FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0040535

Facility Name: Harmony Nursing & Rehab Ctr

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	180	Skilled (SNF)	180	65,880	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	65,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,312	6,544	23,310	60,166	8
9	SNF/PED					9
10	ICF	716			716	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,028	6,544	23,310	60,882	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.41%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 180 and days of care provided 6,085

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	466,306	131,119	19,334	616,759		616,759	6,221	622,980			1
2	Food Purchase		485,957		485,957	(87,364)	398,593	(992)	397,601			2
3	Housekeeping	444,138	58,970		503,108		503,108	8,766	511,874			3
4	Laundry	80,196	36,873		117,069		117,069		117,069			4
5	Heat and Other Utilities			231,692	231,692		231,692	(5,502)	226,190			5
6	Maintenance	95,051	76,823	172,504	344,378		344,378	(7,730)	336,648			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,085,691	789,742	423,530	2,298,963	(87,364)	2,211,599	763	2,212,362			8
	B. Health Care and Programs											
9	Medical Director			145,663	145,663		145,663		145,663			9
10	Nursing and Medical Records	4,101,002	348,502	66,840	4,516,344		4,516,344	(24,687)	4,491,657			10
10a	Therapy	105,834			105,834		105,834		105,834			10a
11	Activities	152,449	12,226	7,472	172,147		172,147		172,147			11
12	Social Services	241,384		6,298	247,682		247,682		247,682			12
13	CNA Training											13
14	Program Transportation			31,346	31,346		31,346		31,346			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,600,669	360,728	257,619	5,219,016		5,219,016	(24,687)	5,194,329			16
	C. General Administration											
17	Administrative	142,032		85,100	227,132		227,132		227,132			17
18	Directors Fees											18
19	Professional Services			613,553	613,553		613,553	(448,967)	164,586			19
20	Dues, Fees, Subscriptions & Promotions			159,294	159,294		159,294	(108,664)	50,630			20
21	Clerical & General Office Expenses	241,385	28,221	722,596	992,202		992,202	(145,645)	846,557			21
22	Employee Benefits & Payroll Taxes			1,040,779	1,040,779	87,364	1,128,143		1,128,143			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,072	2,072		2,072	44	2,116			24
25	Other Admin. Staff Transportation			4,913	4,913		4,913		4,913			25
26	Insurance-Prop.Liab.Malpractice			519,776	519,776		519,776	2,733	522,509			26
27	Other (specify):*							100,124	100,124			27
28	**TOTAL General Administration**	383,417	28,221	3,148,083	3,559,721	87,364	3,647,085	(600,375)	3,046,710			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,069,777	1,178,691	3,829,232	11,077,700		11,077,700	(624,299)	10,453,401			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: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			127,642	127,642		127,642	51,259	178,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,676	182,676		182,676	183,950	366,626			32
33	Real Estate Taxes							378,450	378,450			33
34	Rent-Facility & Grounds			851,700	851,700		851,700	(851,700)				34
35	Rent-Equipment & Vehicles			43,214	43,214		43,214	1,978	45,192			35
36	Other (specify):*							43,350	43,350			36
37	**TOTAL Ownership**			1,205,232	1,205,232		1,205,232	(192,713)	1,012,519			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		431,891	864,281	1,296,172		1,296,172		1,296,172			39
40	Barber and Beauty Shops			2,938	2,938		2,938	(2,938)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			377,009	377,009		377,009		377,009			42
43	Other (specify):*	107,762		1,608	109,370		109,370	(109,370)	0			43
44	**TOTAL Special Cost Centers**	107,762	431,891	1,245,836	1,785,489		1,785,489	(112,308)	1,673,181			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,177,539	1,610,582	6,280,300	14,068,421		14,068,421	(929,320)	13,139,101			45

***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: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(473)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,049)	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	(192,610)	30		9
10	Interest and Other Investment Income	(139,035)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(519)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7)	21		18
19	Entertainment				19
20	Contributions	(12,800)	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	(420,414)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(482,820)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,256,727)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	327,407		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 327,407		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (929,320)		37

