

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	27,595	6,821	11,976	46,392	8
9	SNF/PED					9
10	ICF	13,384	6		13,390	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,979	6,827	11,976	59,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

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 6,936

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	398,161	83,459	15,818	497,438		497,438	4,707	502,145		1
2	Food Purchase		482,040		482,040	(87,929)	394,112	(1,557)	392,555		2
3	Housekeeping	433,213	48,553		481,766		481,766	6,527	488,293		3
4	Laundry	75,037	44,022		119,059		119,059		119,059		4
5	Heat and Other Utilities			264,936	264,936		264,936	(4,059)	260,877		5
6	Maintenance	81,427	59,717	122,716	263,860		263,860	11,766	275,626		6
7	Other (specify):*										7
8	TOTAL General Services	987,838	717,791	403,470	2,109,099	(87,929)	2,021,171	17,384	2,038,555		8
	B. Health Care and Programs										
9	Medical Director			170,317	170,317		170,317	(16,716)	153,601		9
10	Nursing and Medical Records	3,796,690	326,438	77,156	4,200,284		4,200,284	(51,888)	4,148,396		10
10a	Therapy	128,876			128,876		128,876		128,876		10a
11	Activities	144,384	12,950	7,221	164,555		164,555		164,555		11
12	Social Services	231,894		28,658	260,552		260,552		260,552		12
13	CNA Training										13
14	Program Transportation			13,915	13,915		13,915	(9)	13,906		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,301,844	339,388	297,267	4,938,499		4,938,499	(68,613)	4,869,886		16
	C. General Administration										
17	Administrative	122,511		33,000	155,511		155,511		155,511		17
18	Directors Fees										18
19	Professional Services			548,063	548,063	(560)	547,503	(396,669)	150,834		19
20	Dues, Fees, Subscriptions & Promotions			146,104	146,104		146,104	(106,799)	39,305		20
21	Clerical & General Office Expenses	214,875	14,140	445,375	674,390		674,390	55,326	729,716		21
22	Employee Benefits & Payroll Taxes			1,059,431	1,059,431	87,929	1,147,360		1,147,360		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,452	4,452		4,452	(164)	4,288		24
25	Other Admin. Staff Transportation			240	240		240		240		25
26	Insurance-Prop.Liab.Malpractice			272,471	272,471		272,471	2,034	274,505		26
27	Other (specify):*							104,922	104,922		27
28	TOTAL General Administration	337,386	14,140	2,509,136	2,860,662	87,368	2,948,030	(341,350)	2,606,680		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,627,068	1,071,319	3,209,873	9,908,260	(560)	9,907,700	(392,579)	9,515,121		29

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

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

Facility Name & ID Number

Harmony Nursing & Rehab Ctr

#0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			157,048	157,048		157,048	354,911	511,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,189	162,189		162,189	209,202	371,391			32
33	Real Estate Taxes					560	560	303,474	304,034			33
34	Rent-Facility & Grounds			851,700	851,700		851,700	(851,700)				34
35	Rent-Equipment & Vehicles			40,939	40,939		40,939	1,839	42,778			35
36	Other (specify):*							48,450	48,450			36
37	TOTAL Ownership			1,211,876	1,211,876	560	1,212,436	66,176	1,278,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		548,732	903,668	1,452,400		1,452,400		1,452,400			39
40	Barber and Beauty Shops			3,665	3,665		3,665	(3,665)	(0)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			417,585	417,585		417,585		417,585			42
43	Other (specify):*	105,432		2,578	108,010		108,010	(108,010)	0			43
44	TOTAL Special Cost Centers	105,432	548,732	1,327,496	1,981,660		1,981,660	(111,675)	1,869,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,732,500	1,620,051	5,749,245	13,101,796	0	13,101,796	(438,078)	12,663,718			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		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	(1,009)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,433)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	162,086	30		9
10	Interest and Other Investment Income	(121,904)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(548)	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	(2,121)	21		18
19	Entertainment				19
20	Contributions	(16,349)	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	(152,705)	21		24
25	Fund Raising, Advertising and Promotional	(84,888)	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	(401,117)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (625,988)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	187,910		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 187,910		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (438,078)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Additional R&M	\$ 6,036	06	1
2	Veterans Expense	(25,582)	10	2
3	Patient Purchases	(26,254)	10	3
4	Bank Charges	(9,098)	21	4
5	Franchise Tax	(100)	21	5
6	Barber and Beauty Shop Income	(3,665)	40	6
7	Telephone Commissions	(2,720)	21	7
8	State of Illinois Income	(80)	21	8
9	Jury Duty	(52)	10	9
10	Marketing Salary	(83,076)	43	10
11	Collections Salary	(22,356)	43	11
12	COPE Dues	(6,237)	20	12
13	Non-Allowable Professional Fees	(4,000)	19	13
14	Non-Allowable Legal	(14,838)	19	14
15	Non-Allowable Seminars	(280)	24	15
16	Building Company - Franchise Tax	(250)	21	16
17	Building Company - Office Expense	(39)	21	17
18	Building Company - Accounting	(16,048)	19	18
19	Building Company - Amortization of Loan Costs	(3,615)	19	19
20	Junk Fax Settlement	(9,569)	21	20
21	Non-Allowable Fees	(160,000)	21	21
22	Non-Allowable Expense	(16,716)	09	22
23	Marketing Expense	(2,578)	43	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(401,117)	49

