20
21	Office Carpeting	2009	6,532		20	933	933	1,244	21
22	Elevator Work	2009	4,190		20	105	105	175	22
23	Parking Lot Sealcoat	2009	2,550		20	128	128	213	23
24	Wall Signs	2009	3,878		20	194	194	226	24
25	Pedestal Sinks	2010	7,715		20	643	643	643	25
26	Radiator Assembly	2010	3,125		20	573	573	573	26
27	Cameras And Cctv Equipment	2010	2,590		20	216	216	216	27
28	Resident Room Improvements - Vinyl Tile Flooring - 17 Bedrooms	2010	29,798		20	1,242	1,242	1,242	28
29	Resident Rooms - Install New Wood Railing, 3Rd Floor Windows	2010	4,350		20	36	36	36	29
30	Telephone System	2010	38,594		20	3,216	3,216	3,216	30
31	Insulated Glass	2010	3,610		20	60	60	60	31
32	Built In Cabinets & Wardrobes	2010	34,640		20	2,598	2,598	2,598	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,500,690	$ 384,260		$ 468,973	$ 84,713	$ 5,950,548	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: 01/01/10 Ending: 12/31/10

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	Totals from Page 12C, Carried Forward		$ 8,500,690	$ 384,260		$ 468,973	$ 84,713	$ 5,950,548	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
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19									19
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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 (lines 1 thru 33)		$ 8,500,690	$ 384,260		$ 468,973	$ 84,713	$ 5,950,548	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: 01/01/10 Ending: 12/31/10

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	Totals from Page 12D, Carried Forward		$ 8,500,690	$ 384,260		$ 468,973	$ 84,713	$ 5,950,548	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)		$ 8,500,690	$ 384,260		$ 468,973	$ 84,713	$ 5,950,548	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: 01/01/10 Ending: 12/31/10

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	Building Company Information								1
2	Buildings:								2
3	Keiro Building LLC	1993	7,019,409	180,072	20	350,970	170,898	5,306,755	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Keiro Building LLC	1995	19,743		20	987	987	15,371	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.

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	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
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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)		$ 7,039,152	$ 180,072		$ 351,957	$ 171,885	$ 5,322,126	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: 01/01/10 Ending: 12/31/10

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from ITEX/AK Care	1993	294,022	7,539	35	8,401	862	147,710	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ITEX/AK Care	1993	36,996	194	20	1,850	1,656	32,754	9
10	Allocated from ITEX/AK Care	1994	19,872	517	20	994	477	16,176	10
11	Allocated from ITEX/AK Care	1995	3,387	9	20	169	160	2,573	11
12	Allocated from ITEX/AK Care	1996	192		20	10	10	144	12
13	Allocated from ITEX/AK Care	1997	5,713	146	20	286	140	3,856	13
14	Allocated from ITEX/AK Care	1999	634	16	20	32	16	381	14
15	Allocated from ITEX/AK Care	2005	2,778	160	20	(1,164)	(1,324)	746	15
16	Allocated from ITEX/AK Care	2007	3,439	116	20	(249)	(365)	560	16
17	Allocated from ITEX/AK Care	2008	13,108	336	20	433	97	1,118	17
18	Allocated from ITEX/AK Care	2009	714	18	20	71	53	107	18
19	Allocated from ITEX/AK Care	2010	1,526	915	20	29	(886)	29	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.

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	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
15									15
16									16
17									17
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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)		$ 382,381	$ 9,966		$ 10,862	$ 896	$ 206,154	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: 01/01/10 Ending: 12/31/10

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	$ 536,413	$ 2,017	$ 84,263	$ 82,246	10	$ 394,203	71
72	Current Year Purchases	36,390	911	2,618	1,707	10	2,618	72
73	Fully Depreciated Assets	230,163		517	517	10	230,163	73
74								74
75	TOTALS	$ 802,965	$ 2,928	$ 87,397	$ 84,469		$ 626,983	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	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,903,656	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 387,188	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 556,370	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 169,182	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,577,531	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.

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 29,985 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	Lexus	$ 779.00	$ 9,348	17
18					18
19					19
20					20
21	TOTAL		$ 779.00	$ 9,348	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$		$ 216,300	$		$ 216,300	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			31,556			31,556	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			330,213			330,213	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				366,339		366,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					7,689	118,222		125,911	13
14	TOTAL			$		$ 585,758	$ 484,561		$ 1,070,319	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

