

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>180</u>	Skilled (SNF)	<u>180</u>	<u>65,700</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,700</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>31,760</u>	<u>6,259</u>	<u>9,404</u>	<u>47,423</u>	8
9	SNF/PED					9
10	ICF	<u>11,461</u>	<u>1,506</u>	<u>915</u>	<u>13,882</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,221</u>	<u>7,765</u>	<u>10,319</u>	<u>61,305</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.31%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 12/14/1994

J. Was the facility purchased or leased after January 1, 1978?

YES Date 5/25/1994 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 180 and days of care provided 8,899

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	405,359	98,500	7,811	511,670		511,670	3,237	514,907		1
2	Food Purchase		297,960		297,960	(53,400)	244,561	(1,279)	243,281		2
3	Housekeeping	332,738	30,898		363,636		363,636	9,047	372,683		3
4	Laundry	96,086	21,647		117,733		117,733		117,733		4
5	Heat and Other Utilities			240,649	240,649		240,649	1,718	242,367		5
6	Maintenance	65,330	24,883	105,733	195,946		195,946	(302)	195,644		6
7	Other (specify):*										7
8	TOTAL General Services	899,513	473,888	354,193	1,727,594	(53,400)	1,674,195	12,421	1,686,615		8
	B. Health Care and Programs										
9	Medical Director			60,000	60,000		60,000		60,000		9
10	Nursing and Medical Records	2,775,449	206,980	55,156	3,037,585		3,037,585	(15,327)	3,022,258		10
10a	Therapy	273,871		2,834	276,705		276,705		276,705		10a
11	Activities	128,052	14,392	2,432	144,876		144,876		144,876		11
12	Social Services	246,995		6,161	253,156		253,156		253,156		12
13	CNA Training										13
14	Program Transportation			420	420		420		420		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,424,367	221,372	127,003	3,772,742		3,772,742	(15,327)	3,757,415		16
	C. General Administration										
17	Administrative	136,524		58,000	194,524		194,524	13,301	207,825		17
18	Directors Fees										18
19	Professional Services			566,139	566,139		566,139	(389,221)	176,918		19
20	Dues, Fees, Subscriptions & Promotions			129,820	129,820		129,820	(94,552)	35,268		20
21	Clerical & General Office Expenses	229,237	4,972	333,262	567,471		567,471	27,361	594,832		21
22	Employee Benefits & Payroll Taxes			882,647	882,647	53,400	936,047		936,047		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,915	7,915		7,915	882	8,797		24
25	Other Admin. Staff Transportation			5,528	5,528		5,528	(622)	4,906		25
26	Insurance-Prop.Liab.Malpractice			278,451	278,451		278,451	788	279,239		26
27	Other (specify):*							86,792	86,792		27
28	TOTAL General Administration	365,761	4,972	2,261,762	2,632,495	53,400	2,685,895	(355,271)	2,330,624		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,689,641	700,232	2,742,958	8,132,831		8,132,831	(358,177)	7,774,654		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			91,580	91,580	91,580	381,039	472,619			30
31	Amortization of Pre-Op. & Org.						24	24			31
32	Interest			264,302	264,302	264,302	395,245	659,547			32
33	Real Estate Taxes						314,214	314,214			33
34	Rent-Facility & Grounds			952,650	952,650	952,650	(952,650)				34
35	Rent-Equipment & Vehicles			30,032	30,032	30,032	2,079	32,111			35
36	Other (specify):*			531	531	531	46,485	47,016			36
37	TOTAL Ownership			1,339,095	1,339,095	1,339,095	186,436	1,525,531			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	185,830	440,090	241,674	867,594	867,594		867,594			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			98,550	98,550	98,550		98,550			42
43	Other (specify):*	59,489			59,489	59,489	(59,489)				43
44	TOTAL Special Cost Centers	245,319	440,090	340,224	1,025,633	1,025,633	(59,489)	966,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,934,960	1,140,322	4,422,277	10,497,559	10,497,559	(231,231)	10,266,328			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: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(902)	02		4
5	Telephone, TV & Radio in Resident Rooms	(23,082)	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	191,095	30		9
10	Interest and Other Investment Income	(120,977)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(377)	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	(266)	21		18
19	Entertainment				19
20	Contributions	(20,204)	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	(136,411)	21		24
25	Fund Raising, Advertising and Promotional	(5,807)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(355,036)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (471,968)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	240,737		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 240,737		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (231,231)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Sch. V Line
	Reference	
1	Telephone Commissions	(5,790) 21
2	Veteran Expenses - Misc	(415) 10
3	Veteran Expenses - Pharmacy	(14,860) 10
4	Bank Charges	(3,585) 21
5	Public Relations	(70,464) 20
6	Duty Duty Income	(52) 10
7	Non-Allowable Professional Fees	(4,400) 19
8	Out of State Seminars	(754) 24
9	Accounting Fees - Bldg. Co	(11,441) 19
10	Franchise Tax/LLC Fee - Bldg. Co	(250) 20
11	Misc. Income	(20) 21
12	Marketing Salary	(59,489) 43
13	Collection salary	(18,244) 21
14	Non-Allowable Auto & Travel	(622) 28
15	Non-Allowable Legal Fees	(34,434) 19
16	Non-Allowable Expense	(125,000) 21
17	Capitalized R&M	(5,489) 06
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101	Total	(355,036) 101