Harmony Nursing & Rehab Ctr

ID# 0040535

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			4,707									4,707	1
2	Food Purchase	(1,557)											(1,557)	2
3	Housekeeping			6,527									6,527	3
4	Laundry													4
5	Heat and Other Utilities	(7,433)		3,374									(4,059)	5
6	Maintenance	6,036		5,730									11,766	6
7	Other (specify):*													7
8	TOTAL General Services	(2,954)		20,338									17,384	8
	B. Health Care and Programs													
9	Medical Director	(16,716)											(16,716)	9
10	Nursing and Medical Records	(51,888)											(51,888)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				(9)								(9)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(68,604)			(9)								(68,613)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(38,501)	16,048	(374,216)									(396,669)	19
20	Fees, Subscriptions & Promotions	(107,474)		675									(106,799)	20
21	Clerical & General Office Expenses	(336,682)	(10,378)	402,386									55,326	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(280)		116									(164)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			2,034									2,034	26
27	Other (specify):*			104,922									104,922	27
28	TOTAL General Administration	(482,937)	5,670	135,917									(341,350)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(554,495)	5,670	156,255	(9)								(392,579)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14 Ending:

12/31/14

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	162,086	180,072	12,753									354,911	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(121,904)	321,738	9,368									209,202	32
33	Real Estate Taxes		294,167	9,307									303,474	33
34	Rent-Facility & Grounds		(851,700)										(851,700)	34
35	Rent-Equipment & Vehicles			1,839									1,839	35
36	Other (specify):*		48,450										48,450	36
37	TOTAL Ownership	40,182	(7,273)	33,267									66,176	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(3,665)											(3,665)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(108,010)											(108,010)	43
44	TOTAL Special Cost Centers	(111,675)											(111,675)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(625,988)	(1,603)	189,522	(9)								(438,078)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 851,700	Keiro Building LLC	100.00%	\$	\$ (851,700)	1
2	V	32 Interest	1,098	Keiro Building LLC	100.00%	322,836	321,738	2
3	V	21 Miscellaneous Income	10,667	Keiro Building LLC	100.00%		(10,667)	3
4	V	21 Franchise Tax		Keiro Building LLC	100.00%	250	250	4
5	V	36 MIP Insurance		Keiro Building LLC	100.00%	44,835	44,835	5
6	V	21 Office Expense		Keiro Building LLC	100.00%	39	39	6
7	V	19 Accounting		Keiro Building LLC	100.00%	16,048	16,048	7
8	V	33 Real Estate Taxes		Keiro Building LLC	100.00%	294,167	294,167	8
9	V	30 Depreciation		Keiro Building LLC	100.00%	180,072	180,072	9
10	V	36 Amortization of Loan Costs		Keiro Building LLC	100.00%	3,615	3,615	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 863,465			\$ 861,862	\$ * (1,603)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>DIETARY</u>	\$	<u>ITEX / AK CARE COMPANY</u>	100.00%	\$ 4,707	\$	4,707	15
16	V	3 <u>HOUSEKEEPING</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	6,527		6,527	16
17	V	5 <u>UTILITIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	3,374		3,374	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	5,730		5,730	18
19	V	19 <u>PROFESSIONAL FEES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	8,784		8,784	19
20	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	675		675	20
21	V	21 <u>CLERICAL AND GENERAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	31,955		31,955	21
22	V	24 <u>EDUCATION AND SEMINARS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	116		116	22