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

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

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

Harmony Nursing & Rehab Ctr

ID# 0040535

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber/Beauty Shop Income	$ (2,938)	40	1
2	Miscellaneous Income	(808)	21	2
3	Telephone Commissions	(2,510)	21	3
4	Marketing Salary	(101,749)	43	4
5	Veterans Expense	(3,452)	10	5
6	Patient Purchases	(21,160)	10	6
7	Bank Charges	(8,876)	21	7
8	Franchise Tax	(100)	21	8
9	Public Relations	(92,548)	20	9
10	Collections Salary	(6,013)	43	10
11	PAC Dues	(7,887)	20	11
12	Marketing Expense	(1,608)	43	12
13	Jury Duty	(75)	10	13
14	Blue Cross Blue Sheild Refund	(311)	21	14
15	Building Company - Franchise Tax	(250)	21	15
16	Building Company - Office Expense	(290)	21	16
17	Building Company - Accounting	(13,660)	19	17
18	Building Company - Amortization of Loan Costs	(3,615)	36	18
19	Capitalized R&M	(14,247)	06	19
20	Non-Allowable Legal Fees	(42,823)	19	20
21	Non-Allowable Fees	(157,900)	21	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(482,820)		49

Harmony Nursing & Rehab Ctr

ID# 0040535

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			6,221									6,221	1
2	Food Purchase	(992)											(992)	2
3	Housekeeping			8,766									8,766	3
4	Laundry													4
5	Heat and Other Utilities	(8,049)		2,547									(5,502)	5
6	Maintenance	(14,247)		6,517									(7,730)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(23,288)		24,051									763	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(24,687)											(24,687)	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**	(24,687)											(24,687)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(56,483)	13,660	(406,144)									(448,967)	19
20	Fees, Subscriptions & Promotions	(113,235)		4,571									(108,664)	20
21	Clerical & General Office Expenses	(591,466)	(10,127)	455,948									(145,645)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			44									44	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			2,733									2,733	26
27	Other (specify):*			100,124									100,124	27
28	**TOTAL General Administration**	(761,184)	3,533	157,276									(600,375)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(809,159)	3,533	181,327									(624,299)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	(192,610)	230,748	13,121									51,259	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(139,035)	311,483	11,502									183,950	32
33	Real Estate Taxes		367,108	11,342									378,450	33
34	Rent-Facility & Grounds		(851,700)										(851,700)	34
35	Rent-Equipment & Vehicles			1,978									1,978	35
36	Other (specify):*	(3,615)	46,965										43,350	36
37	TOTAL Ownership	(335,260)	104,604	37,943									(192,713)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(2,938)											(2,938)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(109,370)											(109,370)	43
44	TOTAL Special Cost Centers	(112,308)											(112,308)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,256,727)	108,137	219,270									(929,320)	45

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 851,700	Keiro Building LLC	100.00%	$	$ (851,700)	1
2	V	32	Interest	658	Keiro Building LLC	100.00%	312,141	311,483	2
3	V	21	Miscellaneous Income	10,667	Keiro Building LLC	100.00%		(10,667)	3
4	V	21	Franchise Tax/LLC Fee		Keiro Building LLC	100.00%	250	250	4
5	V	36	MIP Insurance		Keiro Building LLC	100.00%	43,350	43,350	5
6	V	21	Office Expense		Keiro Building LLC	100.00%	290	290	6
7	V	19	Accounting		Keiro Building LLC	100.00%	13,660	13,660	7
8	V	33	Real Estate Taxes		Keiro Building LLC	100.00%	367,108	367,108	8
9	V	30	Depreciation		Keiro Building LLC	100.00%	230,748	230,748	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			$ 863,025			$ 971,162	$ * 108,137	14