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/07

Ending:

12/31/07**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	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)	
	A. General Services													
1	Dietary				3,237								3,237	1
2	Food Purchase	(1,279)											(1,279)	2
3	Housekeeping				9,047								9,047	3
4	Laundry													4
5	Heat and Other Utilities				1,718								1,718	5
6	Maintenance	(5,489)			5,187								(302)	6
7	Other (specify):*													7
8	TOTAL General Services	(6,768)			19,189								12,421	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,327)											(15,327)	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	(15,327)											(15,327)	16
	C. General Administration													
17	Administrative						13,301						13,301	17
18	Directors Fees													18
19	Professional Services	(50,272)	11,441		(320,679)		(29,711)						(389,221)	19
20	Fees, Subscriptions & Promotions	(96,725)	250		1,898		25						(94,552)	20
21	Clerical & General Office Expenses	(312,308)			339,066		603						27,361	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(574)			1,456								882	24
25	Other Admin. Staff Transportation	(622)											(622)	25
26	Insurance-Prop.Liab.Malpractice				788								788	26
27	Other (specify):*				84,162		2,630						86,792	27
28	TOTAL General Administration	(460,501)	11,691		106,691		(13,152)						(355,271)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(482,596)	11,691		125,880		(13,152)						(358,177)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	191,095	180,072		9,872								381,039	30
31	Amortization of Pre-Op. & Org.				24								24	31
32	Interest	(120,977)	493,211		23,011								395,245	32
33	Real Estate Taxes		306,019		8,195								314,214	33
34	Rent-Facility & Grounds		(952,650)										(952,650)	34
35	Rent-Equipment & Vehicles				2,079								2,079	35
36	Other (specify):*		46,485										46,485	36
37	TOTAL Ownership	70,118	73,137		43,181								186,436	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):*	(59,489)											(59,489)	43
44	TOTAL Special Cost Centers	(59,489)											(59,489)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(471,968)	84,828		169,061		(13,152)						(231,231)	45

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		Keiro Building LLC		Building Co.
				See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 952,650	Keiro Building LLC		\$	\$ (952,650)	1
2	V	32 Interest	3,348	Keiro Building LLC		5,143	1,795	2
3	V	20 Franchise Tax/LLC Fee		Keiro Building LLC		250	250	3
4	V	36 MIP Insurance		Keiro Building LLC		44,627	44,627	4
5	V	33 Legal Fees - Protest R/E Taxes		Keiro Building LLC		35,989	35,989	5
6	V	19 Accounting		Keiro Building LLC		11,441	11,441	6
7	V	32 Mortgage Interest		Keiro Building LLC		491,416	491,416	7
8	V	33 Real Estate Taxes		Keiro Building LLC		270,030	270,030	8
9	V	30 Depreciation		Keiro Building LLC		180,072	180,072	9
10	V	36 Amortization		Keiro Building LLC		1,858	1,858	10
11	V	Real Estate Tax Refund (2004)	63,103	Keiro Building LLC			(63,103)	11
12	V							12
13	V							13
14	Total		\$ 1,019,101			\$ 1,040,826	\$ * 21,725	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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.