23	V	26 <u>INSURANCE</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	2,034		2,034	23
24	V	30 <u>DEPRECIATION</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	12,753		12,753	24
25	V	32 <u>INTEREST</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	9,368		9,368	25
26	V	33 <u>REAL ESTATE TAXES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	9,307		9,307	26
27	V	35 <u>EQUIPMENT RENTAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	1,839		1,839	27
28	V								28
29	V								29
30	V								30
31	V	21 <u>CLERICAL SALARIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	370,431		370,431	31
32	V	27 <u>GEN ADMIN. - EMP. BEN.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	104,922		104,922	32
33	V								33
34	V								34
35	V	19 <u>HOME OFFICE</u>	383,000	<u>ITEX / AK CARE COMPANY</u>	100.00%			(383,000)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 383,000			\$ 572,522	\$ *	189,522	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	14 AMBULANCE SERVICES	\$ 40	LIFELINE AMBULANCE		\$ 31	\$ (9)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 40			\$ 31	\$ * (9)

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number

Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JACK RAJCHENBACH	30.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	KEIRO BUILDING LLC	CHICAGO	BUILDING CO.	1
2	MARK HOLLANDER	10.000%	GLENVIEW TERRACE N. C.	GLENVIEW	ITEX / A.K. CARE	LINCOLNWOOD	BOOKEEPING CO./MANAGE	2
3	MARK HOLLANDER DISCRETIONARY TRUST	20.000%	THE CARLTON AT THE LAKE, INC.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	SHARON HOLLANDER DISCRETIONARY TRUST	20.000%	WHITEHALL NORTH	DEERFIELD	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	4
5	FEIGE KNOBEL DISCRETIONARY TRUST	20.000%						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Jack Rajchenbach	Owner	Administrative	30.00%	See Attached	5.00	8.33%		\$	1
2	Mark Hollander	Owner	Administrative	10.00%	See Attached	20.00	33.33%	Mgmt Fees	33,000	17-03
3	Allen Hollander	Relative	Administrative	0.00%	See Attached	36.67	91.68%	Salary	87,372	17-01
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts									11
12	anticipated to be considered allowable by the IL. Dept. of HFS.									12
13								TOTAL	\$ 120,372	13

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	DIETARY	AVAILABLE BED DAYS	359,890	4	\$ 25,783	\$ 65,700	\$ 4,707	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	359,890	4	35,754	65,700	6,527	2
3	5	UTILITIES	AVAILABLE BED DAYS	359,890	4	18,480	65,700	3,374	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	359,890	4	31,390	65,700	5,730	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	359,890	4	48,116	65,700	8,784	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	359,890	4	3,699	65,700	675	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	359,890	4	175,045	65,700	31,955	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	359,890	4	635	65,700	116	8
9	26	INSURANCE	AVAILABLE BED DAYS	359,890	4	11,140	65,700	2,034	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	359,890	4	69,859	65,700	12,753	10
11	32	INTEREST	AVAILABLE BED DAYS	359,890	4	51,314	65,700	9,368	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	359,890	4	50,980	65,700	9,307	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	359,890	4	10,076	65,700	1,839	13
14									14
15									15
16									16
17	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	1,133,459	1,133,459	370,431	17
18	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	321,043		104,922	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,986,773	\$ 1,133,459	\$ 572,522	25

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lifeline Ambulance LLC
 Street Address 2424 S. Wabash Avenue
 City / State / Zip Code Chicago, Illinois 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