*** 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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	ITEX / AK CARE COMPANY	100.00%	$ 6,221	$ 6,221	15
16	V	3	HOUSEKEEPING		ITEX / AK CARE COMPANY	100.00%	8,766	8,766	16
17	V	5	UTILITIES		ITEX / AK CARE COMPANY	100.00%	2,547	2,547	17
18	V	6	REPAIRS AND MAINT.		ITEX / AK CARE COMPANY	100.00%	6,517	6,517	18
19	V	19	PROFESSIONAL FEES		ITEX / AK CARE COMPANY	100.00%	10,856	10,856	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX / AK CARE COMPANY	100.00%	4,571	4,571	20
21	V	21	CLERICAL AND GENERAL		ITEX / AK CARE COMPANY	100.00%	47,854	47,854	21
22	V	24	EDUCATION AND SEMINARS		ITEX / AK CARE COMPANY	100.00%	44	44	22
23	V	26	INSURANCE		ITEX / AK CARE COMPANY	100.00%	2,733	2,733	23
24	V	30	DEPRECIATION		ITEX / AK CARE COMPANY	100.00%	13,121	13,121	24
25	V	32	INTEREST		ITEX / AK CARE COMPANY	100.00%	11,502	11,502	25
26	V	33	REAL ESTATE TAXES		ITEX / AK CARE COMPANY	100.00%	11,342	11,342	26
27	V	35	EQUIPMENT RENTAL		ITEX / AK CARE COMPANY	100.00%	1,978	1,978	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX / AK CARE COMPANY	100.00%	408,094	408,094	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX / AK CARE COMPANY	100.00%	100,124	100,124	33
34	V								34
35	V								35
36	V	19	HOME OFFICE	417,000	ITEX / AK CARE COMPANY	100.00%		(417,000)	36
37	V								37
38	V								38
39	Total			$ 417,000			$ 636,270	$ * 219,270	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	30.00%	CLARIDGE IMPERIAL, LTD.	CHICAGO	KEIRO BUILDING LLC	CHICAGO	BUILDING CO.	1
2	MARK HOLLANDER	10.00%	GLENVIEW TERRACE N. C.	GLENVIEW	ITEX / A.K. CARE	LINCOLNWOOD	BOOKEEPING CO./MANAGE	2
3	MARK HOLLANDER DISCRETIONARY TRUST	20.00%	WHITEHALL NORTH	DEERFIELD	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	SHARON HOLLANDER DISCRETIONARY TRUST	20.00%			LIFELINE AMBULANCE	CHICAGO	AMBULANCE	4
5	FEIGE KNOBEL DISCRETIONARY TRUST	20.00%						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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Hollander	Owner	Administrative	10.00%	See Attached	20	33.33%	Mgmt Fees	$ 85,100	17-03	1
2	Allen Hollander	Relative	Administrative	0.00%	See Attached	40	100.00%	Salary	106,724	17-01	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 191,824		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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	271,572	3	$ 25,643	$	65,880	$ 6,221	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	271,572	3	36,137		65,880	8,766	2
3	5	UTILITIES	AVAILABLE BED DAYS	271,572	3	10,501		65,880	2,547	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	271,572	3	26,863		65,880	6,517	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	271,572	3	44,750		65,880	10,856	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	271,572	3	18,841		65,880	4,571	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	271,572	3	197,264		65,880	47,854	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	271,572	3	180		65,880	44	8
9	26	INSURANCE	AVAILABLE BED DAYS	271,572	3	11,266		65,880	2,733	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	271,572	3	54,090		65,880	13,121	10
11	32	INTEREST	AVAILABLE BED DAYS	271,572	3	47,416		65,880	11,502	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	271,572	3	46,754		65,880	11,342	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	271,572	3	8,156		65,880	1,978	13
14										14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	1,051,890	1,051,890		408,094	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	258,078			100,124	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,837,829	$ 1,051,890		$ 636,270	25