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1		ITEX / AK CARE COMPANY	100.00%	\$ 3,237	\$ 3,237	15
16	V	3		ITEX / AK CARE COMPANY		9,047	9,047	16
17	V	5		ITEX / AK CARE COMPANY		1,718	1,718	17
18	V	6		ITEX / AK CARE COMPANY		5,187	5,187	18
19	V	19		ITEX / AK CARE COMPANY		6,381	6,381	19
20	V	20		ITEX / AK CARE COMPANY		1,898	1,898	20
21	V	21		ITEX / AK CARE COMPANY		21,702	21,702	21
22	V	24		ITEX / AK CARE COMPANY		1,456	1,456	22
23	V	26		ITEX / AK CARE COMPANY		788	788	23
24	V	30		ITEX / AK CARE COMPANY		9,872	9,872	24
25	V	31		ITEX / AK CARE COMPANY		24	24	25
26	V	32		ITEX / AK CARE COMPANY		23,011	23,011	26
27	V	33		ITEX / AK CARE COMPANY		8,195	8,195	27
28	V	35		ITEX / AK CARE COMPANY		2,079	2,079	28
29	V							29
30	V							30
31	V							31
32	V	21		ITEX / AK CARE COMPANY		317,364	317,364	32
33	V	27		ITEX / AK CARE COMPANY		84,162	84,162	33
34	V							34
35	V	19	327,060	ITEX / AK CARE COMPANY			(327,060)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 327,060			\$ 496,121	\$ * 169,061	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 13,301	\$ 13,301	15
16	V	19 PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		(199)	(199)	16
17	V	20 DUES AND SUBSCRIPRTIONS		CAREPATH HEALTH NETWORK		25	25	17
18	V	21 CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		603	603	18
19	V	27 GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		2,630	2,630	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	19 BOOKKEEPING FEES	29,512	CAREPATH HEALTH NETWORK			(29,512)	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		\$ 29,512			\$ 16,360	\$ * (13,152)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Harmony Nursing & Rehab Center # 0040535 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	Owner	Administrative	28.67%	See Attached	11.00	16.92%		\$		1
2	Jack Rajchenbach	Owner	Administrative	28.67%	See Attached	4.00	6.15%				2
3	Mark Hollander	Owner	Administrative	9.56%	See Attached	23.00	38.33%	Mgmt. Fee	58,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 58,000		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	412,656	5	\$ 20,328	\$ 65,700	\$ 3,237	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	412,656	5	56,825	65,700	9,047	2
3	5	UTILITIES	AVAILABLE BED DAYS	412,656	5	10,791	65,700	1,718	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	412,656	5	32,579	65,700	5,187	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	412,656	5	40,078	65,700	6,381	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	412,656	5	11,921	65,700	1,898	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	412,656	5	136,311	65,700	21,702	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	412,656	5	9,145	65,700	1,456	8
9	26	INSURANCE	AVAILABLE BED DAYS	412,656	5	4,952	65,700	788	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	412,656	5	62,006	65,700	9,872	10
11	31	AMORTIZATION	AVAILABLE BED DAYS	412,656	5	152	65,700	24	11
12	32	INTEREST	AVAILABLE BED DAYS	412,656	5	144,533	65,700	23,011	12
13	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	412,656	5	51,475	65,700	8,195	13
14	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	412,656	5	13,061	65,700	2,079	14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	1,004,580	1,004,580	317,364	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	266,404		84,162	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,865,141	\$ 1,004,580	\$ 496,121	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	CARE PATH FEES	388,800	9	\$ 175,237	\$ 175,237	29,512	\$ 13,301	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	388,800	9	(2,628)		29,512	(199)	2
3	20	DUES AND SUBSCRIPRTIONS	CARE PATH FEES	388,800	9	332		29,512	25	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	388,800	9	7,946		29,512	603	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	388,800	9	34,646		29,512	2,630	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					\$ 215,533	\$ 175,237		\$ 16,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Cambridge		X	Mortgage	\$49,917.00	10/1/03	\$ 9,295,200	\$ 8,897,667	10/1/38	5.5000	\$ 496,559	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Bank One		X	Line of Credit				2,629,505			258,924	6								
7	Insurance Financing		X								5,378	7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related				\$49,917.00		\$ 9,295,200	\$ 11,527,172			\$ 760,861	9								
B. Non-Facility Related*																				
10	Interest Income		X								(120,977)	10								
11	Interest Income - Bldg Co		X								(3,348)	11								
12	Alloc. From ITEX/AK Care		X								23,011	12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(101,314)	14								
15	TOTALS (line 9+line14)						\$ 9,295,200	\$ 11,527,172			\$ 659,547	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,627 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: 01/01/07 Ending: 12/31/07