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	14	AMBULANCE SERVICES	DIRECT ALLOCATION		\$	\$		\$ 31	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				\$	\$		\$ 31	25

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Cambridge		X	Mortgage	\$49,971.00	10/1/03	\$ 9,295,200	\$ 8,901,673	10/1/2038	5.5000	\$ 322,836	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Citi Bank		X	Line of Credit				2,650,000			162,189	6					
7	Allocated from ITEX/AK Care		X								9,368	7					
8												8					
9	TOTAL Facility Related				\$49,971.00		\$ 9,295,200	\$ 11,551,673			\$ 494,393	9					
	B. Non-Facility Related*																
10	Interest Income		X								(121,904)	10					
11	Interest Income - Bldg Co.		X								(1,098)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (123,002)	14					
15	TOTALS (line 9+line14)						\$ 9,295,200	\$ 11,551,673			\$ 371,391	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,835 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.)

** 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 Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

* 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.)

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing & Rehab Ctr 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-300-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>288,999.10</u>	\$ <u>288,999.10</u>
2. <u>10-35-312-022-0000</u>	<u>Allocated from ITEX</u>	\$ <u>53,423.84</u>	\$ <u>9,323.71</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>342,422.94</u></u>	\$ <u><u>298,322.81</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

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 Ctr

0040535 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180		1993	\$ 7,019,409	\$ 180,072	20	\$ 350,970	\$ 170,898	\$ 6,710,635	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1995	11,156		20			11,156	9
10	Various		1996	9,553		20	478	478	8,970	10
11	Various		1997	8,612		20	431	431	7,658	11
12	Various		1998	12,911		20	646	646	10,720	12
13	Various		1999	61,368		20	3,068	3,068	48,279	13
14	Various		2000	36,671		20	1,834	1,834	26,071	14
15	Various		2001	19,752		20	988	988	13,657	15
16	Various		2002	23,793		20	650	650	19,526	16
17	Various		2003	19,176		20	517	517	18,787	17
18	Various		2004	5,922		20	337	337	3,558	18
19	Various		2005	60,851		20	2,728	2,728	55,834	19
20	Various		2006	20,548		20	1,650	1,650	17,874	20
21	Various		2007	369,784		20	22,472	22,472	304,909	21
22	Various		2008	109,693		20	7,190	7,190	87,179	22
23	Various		2009	184,944		20	10,945	10,945	70,460	23
24	Various		2010	124,422		20	17,645	17,645	79,162	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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			19,743		987	987	19,319	67
68			387,170	12,606	10,624	(1,982)	252,399	68
69				157,048		(157,048)		69
70			\$ 8,505,479	\$ 349,726		\$ 434,159	\$ 84,433	\$ 7,766,153 70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,505,479	\$ 349,726		\$ 434,159	\$ 84,433	\$ 7,766,153	1
2	Parking Lot Paving	2011	8,250		20	550	550	1,833	2
3	A & J Paving - Sewer & Concrete	2012	3,200		20	213	213	604	3
4	Water Heater For Kitchen/ Laundry	2012	7,474		20	1,495	1,495	4,360	4
5	Installed New Pump Motor On Elevator	2012	3,650		20	365	365	882	5
6	Parking Lot Paving	2013	5,600		20	373	373	436	6
7	Nurse Call System	2013	41,000		20	8,200	8,200	10,933	7
8	Vinyl Flooring - 2Nd & 4Th Floor Davrooms	2013	33,635		20	6,727	6,727	10,651	8
9	Monument Sign In Brick Base	2013	10,979		20	732	732	1,220	9
10	Custom Built In Cabinetry - 2Nd & 4Th Floor Dining Rooms	2013	7,000		20	1,400	1,400	2,567	10
11	Kitchen Cabinets And Counter Top	2013	3,900		20	780	780	1,300	11
12	Cable In Walls For New Mds System	2013	16,410		20	3,282	3,282	4,923	12
13	Kitchen Hood Suppression System Updates	2013	6,614		20	1,323	1,323	1,874	13
14	Fire Alarm System Panel Connection To Kitchen Hood System	2013	2,892		20	145	145	193	14
15	A/C Chiller	2014	3,976		20	464	464	464	15
16	Laundry Water Heater	2014	5,575		20	1,115	1,115	1,115	16
17	New Condensing Unit	2014	3,676		20	306	306	306	17
18	Wet Sprinkler Repair	2014	5,739		20	96	96	96	18
19	Wiring And Cable Wiring For Better Cable Signal	2014	7,780		20	389	389	389	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)		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	34