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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Name of Related Organization
Street Address
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Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	Mortgage	49,971	10/1/2003	$ 9,295,200	$ 8,599,678	10/1/2038	5.5000	$ 312,141	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	City Bank		X	Line of Credit				3,000,000			182,676	6
7	Allocated from ITEX/AK Care	X									11,502	7
8					-							8
9	TOTAL Facility Related				49971.00		$ 9,295,200	$ 11,599,678			$ 506,319	9
	B. Non-Facility Related*											
10	Interest Income		X								(139,035)	10
11	Interest Income - Bldg Co.		X								(658)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (139,693)	14
15	TOTALS (line 9+line14)						$ 9,295,200	$ 11,599,678			$ 366,626	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 43,350 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: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr **#** 0040535 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 309,567	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.)		$ 341,421	2
3. Under or (over) accrual (line 2 minus line 1).		$ 31,854	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 346,596	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 378,450	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	256,553	8
	2012	284,101	9
	2013	288,999	10
	2014	294,825	11
	2015	330,079	12

***Beginning Accrual Adjusted for Rounding**
2016 Accrual: $330,079 x 1.05 = $346,583
Allocated from ITEX/AK Care: $11,342

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-007-0000	Long Term Care Property	$ 330,079.11	$ 330,079.11
2.	10-35-312-022-0000	Allocated from ITEX	$ 54,446.07	$ 13,207.94
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 384,525.18	$ 343,287.05

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 600,000	1
2					2
3	TOTALS			$ 600,000	3

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	180			1993	$ 7,019,409	$ 230,748	20	$	$ (230,748)	$ 7,019,409	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	100	100	9,548	10
11	Various			1997	8,612		20	400	400	8,489	11
12	Various			1998	12,911		20	646	646	12,011	12
13	Various			1999	61,368		20	3,068	3,068	54,416	13
14	Various			2000	36,671		20	1,834	1,834	29,738	14
15	Various			2001	19,752		20	988	988	15,632	15
16	Various			2002	23,793		20	560	560	20,646	16
17	Various			2003	19,176		20			19,176	17
18	Various			2004	5,922		20	337	337	4,232	18
19	Various			2005	60,851		20	778	778	57,879	19
20	Various			2006	20,548		20	1,025	1,025	20,548	20
21	Various			2007	369,784		20	22,472	22,472	349,853	21
22	Various			2008	109,693		20	7,190	7,190	101,559	22
23	Various			2009	184,944		20	9,214	9,214	89,199	23
24	Various			2010	124,422		20	7,240	7,240	99,399	24
25	Various			2011	8,250		20	550	550	2,933	25
26	Various			2012	14,324		20	2,073	2,073	9,993	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: 01/01/16 Ending: 12/31/16

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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49									49
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53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		601,250			29,075	29,075	48,818	67
68	Related Party Allocations (Pages 12H & 12I)		515,453	12,565		13,189	624	361,900	68
69	Financial Statement Depreciation			127,642			(127,642)		69
70	TOTAL (lines 4 thru 69)		$ 9,237,843	$ 370,955		$ 100,738	$ (270,217)	$ 8,346,533	70

**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: 01/01/16 Ending: 12/31/16

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 12A, Carried Forward		$ 9,237,843	$ 370,955		$ 100,738	$ (270,217)	$ 8,346,533	1
2	Parking Lot Paving	2013	5,600		20	373	373	1,182	2
3	Nurse Call System	2013	41,000		20	8,200	8,200	27,333	3
4	Vinyl Flooring - 2Nd & 4Th Floor Dayrooms	2013	33,635		20	6,727	6,727	24,105	4
5	Monument Sign In Brick Base	2013	10,979		20	732	732	2,684	5
6	Custom Built In Cabinetry - 2Nd & 4Th Floor Dining Rooms	2013	7,000		20	1,400	1,400	5,367	6
7	Kitchen Cabinets And Counter Top	2013	3,900		20	780	780	2,860	7
8	Cable In Walls For New Mds System	2013	16,410		20	3,282	3,282	11,487	8
9	Kitchen Hood Suppression System Updates	2013	6,614		20	1,323	1,323	4,520	9
10	Fire Alarm System Panel Connection To Kitchen Hood System	2013	2,892		20	145	145	482	10
11	A/C Chiller	2014	3,976		20	795	795	2,054	11
12	Laundry Water Heater	2014	5,575		20	1,115	1,115	3,345	12
13	New Condensing Unit	2014	3,676		20	735	735	1,777	13
14	Wet Sprinkler Repair	2014	5,739		20	574	574	1,243	14
15	Wiring And Cable Wiring For Better Cable Signal	2014	7,780		20	1,556	1,556	3,501	15
16	Outlets And Panel	2015	5,555		20	278	278	324	16
17	Circulating Pump	2015	3,926		20	785	785	1,440	17
18	Pressure Pump	2015	4,122		20	824	824	1,512	18
19	Replace Data Station On 3Rd Floor In 304A /Smoke Detectors In 3	2016	2,597		20	130	130	130	19
20	Wiring Door Holder/Lights/Door Dealease/Alarm Light/New Powe	2016	2,882		20	144	144	144	20
21	Relocation Of Sprinkler Line Piping And Heads On Two Floors	2016	3,227		20	161	161	161	21
22	Install, Conduit, And Wire New Fire Alarm System Switch	2016	2,590		20	130	130	130	22
23	Install Reinsulting Ductwork, Kitchen Water Booster Heater, Wat	2016	2,952		20	148	148	148	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)		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	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: 01/01/16 Ending: 12/31/16