STATE OF ILLINOIS

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,737,168	$ 2,064,776	1
2	Cash-Patient Deposits	60,206	60,206	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	189,831	189,831	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	160,875	192,663	6
7	Other Prepaid Expenses	18,461	18,461	7
8	Accounts Receivable (owners or related parties)	1,066,438	1,066,438	8
9	Other(specify): See Attached Schedule	546,510	1,092,600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,779,489	$ 4,684,975	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	688,506	691,906	15
16	Equipment, at Historical Cost	1,042,392	1,965,875	16
17	Accumulated Depreciation (book methods)	(949,579)	(4,760,726)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	20,221	85,253	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(20,221)	(33,692)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 781,319	$ 5,568,025	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,560,808	$ 10,253,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 304,110	$ 316,110	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,195	58,195	28
29	Short-Term Notes Payable	3,000,000	3,001,554	29
30	Accrued Salaries Payable	453,225	453,225	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,431	27,431	31
32	Accrued Real Estate Taxes(Sch.IX-B)		259,221	32
33	Accrued Interest Payable	10,333	49,412	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	13,000	13,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule		149,778	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,866,294	$ 4,327,926	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,526,359	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)**	$	$ 8,526,359	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,866,294	$ 12,854,285	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 694,514	$ (2,601,285)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,560,808	$ 10,253,000	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 697,782	1
2	Restatements (describe):		2
3	To Accrue Est. State Replacement Tax	(4,500)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 693,282	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	301,232	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	(300,000)	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)**	$ 1,232	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)**	$ 694,514	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,764,831	1
2	Discounts and Allowances for all Levels	(1,288,153)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,476,678	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,229,993	6
7	Oxygen	40,008	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,270,001	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	4,528	13
14	Non-Patient Meals	558	14
15	Telephone, Television and Radio	4,290	15
16	Rental of Facility Space		16
17	Sale of Drugs	492,806	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,755	19
20	Radiology and X-Ray		20
21	Other Medical Services	128,565	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 716,502	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	95,715	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 95,715	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	51,989	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,989	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,610,885	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,862,058	31
32	Health Care	4,455,464	32
33	General Administration	2,299,537	33
	B. Capital Expense		
34	Ownership	1,456,360	34
	C. Ancillary Expense		
35	Special Cost Centers	1,137,684	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,309,653	40
41	**Income before Income Taxes (line 30 minus line 40)****	301,232	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 301,232	43

* **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: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,832	2,085	$ 112,047	$ 53.74	1
2	Assistant Director of Nursing	1,933	2,082	73,471	35.29	2
3	Registered Nurses	42,821	50,314	1,337,662	26.59	3
4	Licensed Practical Nurses	23,157	27,626	669,538	24.24	4
5	CNAs & Orderlies	105,570	119,925	1,248,795	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,964	8,919	137,979	15.47	8
9	Activity Director	3,772	4,159	65,759	15.81	9
10	Activity Assistants	6,721	7,373	76,354	10.36	10
11	Social Service Workers	11,816	11,657	283,390	24.31	11
12	Dietician					12
13	Food Service Supervisor	4,652	5,146	86,466	16.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,047	35,158	353,936	10.07	15
16	Dishwashers					16
17	Maintenance Workers	6,037	6,590	80,055	12.15	17
18	Housekeepers	30,182	32,131	355,497	11.06	18
19	Laundry	9,841	10,735	114,095	10.63	19
20	Administrator	1,856	2,096	79,086	37.73	20
21	Assistant Administrator					21
22	Other Administrative	1,444	1,543	36,484	23.64	22
23	Office Manager	2,692	2,834	34,890	12.31	23
24	Clerical	8,357	9,424	159,987	16.98	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	3,707	4,068	53,337	13.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,121	2,356	63,274	26.86	33
34	TOTAL (lines 1 - 33)	308,522	346,221	$ 5,422,102 *	$ 15.66	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,318	01-03	35
36	Medical Director	Monthly	122,139	09-03	36
37	Medical Records Consultant	Monthly	4,416	10-03	37
38	Nurse Consultant	Monthly	7,413	10-03	38
39	Pharmacist Consultant	Monthly	9,210	10-03	39
40	Physical Therapy Consultant	Monthly	1,080	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	5,876	10a-03	43
44	Activity Consultant	Monthly	2,544	11-03	44
45	Social Service Consultant	Monthly	4,990	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 168,986		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				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.

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Kolovitz	Former Admin.	0.00%	$ 34,988
Christopher John Kropp	Administrator	0.00%	44,099
Joanna Castro	Former VP Operations	0.00%	4,849
Ian Crook	VP Operations	0.00%	31,635
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,570

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	$ 34,529
Personnel Planners	Unemployment Consulting	2,574
AK Care	Centralized Bookkeeping	149,000
See Attached	Legal	53,493
ADL Data Systems	Data Processing	4,750
PSD Solutions	Data Processing	5,005
AK Care	Data Processing	3,049
E-Health Data Solutions	Data Processing	4,975
Giftrap Corp	Computer Consulting	7,290
M L Enterprises	Purchasing Consultant	1,500
Healthcare Horizons	Admin Consult (Adj. Pg 5A)	4,400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 270,565

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,735
Unemployment Compensation Insurance	36,883
FICA Taxes	406,117
Employee Health Insurance	371,758
Employee Meals	58,619
Illinois Municipal Retirement Fund (IMRF)*	
Christmas Expense	511
Pension Expense	66,204
Chicago Head Tax	9,368
401K Expense	9,576
Other Employee Benefits	1,062
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,036,832

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	48,640
Health Care Worker Background Check	4,925
(Indicate # of checks performed 492)	
Patient Background Checks	
Advertising & Public Relations	123,767
Dues & Subscriptions	7,729
Association Dues	18,360
Licenses	3,575
See Supplemental Schedule	2,312
Less: Public Relations Expense	(120,531)
Non-allowable advertising	(2,682)
Yellow page advertising	(554)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 85,541

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,401
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,401

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ILCLTC - $16,200**

(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. $ **47,376** 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. $ **558**

(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.