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

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

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	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)		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	34

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

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

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	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		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	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)		\$ 8,682,829	\$ 349,726		\$ 462,113	\$ 112,387	\$ 7,810,299	34

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Keiro Building LLC	1995	19,743		20	987	987	19,319	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)		\$ 19,743	\$		\$ 987	\$ 987	\$ 19,319	34

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 19,743	\$		\$ 987	\$ 987	\$ 19,319		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)	\$ 19,743	\$		\$ 987	\$ 987	\$ 19,319		34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated ITEX/AK Care	1993	292,829	7,509	20	8,366	857	180,577	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from ITEX/AK Care	1993	36,846	217	20		(217)	36,846	9
10	Allocated from ITEX/AK Care	1994	19,791	515	20	709	194	19,789	10
11	Allocated from ITEX/AK Care	1995	3,373	9	20	169	160	3,238	11
12	Allocated from ITEX/AK Care	1996	191		20	10	10	182	12
13	Allocated from ITEX/AK Care	1997	5,690	146	20	284	138	4,978	13
14	Allocated from ITEX/AK Care	1999	632	16	20	32	16	505	14
15	Allocated from ITEX/AK Care	2005	2,767		20	138	138	1,313	15
16	Allocated from ITEX/AK Care	2007	3,425	80	20	171	91	1,243	16
17	Allocated from ITEX/AK Care	2008	13,054	335	20	431	96	2,838	17
18	Allocated from ITEX/AK Care	2009	711	18	20	71	53	391	18
19	Allocated from ITEX/AK Care	2010	1,519	64	20	76	12	332	19
20	Allocated from ITEX/AK Care	2014	6,342	3,697	20	167	(3,530)	167	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)		\$ 387,170	\$ 12,606		\$ 10,624	\$ (1,982)	\$ 252,399	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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 12H, Carried Forward		\$ 387,170	\$ 12,606		\$ 10,624	\$ (1,982)	\$ 252,399	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
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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)		\$ 387,170	\$ 12,606		\$ 10,624	\$ (1,982)	\$ 252,399	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 304,537	\$ 149	\$ 45,211	\$ 45,062	10	\$ 197,407	71
72	Current Year Purchases	34,393		4,636	4,636	10	4,636	72
73	Fully Depreciated Assets	1,570,062				10	1,569,961	73
74								74
75	TOTALS	\$ 1,908,993	\$ 149	\$ 49,848	\$ 49,699		\$ 1,772,004	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 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)	\$ 11,191,821	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 349,875	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 511,961	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 162,086	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,582,303	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	Parking Lot	\$ 30,000	92
93			93
94			94
95		\$ 30,000	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 36,178 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	<u>Admin Car</u>	<u>Honda</u>	\$ <u>555.00</u>	\$ <u>6,600</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 555.00	\$ 6,600	21

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	364,198	\$		\$	364,198	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				89,781				89,781	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				449,689				449,689	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					438,779			438,779	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>							109,953			109,953	13
14	TOTAL			\$		\$	903,668	\$	548,732	\$	1,452,400	14