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 263,653	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.)		\$ 304,517	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 40,864	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 273,350	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>63,103</u> For <u>2004</u> 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.		\$ 314,214	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>340,956</u>	8
	2003	<u>346,353</u>	9
	2004	<u>309,791</u>	10
	2005	<u>251,098</u>	11
	2006	<u>260,333</u>	12
<u>2007 accruals = \$260,333 x 1.05 = \$273,350</u>			
<u>Alloc. From IteX/AK Care \$8,195.43 Included in line 2</u>			
<u>Did not offset the Real Estate Tax Refund since it did not relate to a tax bill used to set the R/E Tax Reimb. Rate</u>			
<u>Line 2 includes Allocation from IteX/AK Care and legal fees to protest taxes \$35,989</u>			
		FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY 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 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 24 4. Dates Incurred: _____

Nature of Costs: Allocation from ITEX/AK Care
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			1994	11,156		20	621	621	8,041	9
10	Various			1996	9,553		20	477	477	5,627	10
11	Various			1997	8,612		20	431	431	4,645	11
12	Various			1998	12,911		20	646	646	6,202	12
13	Various			1999	61,368		20	3,068	3,068	26,802	13
14	Various			2000	36,671		20	1,833	1,833	13,237	14
15	Various			2001	21,772		20	1,089	1,089	6,912	15
16	Various			2002	28,919		20	1,944	1,944	15,793	16
17	Various			2003	24,492		20	2,482	2,482	11,226	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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		7,039,152	180,072		351,958	171,886	4,266,255	67
68		318,802	8,181		10,672	2,491	147,206	68
69			91,580			(91,580)		69
70		\$ 7,573,408	\$ 279,833		\$ 375,221	\$ 95,388	\$ 4,511,946	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,573,408	\$ 279,833		\$ 375,221	\$ 95,388	\$ 4,511,946	1
2	Concrete Sidewalk And Gate	2004	2,457		20	164	164	573	2
3	Replaced Smoke Detector	2004	1,510		20	76	76	302	3
4	Generator Repair	2004	846		20	42	42	162	4
5	Fixed Water Line	2004	1,375		20	69	69	258	5
6	Pump & Motor	2004	726		20	36	36	136	6
7	Replaced Pilot On Water Boiler	2004	523		20	26	26	96	7
8	Installed 2 Reversing Contactors	2004	1,069		20	53	53	178	8
9	Relocated Smoke Detector	2004	1,441		20	72	72	240	9
10	Replaced Smoke Detector	2004	514		20	26	26	84	10
11	Pump	2004	885		20	44	44	144	11
12	Adjusted Door Release	2004	607		20	30	30	96	12
13	Nurse Call System Repair	2004	770		20	39	39	125	13
14	Nurse Call System Repair	2004	678		20	34	34	110	14
15	Replaced Lamps & Photo Cells	2004	794		20	40	40	122	15
16	Circuit Breaker	2005	2,750		20	183	183	436	16
17	Bathroom Door	2005	4,110		20	822	822	2,123	17
18	Bathroom Door	2005	672		20	134	134	303	18
19	Walk In Cooler - Gasket & Heater Wire Repairs	2005	991		20	198	198	496	19
20	Walk In Freezer	2005	901		20	180	180	436	20
21	Walk In Freezer	2005	765		20	153	153	447	21
22	Fluid Pump Service - Need Invoice	2005	2,234		20	149	149	317	22
23	Kroeschell Engineering - Need Invoice	2005	3,812		20	254	254	540	23