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 12B, Carried Forward		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	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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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)		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	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: 01/01/16 Ending: 12/31/16

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 12D, Carried Forward		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	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
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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)		$ 9,420,469	$ 370,955		$ 131,075	$ (239,880)	$ 8,442,461	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: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Keiro Building LLC	1995	19,743		20			19,743	9
10	Toilets, Grab Bars, Faucets in Shower Rooms	2016	11,544		20	577	577	577	10
11	Design/Install Roman Shades in Resident Rooms	2016	21,803		20	1,090	1,090	1,090	11
12	Wallpapaer in Hallways and Resident Rooms/3rd floor	2016	40,767		20	2,038	2,038	2,038	12
13	Wallpaper lobby & 1st floor	2016	42,129		20	2,106	2,106	2,106	13
14	Design & Install Roman shades Halls & Rooms	2016	25,437		20	1,272	1,272	1,272	14
15	Lighting Fixtures and Sconces Patient/Toilet Room Ortho Wing	2016	40,991		20	2,050	2,050	2,050	15
16	Handrails throughout Facility/Patient/1st Floor Hallways	2016	32,600		20	1,630	1,630	1,630	16
17	Shades, Privacy Curtains, Tile, Cabinets in Dining/Patient/Spa/To	2016	61,560		20	3,078	3,078	3,078	17
18	Tile for Offices	2016	15,200		20	760	760	760	18
19	Create temp/perm shower room w/toilet on 2nd/3rd floor	2016	8,400		20	420	420	420	19
20	Tile,Counter, Fixtures in Bathrooms, Drywall, Partitions, Lights	2016	21,000		20	1,050	1,050	1,050	20
21	Demolish/Install new plumbing, lighting, flooring in bathrooms	2016	87,500		20	4,375	4,375	4,375	21
22	Corridors & Nurses Stations/ new tile, doors, drywall, electrical, li	2016	112,900		20	5,645	5,645	5,645	22
23	Wallpaper lobby & 1st floor	2016	35,000		20	1,750	1,750	1,750	23
24	Window Replacements	2016	3,700		20	185	185	185	24
25	Install Cove Base/Wallpaper/Quartz Counter in computer room	2016	3,800		20	190	190	190	25
26	Replacement of Fire Dumper & Actuator	2016	5,121		20	256	256	256	26
27	Repair of water leak in Boiler	2016	8,982		20	449	449	449	27
28	Install electric outlet in server room/relocate outlets/time clock	2016	3,073		20	154	154	154	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 601,250	$		$ 29,075	$ 29,075	$ 48,818	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: 01/01/16 Ending: 12/31/16