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr# 0040535Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 63,014	\$ 314,114	1
2	Cash-Patient Deposits	2,011	2,011	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,303,663	3,303,663	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	256,595	271,461	6
7	Other Prepaid Expenses	417,663	417,663	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	768,210	2,125,795	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,811,156	\$ 6,434,707	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	779,515	782,915	15
16	Equipment, at Historical Cost	1,334,067	2,257,550	16
17	Accumulated Depreciation (book methods)	(1,606,501)	(6,137,935)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		126,525	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(9,941)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	2,030,764	1,985,793	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,537,845	\$ 6,624,316	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,349,001	\$ 13,059,023	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,508,102	\$ 1,522,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,650,000	2,650,000	29
30	Accrued Salaries Payable	346,248	346,248	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,224	19,224	31
32	Accrued Real Estate Taxes(Sch.IX-B)		303,462	32
33	Accrued Interest Payable	3,157	29,862	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,000	1,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	376,578	387,245	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,904,309	\$ 5,259,143	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,901,673	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			96,443	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,998,116	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,904,309	\$ 14,257,259	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,444,692	\$ (1,198,236)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,349,001	\$ 13,059,023	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,071,009	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,071,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	513,686	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	(140,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 373,686	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)	\$ 2,444,692	24 *

* This must agree with page 17, line 47.

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		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 13,101,731		1
2	Discounts and Allowances for all Levels	(2,179,086)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,922,645		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	1,805,526		6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,805,526		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	3,877		13
14	Non-Patient Meals	1,009		14
15	Telephone, Television and Radio	2,720		15
16	Rental of Facility Space			16
17	Sale of Drugs	590,885		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory	37,408		19
20	Radiology and X-Ray			20
21	Other Medical Services	119,807		21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 755,706		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***	121,904		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 121,904		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See Supplemental Schedule	9,701		28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,701		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,615,482		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	2,109,099		31
32	Health Care	4,938,499		32
33	General Administration	2,860,662		33
B. Capital Expense				
34	Ownership	1,211,876		34
C. Ancillary Expense				
35	Special Cost Centers	1,564,075		35
36	Provider Participation Fee	417,585		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,101,796		40
41	Income before Income Taxes (line 30 minus line 40)**	513,686		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 513,686		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,901,958	44
45	Private Pay - Net Inpatient Revenue	1,222,590	45
46	Medicare - Net Inpatient Revenue	1,722,088	46
47	Other-(specify) <u>Insurance</u>	566,386	47
48	Other-(specify) <u>Veterans</u>	509,623	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,922,645	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr

0040535

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,840	2,080	\$ 108,838	\$ 52.33	1
2	Assistant Director of Nursing	1,912	2,080	76,533	36.79	2
3	Registered Nurses	45,326	52,177	1,408,222	26.99	3
4	Licensed Practical Nurses	28,029	33,199	742,503	22.37	4
5	CNAs & Orderlies	96,507	114,565	1,434,269	12.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,558	10,269	128,876	12.55	8
9	Activity Director	3,616	4,160	65,892	15.84	9
10	Activity Assistants	6,151	7,097	78,492	11.06	10
11	Social Service Workers	8,508	9,957	231,894	23.29	11
12	Dietician					12
13	Food Service Supervisor	4,752	5,248	90,547	17.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,471	34,983	307,614	8.79	15
16	Dishwashers					16
17	Maintenance Workers	4,116	4,329	81,427	18.81	17
18	Housekeepers	37,589	40,606	433,213	10.67	18
19	Laundry	5,538	6,405	75,037	11.72	19
20	Administrator	1,896	2,080	87,372	42.01	20
21	Assistant Administrator					21
22	Other Administrative	949	991	35,139	35.46	22
23	Office Manager	2,988	3,320	41,902	12.62	23
24	Clerical	13,415	15,312	172,973	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,877	2,115	26,325	12.45	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,829	2,953	105,432	35.70	33
34	TOTAL (lines 1 - 33)	308,867	353,926	\$ 5,732,500 *	\$ 16.20	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	\$ 15,818	01-03	35
36	Medical Director	Monthly	170,317	09-03	36
37	Medical Records Consultant	Monthly	4,616	10-03	37
38	Nurse Consultant	Monthly	63,000	10-03	38
39	Pharmacist Consultant	Monthly	9,540	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	7,221	11-03	44
45	Social Service Consultant	521	28,658	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	521	\$ 299,170		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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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

Report Period Beginning:

01/01/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC \$18,900
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,620 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 417,585
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. \$ 87,929 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,009
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.