24	Kroeschell Engineering	2005	1,104		20	74	74	156	24
25	Alarm Bell	2005	3,638		20	728	728	1,880	25
26	Smoke Detectors	2005	21,247		20	3,035	3,035	7,588	26
27	Taylor Plumbing - Need Invoice	2005	909		20	182	182	379	27
28	Windows	2005	2,888		20	193	193	409	28
29	Amc Electric Bill	2005	19,500		20	1,950	1,950	5,363	29
30	Repairs To Driveway And Parking	2006	9,750		20	975	975	1,544	30
31	Air Damper Motor	2006	827		20	165	165	207	31
32	Heat Exchanger	2006	4,051		20	810	810	1,013	32
33	Water Heater Parts	2006	585		20	117	117	146	33
34	TOTAL (lines 1 thru 33)		\$ 7,668,337	\$ 279,833		\$ 386,274	\$ 106,441	\$ 4,538,355	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,668,337	\$ 279,833		\$ 386,274	\$ 106,441	\$ 4,538,355	1
2	Window Replacements	2006	6,747		20	675	675	731	2
3	Concrete To Main Entrance	2007	3,050		20	34	34	34	3
4	Japanese Garden Design In Lobby	2007	3,200		20	36	36	36	4
5	Landscaping For Tree Planting	2007	6,550		20	182	182	182	5
6	Wallpaper	2007	3,200		20	187	187	187	6
7	Wallpaper	2007	3,000		20	50	50	50	7
8	Additional Outlets, Wiring For Cable Tv	2007	7,500		20	688	688	688	8
9	Cameras/Monitors/Drive/Labor	2007	7,085		20	1,299	1,299	1,299	9
10	Wallcoverings	2007	6,620		20	772	772	772	10
11	Borders	2007	7,858		20	655	655	655	11
12	Curtains, Draperies, Cubicle Curtains (Resident Rooms)	2007	65,996		20	4,400	4,400	4,400	12
13	Draperies	2007	6,892		20	459	459	459	13
14	Cornice Boards	2007	28,717		20	718	718	718	14
15	Spool Borders, Swag Sets Sanboxes	2007	23,405		20	195	195	195	15
16	Drywall Repairs Post Wiring	2007	2,500		20	229	229	229	16
17	Lobby And Corridor Remodeling	2007	20,767		20	865	865	865	17
18	Lobby And Corridor Remodeling	2007	24,099		20	803	803	803	18
19	Lobby And Corridor Remodeling	2007	43,378		20	1,084	1,084	1,084	19
20	Down Payment- Lobby And Corridor Remodeling	2007	35,000		20	2,625	2,625	2,625	20
21	Pedimat Floor System And Delivery	2007	3,450		20	115	115	115	21
22	Nurses Station & Reception Station & Installation	2007	45,000		20	4,500	4,500	4,500	22
23	Refinish Elevators	2007	5,500		20	138	138	138	23
24	Lobby Wallpaper	2007	1,710		20	86	86	86	24
25	New Valve & Gasket Replace	2007	2,689		20	134	134	134	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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11									11
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24									24
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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19									19
20									20
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12E, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12F, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12G, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12H, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12I, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12J, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12K, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12L, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12M, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12N, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12O, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