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 12F, Carried Forward		$ 601,250	$		$ 29,075	$ 29,075	$ 48,818	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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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)		$ 601,250	$		$ 29,075	$ 29,075	$ 48,818	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated ITEX/AK Care	1993	389,123	9,978	35	11,118	1,140	262,194	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ITEX/AK Care	1993	48,963	288	20		(288)	48,963	9
10	Allocated from ITEX/AK Care	1994	26,299	684	20		(684)	26,297	10
11	Allocated from ITEX/AK Care	1995	4,482	12	20	1	(11)	4,482	11
12	Allocated from ITEX/AK Care	1996	254		20			254	12
13	Allocated from ITEX/AK Care	1997	7,561	194	20	378	184	7,372	13
14	Allocated from ITEX/AK Care	1999	840	22	20	42	20	756	14
15	Allocated from ITEX/AK Care	2005	3,676		20	184	184	2,091	15
16	Allocated from ITEX/AK Care	2007	4,551	106	20	228	122	2,107	16
17	Allocated from ITEX/AK Care	2008	17,347	445	20	573	128	4,918	17
18	Allocated from ITEX/AK Care	2009	945	24	20	95	71	709	18
19	Allocated from ITEX/AK Care	2010	2,019		20	101	101	644	19
20	Allocated from ITEX/AK Care	2014	8,428	809	20	421	(388)	1,065	20
21	Allocated from ITEX/AK Care	2016	965	3	20	48	45	48	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)		$ 515,453	$ 12,565		$ 13,189	$ 624	$ 361,900	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: 01/01/16 Ending: 12/31/16

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 12H, Carried Forward		$ 515,453	$ 12,565		$ 13,189	$ 624	$ 361,900	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)		$ 515,453	$ 12,565		$ 13,189	$ 624	$ 361,900	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: 01/01/16 Ending: 12/31/16

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	$ 268,040	$ 75	$ 37,654	$ 37,579	10	$ 204,360	71
72	Current Year Purchases	101,593	481	10,159	9,678	10	10,159	72
73	Fully Depreciated Assets	1,693,436		13	13	10	1,692,942	73
74								74
75	TOTALS	$ 2,063,069	$ 556	$ 47,826	$ 47,270		$ 1,907,462	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)	$ 12,083,538	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 371,511	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,901	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (192,610)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,349,922	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 36,816 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	Admin Car	Lexus	$ 698	$ 8,376	17
18					18
19					19
20					20
21	TOTAL		$ 698	$ 8,376	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: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 331,111	$		$ 331,111	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			68,473			68,473	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			464,697			464,697	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				328,427		328,427	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						103,464		103,464	13
14	TOTAL			$		$ 864,281	$ 431,891		$ 1,296,172	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 # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 21,916	$ 112,600	1
2	Cash-Patient Deposits	2,011	2,011	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,436,894	3,436,894	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	451,275	465,640	6
7	Other Prepaid Expenses	231,010	231,010	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	833,846	1,822,475	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,976,952	$ 6,070,630	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	785,070	1,455,168	15
16	Equipment, at Historical Cost	1,350,798	2,300,938	16
17	Accumulated Depreciation (book methods)	(1,879,013)	(6,821,268)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		126,523	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(17,171)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,878,334	2,702,806	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,135,189	$ 7,366,405	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,112,141	$ 13,437,035	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,988,757	$ 2,002,757	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,000,000	3,159,337	29
30	Accrued Salaries Payable	406,498	406,498	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,366	22,366	31
32	Accrued Real Estate Taxes(Sch.IX-B)		346,596	32
33	Accrued Interest Payable	4,012	29,811	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,666	4,666	35
	Other Current Liabilities(specify):			
36			10,667	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,426,299	$ 5,982,698	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,440,341	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			75,109	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,515,450	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,426,299	$ 14,498,148	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,685,842	$ (1,061,113)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,112,141	$ 13,437,035	48

***(See instructions.)**

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,430,459	1
2	Restatements (describe):		2
3	**Rounding**	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,430,464	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	495,378	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	(240,000)	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)**	$ 255,378	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)**	$ 2,685,842	24 *

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,677,474	1
2	Discounts and Allowances for all Levels	(1,809,466)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,868,008	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,952,490	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,952,490	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	3,004	13
14	Non-Patient Meals	473	14
15	Telephone, Television and Radio	2,510	15
16	Rental of Facility Space		16
17	Sale of Drugs	472,484	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,351	19
20	Radiology and X-Ray		20
21	Other Medical Services	52,250	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 603,072	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	139,035	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 139,035	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,194	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,563,799	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,298,963	31
32	Health Care	5,219,016	32
33	General Administration	3,559,721	33
	B. Capital Expense		
34	Ownership	1,205,232	34
	C. Ancillary Expense		
35	Special Cost Centers	1,408,480	35
36	Provider Participation Fee	377,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,068,421	40
41	**Income before Income Taxes (line 30 minus line 40)****	495,378	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 495,378	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,852,543	44
45	Private Pay - Net Inpatient Revenue	1,237,242	45
46	Medicare - Net Inpatient Revenue	1,440,949	46
47	Other-(specify) Insurance	493,900	47
48	Other-(specify) Veteran, MMAI	2,843,374	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,868,008	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: 01/01/16 Ending: 12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,814	2,095	$ 116,237	$ 55.48	1
2	Assistant Director of Nursing	3,424	3,640	143,400	39.40	2
3	Registered Nurses	44,503	49,370	1,402,626	28.41	3
4	Licensed Practical Nurses	34,088	36,475	910,669	24.97	4
5	CNAs & Orderlies	116,759	124,686	1,469,091	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,761	7,772	105,834	13.62	8
9	Activity Director	3,603	4,208	66,429	15.79	9
10	Activity Assistants	6,751	7,565	86,020	11.37	10
11	Social Service Workers	8,102	9,418	241,384	25.63	11
12	Dietician					12
13	Food Service Supervisor	4,793	5,326	92,665	17.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,944	33,326	373,641	11.21	15
16	Dishwashers					16
17	Maintenance Workers	5,664	6,411	95,051	14.83	17
18	Housekeepers	33,390	36,119	444,138	12.30	18
19	Laundry	5,952	6,449	80,196	12.44	19
20	Administrator	2,113	2,217	106,724	48.14	20
21	Assistant Administrator					21
22	Other Administrative	536	536	35,308	65.87	22
23	Office Manager					23
24	Clerical	12,088	13,876	241,385	17.40	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	1,891	2,073	26,747	12.90	31
32	Other Health Care(specify)					32
33	Other(specify)	4,536	5,212	139,994	26.86	33
34	TOTAL (lines 1 - 33)	327,712	356,774	$ 6,177,539 *	$ 17.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 19,334	01-03	35
36	Medical Director	Monthly	145,663	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	48,000	10-03	38
39	Pharmacist Consultant	Monthly	14,040	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	7,472	11-03	44
45	Social Service Consultant	115	6,298	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	$ 245,607		49

C. CONTRACT NURSES

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

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Allen Hollander	Administrator	0	$ 106,724
Ian Crook	VP Operations	0	35,308
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,032

B. Administrative - Other

Description	Amount
Management Fees - Mark Hollander	$ 85,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 85,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AK Care	Centralized Bookkeeping	$ 418,417
M L Enterprises	Consultant Fees	25,740
See Attached	Legal Fees	63,642
Marcum LLP	Accounting	25,046
HK Payroll Service	Payroll	3,707
Personnel Planners	Unemployment Consultant	1,734
Netsmart Technologies	Data Processing	61,083
Ability Network	Data Processing	6,016
Paycom	Data Processing	8,168
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 613,552

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,641
Unemployment Compensation Insurance	47,622
FICA Taxes	463,993
Employee Health Insurance	303,566
Employee Meals	87,364
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	15,014
Employee Benefits	225
Pension Plan	46,992
Christmas Expense	13,726
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,128,143

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,362
Health Care Worker Background Check	1,829
(Indicate # of checks performed 182)	
Patient Background Checks	
Dues & Subscriptions	22,533
Licenses & Permits	2,335
Allocated from ITEX/AK Care	4,571
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,630

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,072
Allocated from ITEX/AK Care	44
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,116

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Harmony Nursing & Rehab Ctr # 0040535 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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: $23,900**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **50,560** 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. $ **377,009**
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. $ **87,364** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **473**

(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
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.