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 12P, Carried Forward		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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)		\$ 8,032,250	\$ 279,833		\$ 407,203	\$ 127,370	\$ 4,559,340	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	180		1994	1993	\$ 7,019,409	\$ 179,985	20	\$ 350,971	\$ 170,986	\$ 4,253,845	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10	Keiro Building LLC			1995	19,743	87	20	987	900	12,410	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
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				
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54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	7,039,152	\$	180,072	\$	351,958	\$	171,886	\$	4,266,255	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	Alloc. From ITEX - AK Care		1993	1993	\$ 255,385	\$ 6,548	35	\$ 7,297	\$ 749	\$ 106,410	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Alloc. From ITEX - AK Care			1993	32,135	388	20	1,607	1,219	23,630	10
11	Alloc. From ITEX - AK Care			1994	17,260	449	20	863	414	11,462	11
12	Alloc. From ITEX - AK Care			1995	2,942	8	20	147	139	1,794	12
13	Alloc. From ITEX - AK Care			1996	167	-	20	8	8	100	13
14	Alloc. From ITEX - AK Care			1997	4,962	127	20	248	121	2,605	14
15	Alloc. From ITEX - AK Care			1999	551	14	20	28	14	248	15
16	Alloc. From ITEX - AK Care			2005	2,413	579	20	392	(187)	875	16
17	Alloc. From ITEX - AK Care			2007	2,987	68	20	82	14	82	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
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								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	318,802	\$	8,181	\$	10,672	\$	2,491	\$	147,206	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: 01/01/07 Ending: 12/31/07

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	\$ 374,975	\$ 1,068	\$ 52,382	\$ 51,314	10	\$ 230,486	71
72	Current Year Purchases	133,661	623	12,309	11,686	10	12,309	72
73	Fully Depreciated Assets	1,015,104		725	725	10	1,015,104	73
74								74
75	TOTALS	\$ 1,523,740	\$ 1,691	\$ 65,416	\$ 63,725		\$ 1,257,899	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)	\$ 10,155,990	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 281,524	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 472,619	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 191,095	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,817,239	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 24,395 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	2006 Lexus	\$ 698.00	\$ 2,128	17
18	Facility	2007 Acura	895.00	5,588	18
19					19
20					20
21	TOTAL		\$ #####	\$ 7,716	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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

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

	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 - 01	hrs	\$ 66,526		\$ 142,233	\$		\$ 208,759	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	55,014		11,624			66,638	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	64,290		83,819			148,109	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 prescripts				326,469		326,469	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					3,998	113,621		117,619	13
14	TOTAL			\$ 185,830		\$ 241,674	\$ 440,090		\$ 867,594	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 777,815	\$ 1,001,186	1
2	Cash-Patient Deposits	40,599	40,599	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,266,258	1,266,258	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	175,035	208,197	6
7	Other Prepaid Expenses	26,647	26,647	7
8	Accounts Receivable (owners or related parties)	1,325,299	1,325,299	8
9	Other(specify): <u>See Attached Schedule</u>	341,856	1,166,276	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,953,509	\$ 5,034,462	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	386,267	389,667	15
16	Equipment, at Historical Cost	702,227	1,625,710	16
17	Accumulated Depreciation (book methods)	(425,750)	(3,696,681)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,657	67,689	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,020)	(9,917)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 663,381	\$ 5,995,877	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,616,890	\$ 11,030,339	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,168,436	\$ 1,218,658	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,629,505	2,641,903	29
30	Accrued Salaries Payable	378,644	378,644	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,404	29,404	31
32	Accrued Real Estate Taxes(Sch.IX-B)		273,350	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	41,808	41,808	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,247,797	\$ 4,583,767	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,885,269	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,885,269	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,247,797	\$ 13,469,036	46
47	TOTAL EQUITY (page 18, line 24)	\$ 369,093	\$ (2,438,697)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,616,890	\$ 11,030,339	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 296,401	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 296,401	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	72,692	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 72,692	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)	\$ 369,093	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center# 0040535Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,612,052	1
2	Discounts and Allowances for all Levels	18,781	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,630,833	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,125,978	6
7	Oxygen	32,370	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,158,348	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	271	13
14	Non-Patient Meals	902	14
15	Telephone, Television and Radio	28,862	15
16	Rental of Facility Space		16
17	Sale of Drugs	422,363	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	71,672	19
20	Radiology and X-Ray		20
21	Other Medical Services	135,946	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 660,016	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	120,982	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 120,982	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	72	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 72	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,570,251	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,727,594	31
32	Health Care	3,772,742	32
33	General Administration	2,632,495	33
B. Capital Expense			
34	Ownership	1,339,095	34
C. Ancillary Expense			
35	Special Cost Centers	927,083	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)*	\$ 10,497,559	40
41	Income before Income Taxes (line 30 minus line 40)**	72,692	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 72,692	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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:

01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,080	\$ 80,761	\$ 38.83	1
2	Assistant Director of Nursing	1,752	1,784	61,474	34.46	2
3	Registered Nurses	34,794	37,724	939,947	24.92	3
4	Licensed Practical Nurses	16,389	17,611	416,877	23.67	4
5	CNAs & Orderlies	103,803	110,732	1,145,684	10.35	5
6	CNA Trainees					6
7	Licensed Therapist	4,564	5,378	185,830	34.55	7
8	Rehab/Therapy Aides	12,761	14,609	273,871	18.75	8
9	Activity Director	3,839	4,176	64,973	15.56	9
10	Activity Assistants	5,868	6,706	63,079	9.41	10
11	Social Service Workers	12,641	13,956	246,995	17.70	11
12	Dietician					12
13	Food Service Supervisor	4,653	5,145	84,895	16.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,830	33,908	320,464	9.45	15
16	Dishwashers					16
17	Maintenance Workers	5,328	5,672	65,330	11.52	17
18	Housekeepers	28,598	31,422	332,738	10.59	18
19	Laundry	9,622	11,232	96,086	8.55	19
20	Administrator	1,944	2,160	100,802	46.67	20
21	Assistant Administrator					21
22	Other Administrative	1,178	1,307	35,722	27.33	22
23	Office Manager					23
24	Clerical	13,984	15,118	229,237	15.16	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	6,269	6,660	130,706	19.63	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,179	2,410	59,489	24.68	33
34	TOTAL (lines 1 - 33)	303,916	329,790	\$ 4,934,960 *	\$ 14.96	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 7,811	01-03	35
36	Medical Director	Monthly	60,000	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	44,214	10-03	38
39	Pharmacist Consultant	Monthly	6,718	10-03	39
40	Physical Therapy Consultant	Monthly	770	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	2,064	10a-03	43
44	Activity Consultant	Monthly	2,432	11-03	44
45	Social Service Consultant	52	6,161	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	52	\$ 134,394		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing & Rehab Center

0040535

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Sanghio, John Marc	Administrator	0	\$ 100,802	Workers' Compensation Insurance	\$ 84,068	IDPH License Fee	\$		
Castro, Joanna	VP operations	0	35,722	Unemployment Compensation Insurance	69,982	Advertising: Employee Recruitment	16,819		
				FICA Taxes	370,453	Health Care Worker Background Check	1,698		
				Employee Health Insurance	283,589	(Indicate # of checks performed <u>170</u>)			
				Employee Meals	53,400	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues	10,763		
				Head Tax	8,428	Dues & Subscriptions	1,292		
				401K Contributions	9,225	Licenses	2,553		
				Misc. Employee Benefits	5,375	Permits	220		
				Savings Plan	42,702	See Supplemental Schedule	1,923		
				Christmas Expense	8,825	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 136,524				\$ 936,047			\$ 35,268		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Mangement Fee - Mark Hollander			\$ 58,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		7,341
\$ 58,000				\$			Alloc. From ITEX/AK Care		1,456
C. Professional Services							Entertainment Expense		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
Frost, Ruttenberg & Rothblatt	Accounting		\$ 19,888				TOTAL		\$ 8,797
AK Care	Admin. Consultant		35,100						
Personnel Planners	Unemployment Consult.		1,224						
Power Software Development	Data Processing		14,424						
Carepath	Bookkeeping		29,512						
AK Care	Bookkeeping		291,960						
Healthcare Horizon	Data Processing (adj page 5)		4,400						
Giftwrap	Data Processing		9,479						
RCE	Energy Consultant		750						
See Attached	Legal		159,402						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					
\$ 566,139				\$					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Harmony Nursing & Rehab Center

Report Period Beginning: 01/01/07 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$10,763
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,923 Line 10
- (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. _____
- (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.

- (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. \$ 53,400 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 902
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 1
- 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? N/A
- 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT