FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0040535

Facility Name: Harmony Nursing And Rehab

Address: 3919 West Foster (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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,152	7,524	36,562	58,238	8
9	SNF/PED					9
10	ICF	821			821	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,973	7,524	36,562	59,059	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.89%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 5,678

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	530,148	95,167	19,367	644,682		644,682	5,697	650,379			1
2	Food Purchase		510,362		510,362	(93,951)	416,411	(1,232)	415,179			2
3	Housekeeping	522,572	47,719		570,291		570,291	8,650	578,941			3
4	Laundry	89,012	38,310		127,322		127,322		127,322			4
5	Heat and Other Utilities			243,962	243,962		243,962	(4,567)	239,395			5
6	Maintenance	69,219	36,553	172,515	278,287		278,287	(13,602)	264,685			6
7	Other (specify):*											7
8	TOTAL General Services	1,210,951	728,111	435,844	2,374,906	(93,951)	2,280,955	(5,054)	2,275,901			8
	B. Health Care and Programs											
9	Medical Director			193,283	193,283		193,283		193,283			9
10	Nursing and Medical Records	4,212,063	287,873	65,220	4,565,156		4,565,156	(9,854)	4,555,302			10
10a	Therapy	158,219			158,219		158,219		158,219			10a
11	Activities	162,035	6,852	6,926	175,813		175,813		175,813			11
12	Social Services	257,816		1,408	259,224		259,224		259,224			12
13	CNA Training											13
14	Program Transportation			35,842	35,842		35,842		35,842			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,790,133	294,725	302,679	5,387,537		5,387,537	(9,854)	5,377,683			16
	C. General Administration											
17	Administrative	167,198		63,000	230,198		230,198		230,198			17
18	Directors Fees											18
19	Professional Services			326,694	326,694	(793)	325,901	(161,995)	163,906			19
20	Dues, Fees, Subscriptions & Promotions			147,716	147,716		147,716	(115,594)	32,122			20
21	Clerical & General Office Expenses	222,065	6,075	546,959	775,099		775,099	(53,359)	721,740			21
22	Employee Benefits & Payroll Taxes			1,162,403	1,162,403	93,951	1,256,354		1,256,354			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,009	4,009		4,009	466	4,475			24
25	Other Admin. Staff Transportation			337	337		337		337			25
26	Insurance-Prop.Liab.Malpractice			748,221	748,221		748,221	1,854	750,075			26
27	Other (specify):*							95,241	95,241			27
28	TOTAL General Administration	389,263	6,075	2,999,339	3,394,677	93,158	3,487,835	(233,387)	3,254,448			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,390,347	1,028,911	3,737,862	11,157,120	(793)	11,156,327	(248,295)	10,908,032			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 And Rehab #0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			112,143	112,143		112,143	55,154	167,297			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			215,669	215,669		215,669	164,276	379,945			32
33	Real Estate Taxes					793	793	407,151	407,944			33
34	Rent-Facility & Grounds			851,700	851,700		851,700	(851,700)				34
35	Rent-Equipment & Vehicles			38,769	38,769		38,769	1,581	40,350			35
36	Other (specify):*							42,566	42,566			36
37	**TOTAL Ownership**			1,218,281	1,218,281	793	1,219,074	(180,972)	1,038,102			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		388,592	896,840	1,285,432		1,285,432		1,285,432			39
40	Barber and Beauty Shops			1,853	1,853		1,853	(1,853)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,090	248,090		248,090		248,090			42
43	Other (specify):*	97,593		2,649	100,242		100,242	(100,242)	(0)			43
44	**TOTAL Special Cost Centers**	97,593	388,592	1,149,432	1,635,617		1,635,617	(102,095)	1,533,522			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,487,940	1,417,503	6,105,575	14,011,018	0	14,011,018	(531,362)	13,479,656			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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(582)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,472)	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	(248,426)	30		9
10	Interest and Other Investment Income	(152,682)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(650)	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	(19,546)	21		18
19	Entertainment				19
20	Contributions	(10,800)	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	(390,841)	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	(305,964)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,137,963)		$	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)	606,601		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 606,601		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (531,362)		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 And Rehab

ID# 0040535

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber/Beauty Shop	$ (1,853)	40	1
2	Miscellaneous Income	(63)	21	2
3	Telephone Commissions	(2,550)	21	3
4	Marketing Salary	(97,593)	43	4
5	Veterans Expense	(2,793)	10	5
6	Patient Purchases	(7,027)	10	6
7	Bank Charges	(11,527)	21	7
8	Franchise Tax	(350)	21	8
9	Public Relations	(97,554)	20	9
10	Jury Duty Income	(34)	10	10
11	Building Company - Office Expense	(488)	21	11
12	Building Company - Accounting	(15,047)	19	12
13	Building Company - Amortization of Loan Costs	(3,615)	36	13
14	Out of Period Seminars	(459)	24	14
15	Marketing Expense	(2,649)	43	15
16	Non-Allowable Legal	(34,325)	19	16
17	Capitalized R&M	(21,018)	06	17
18	PAC Dues	(8,613)	20	18
19	Additional R&M	1,594	06	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(305,964)		49

Harmony Nursing And Rehab

ID# 0040535

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 And Rehab # 0040535 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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			5,697									5,697	1
2	Food Purchase	(1,232)											(1,232)	2
3	Housekeeping			8,650									8,650	3
4	Laundry													4
5	Heat and Other Utilities	(8,472)		3,905									(4,567)	5
6	Maintenance	(19,424)		5,822									(13,602)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(29,128)		24,074									(5,054)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,854)											(9,854)	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**	(9,854)											(9,854)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(49,372)	15,047	(127,670)									(161,995)	19
20	Fees, Subscriptions & Promotions	(116,967)		1,373									(115,594)	20
21	Clerical & General Office Expenses	(425,365)	(10,179)	382,185									(53,359)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(459)		925									466	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,854									1,854	26
27	Other (specify):*			95,241									95,241	27
28	**TOTAL General Administration**	(592,163)	4,868	353,908									(233,387)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(631,145)	4,868	377,982									(248,295)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(248,426)	291,151	12,429									55,154	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(152,682)	306,007	10,951									164,276	32
33	Real Estate Taxes		392,899	14,252									407,151	33
34	Rent-Facility & Grounds		(851,700)										(851,700)	34
35	Rent-Equipment & Vehicles			1,581									1,581	35
36	Other (specify):*	(3,615)	46,181										42,566	36
37	TOTAL Ownership	(404,723)	184,538	39,213									(180,972)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(1,853)											(1,853)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(100,242)											(100,242)	43
44	TOTAL Special Cost Centers	(102,095)											(102,095)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,137,963)	189,406	417,195									(531,362)	45

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	491	Keiro Building LLC	100.00%	306,498	306,007	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%			4
5	V	36	MIP Insurance		Keiro Building LLC	100.00%	42,566	42,566	5
6	V	21	Office Expense		Keiro Building LLC	100.00%	488	488	6
7	V	19	Accounting		Keiro Building LLC	100.00%	15,047	15,047	7
8	V	33	Real Estate Taxes		Keiro Building LLC	100.00%	392,899	392,899	8
9	V	30	Depreciation		Keiro Building LLC	100.00%	291,151	291,151	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			$ 862,858			$ 1,052,264	$ * 189,406	14

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 5,697	$ 5,697	15
16	V	3	HOUSEKEEPING		ITEX / AK CARE COMPANY	100.00%	8,650	8,650	16
17	V	5	UTILITIES		ITEX / AK CARE COMPANY	100.00%	3,905	3,905	17
18	V	6	REPAIRS AND MAINT.		ITEX / AK CARE COMPANY	100.00%	5,822	5,822	18
19	V	19	PROFESSIONAL FEES		ITEX / AK CARE COMPANY	100.00%	4,580	4,580	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX / AK CARE COMPANY	100.00%	1,373	1,373	20
21	V	21	CLERICAL AND GENERAL		ITEX / AK CARE COMPANY	100.00%	41,511	41,511	21
22	V	24	EDUCATION AND SEMINARS		ITEX / AK CARE COMPANY	100.00%	925	925	22
23	V	26	INSURANCE		ITEX / AK CARE COMPANY	100.00%	1,854	1,854	23
24	V	30	DEPRECIATION		ITEX / AK CARE COMPANY	100.00%	12,429	12,429	24
25	V	32	INTEREST		ITEX / AK CARE COMPANY	100.00%	10,951	10,951	25
26	V	33	REAL ESTATE TAXES		ITEX / AK CARE COMPANY	100.00%	13,459	13,459	26
27	V	33	RE TAX PROTEST FEES		ITEX / AK CARE COMPANY	100.00%	793	793	27
28	V	35	EQUIPMENT RENTAL		ITEX / AK CARE COMPANY	100.00%	1,581	1,581	28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX / AK CARE COMPANY	100.00%	340,674	340,674	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX / AK CARE COMPANY	100.00%	95,241	95,241	33
34	V								34
35	V								35
36	V	19	BOOKEEPING FEES	132,250	ITEX / AK CARE COMPANY	100.00%		(132,250)	36
37	V								37
38	V								38
39	Total			$ 132,250			$ 549,445	$ * 417,195	39

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 63,000	17-03	1
2	Allen Hollander	Relative	Administrative	0.00%	See Attached	40	100.00%	Salary	122,102	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	$ 185,102		13

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

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	270,830	3	$ 23,483	$	65,700	$ 5,697	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	270,830	3	35,659		65,700	8,650	2
3	5	UTILITIES	AVAILABLE BED DAYS	270,830	3	16,097		65,700	3,905	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	270,830	3	24,000		65,700	5,822	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	270,830	3	18,878		65,700	4,580	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	270,830	3	5,661		65,700	1,373	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	270,830	3	171,117		65,700	41,511	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	270,830	3	3,813		65,700	925	8
9	26	INSURANCE	AVAILABLE BED DAYS	270,830	3	7,643		65,700	1,854	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	270,830	3	51,234		65,700	12,429	10
11	32	INTEREST	AVAILABLE BED DAYS	270,830	3	45,142		65,700	10,951	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	270,830	3	55,482		65,700	13,459	12
13	33	RE TAX PROTEST FEES	AVAILABLE BED DAYS	270,830	3	3,269		65,700	793	13
14	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	270,830	3	6,517		65,700	1,581	14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	903,445	903,445		340,674	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	252,574			95,241	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,624,014	$ 903,445		$ 549,445	25

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	Mortgage	$49,971.00	10/1/2003	$ 9,295,200	$ 8,440,341	10/1/2038	5.5000	$ 306,498	1
2												2
3												3
4												4
5												5
	Working Capital											
6	City Bank		X	Line of Credit				1,650,000			215,669	6
7	Allocated from ITEX/AK Care		X								10,951	7
8												8
9	TOTAL Facility Related				$49,971.00		$ 9,295,200	$ 10,090,341			$ 533,118	9
	B. Non-Facility Related*											
10	Interest Income		X								(152,682)	10
11	Interest Income - Bldg Co.		X								(490)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (153,172)	14
15	TOTALS (line 9+line14)						$ 9,295,200	$ 10,090,341			$ 379,946	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 42,566 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 And Rehab # 0040535 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	346,596	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.)	$	374,981	2
3. Under or (over) accrual (line 2 minus line 1).	$	28,385	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	378,766	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.)**	$	793	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.	$	407,944	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	284,101	8
	2013	288,999	9
	2014	294,825	10
	2015	330,079	11
	2016	360,729	12

2017 Accrual: $360,729 x 1.05 = $378,766

Allocated from ITEX/AK Care: $13,459

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing And Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 360,729.17	$ 360,729.17
2.	10-35-312-022-0000	Allocated from ITEX	$ 58,284.84	$ 13,517.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 419,014.01	$ 374,246.23

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing And Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 291,151	20	$	$ (291,151)	$ 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			9,553	10
11	Various			1997	8,612		20	124	124	8,612	11
12	Various			1998	12,911		20	646	646	12,656	12
13	Various			1999	61,368		20	3,068	3,068	57,484	13
14	Various			2000	36,671		20	1,834	1,834	31,571	14
15	Various			2001	19,752		20	988	988	16,620	15
16	Various			2002	23,793		20	560	560	21,206	16
17	Various			2003	19,176		20			19,176	17
18	Various			2004	5,922		20	337	337	4,570	18
19	Various			2005	60,851		20	779	779	58,658	19
20	Various			2006	20,548		20			20,548	20
21	Various			2007	369,784		20	14,627	14,627	364,480	21
22	Various			2008	109,693		20	7,190	7,190	108,748	22
23	Various			2009	184,944		20	8,592	8,592	97,790	23
24	Various			2010	51,188		20	3,776	3,776	41,199	24
25	Various			2011	8,250		20	550	550	3,483	25
26	Various			2012	14,324		20	703	703	10,696	26
27	Various			2013	128,030		20	22,962	22,962	102,981	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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		745,265			36,276	36,276	85,094	67
68	Related Party Allocations (Pages 12H & 12I)		515,453	12,264		13,047	783	374,909	68
69	Financial Statement Depreciation			112,143			(112,143)		69
70	TOTAL (lines 4 thru 69)		$ 9,436,654	$ 415,558		$ 116,056	$ (299,502)	$ 8,480,600	70

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,436,654	$ 415,558		$ 116,056	$ (299,502)	$ 8,480,600	1
2	A/C Chiller	2014	3,976		20	795	795	2,849	2
3	Laundry Water Heater	2014	5,575		20	1,115	1,115	4,460	3
4	New Condensing Unit	2014	3,676		20	735	735	2,512	4
5	Wet Sprinkler Repair	2014	5,739		20	574	574	1,817	5
6	Wiring And Cable Wiring For Better Cable Signal	2014	7,780		20	1,556	1,556	5,057	6
7	Outlets And Panel	2015	5,555		20	278	278	602	7
8	Circulating Pump	2015	3,926		20	785	785	2,225	8
9	Pressure Pump	2015	4,122		20	824	824	2,336	9
10	Replace Data Station On 3Rd Floor In 304A/Smoke Detectors In 3	2016	2,597		20	130	130	249	10
11	Wire Door Holder/Lights/Door Release/Alarm Light/Power Suppl	2016	2,882		20	144	144	168	11
12	Relocate Sprinkler Line Piping & Heads On Two Floors	2016	3,227		20	161	161	229	12
13	Install, Conduit, Wire New Fire Alarm System Switch	2016	2,590		20	130	130	173	13
14	Install Reinsulating Ductwork, Kitchen Water Booster Heater, Wa	2016	2,952		20	148	148	197	14
15	Interior Signs - 3Rd Floor	2017	3,793		20	79	79	79	15
16	Switches And Lights - 3Rd Floor	2017	6,100		20	51	51	51	16
17	7 Thru The Wall Ac Units	2017	3,202		20	187	187	187	17
18	Walpaper For 2Nd Floor Hallway And Patient Rooms	2017	4,139		20	207	207	207	18
19	Elevator Work On Elevator 1 & 3	2017	7,381		20	369	369	369	19
20	Hvac Repair	2017	3,868		20	193	193	193	20
21	Repairs To Door	2017	2,505		20	125	125	125	21
22	Sprinkler System Repair	2017	3,549		20	177	177	177	22
23	Sprinkler System Repair	2017	3,715		20	186	186	186	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)		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 9,529,503	$ 415,558		$ 125,006	$ (290,552)	$ 8,505,048	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,154	10
11	Design/Install Roman Shades in Resident Rooms	2016	21,803		20	1,090	1,090	2,180	11
12	Wallpapaer in Hallways and Resident Rooms/3rd floor	2016	40,767		20	2,038	2,038	4,077	12
13	Wallpaper lobby & 1st floor	2016	42,129		20	2,106	2,106	4,213	13
14	Design & Install Roman shades Halls & Rooms	2016	25,437		20	1,272	1,272	2,544	14
15	Lighting Fixtures and Sconces Patient/Toilet Room Ortho Wing	2016	40,991		20	2,050	2,050	4,099	15
16	Handrails throughout Facility/Patient/1st Floor Hallways	2016	32,600		20	1,630	1,630	3,260	16
17	Shades, Privacy Curtains, Tile, Cabinets in Dining/Patient/Spa/To	2016	61,560		20	3,078	3,078	6,156	17
18	Tile for Offices	2016	15,200		20	760	760	1,520	18
19	Create temp/perm shower room w/toilet on 2nd/3rd floor	2016	8,400		20	420	420	840	19
20	Tile,Counter, Fixtures in Bathrooms, Drywall, Partitions, Lights	2016	21,000		20	1,050	1,050	2,100	20
21	Demolish/Install new plumbing, lighting, flooring in bathrooms	2016	87,500		20	4,375	4,375	8,750	21
22	Corridors & Nurses Stations/ new tile, doors, drywall, electrical, li	2016	112,900		20	5,645	5,645	11,290	22
23	Wallpaper lobby & 1st floor	2016	35,000		20	1,750	1,750	3,500	23
24	Window Replacements	2016	3,700		20	185	185	370	24
25	Install Cove Base/Wallpaper/Quartz Counter in computer room	2016	3,800		20	190	190	380	25
26	Replacement of Fire Dumper & Actuator	2016	5,121		20	256	256	512	26
27	Repair of water leak in Boiler	2016	8,982		20	449	449	898	27
28	Install electric outlet in server room/relocate outlets/time clock	2016	3,073		20	154	154	307	28
29	Wall Base 1st and 3rd Floor	2017	3,000		20	150	150	150	29
30	Parking Lot Repair	2017	4,374		20	219	219	219	30
31	Interior/Exterior Existing Lighting	2017	49,689		20	2,484	2,484	2,484	31
32	Security System Entire Building	2017	6,400		20	320	320	320	32
33	1st FL Dining Rm-Outlets,Drywall,Cabinets,Counter/Backsplash	2017	6,470		20	324	324	324	33
34	TOTAL (lines 1 thru 33)		$ 671,183	$		$ 32,572	$ 32,572	$ 81,390	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 671,183	$		$ 32,572	$	$ 81,390	1
2	3rd FL Dining Rm-Outlets,Drywall,Cabinets,Counters,Fixtures	2017	12,450		20	623	623	623	2
3	3rd Floor Wallpaper & Paint,Switches, Blinds	2017	8,550		20	428	428	428	3
4	Men's & Woman's Spa Grout & Tile Work, Mirrors	2017	7,375		20	369	369	369	4
5	1st FL Therapy Rm-Wallpaper,Mouldings,Outlets,Cabinetry,Pantry	2017	17,000		20	850	850	850	5
6	Wall Prep,Lights,Outlets,Bathroom Fixtures in 3rd Floor Resident Rm	2017	9,070		20	454	454	454	6
7	Commercial Chiller Repair	2017	6,384		20	319	319	319	7
8	Chiller Pump Replacement	2017	6,938		20	347	347	347	8
9	Boiler Repair	2017	6,315		20	316	316	316	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 745,265	$		$ 36,276	$ 3,704	$ 85,094	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	273,312	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		(12)	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	189	(5)	7,561	13
14	Allocated from ITEX/AK Care	1999	840	22	20	42	20	798	14
15	Allocated from ITEX/AK Care	2005	3,676		20	184	184	2,273	15
16	Allocated from ITEX/AK Care	2007	4,551	106	20	228	122	2,332	16
17	Allocated from ITEX/AK Care	2008	17,347	445	20	573	128	5,491	17
18	Allocated from ITEX/AK Care	2009	945	24	20	95	71	803	18
19	Allocated from ITEX/AK Care	2010	2,019		20	101	101	745	19
20	Allocated from ITEX/AK Care	2014	8,428	486	20	421	(65)	1,486	20
21	Allocated from ITEX/AK Care	2016	965	25	20	96	71	112	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	$ 12,264		$ 13,047	$ 783	$ 374,909	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 12,264		$ 13,047	$ 783	$ 374,909	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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)		$ 515,453	$ 12,264		$ 13,047	$ 783	$ 374,909	34

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 328,517	$ 166	$ 40,046	$ 39,880	10	$ 213,627	71
72	Current Year Purchases	25,232		2,081	2,081	10	2,081	72
73	Fully Depreciated Assets	1,734,552		165	165	10	1,734,441	73
74								74
75	TOTALS	$ 2,088,301	$ 166	$ 42,292	$ 42,126		$ 1,950,150	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)	$ 12,217,804	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 415,724	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,298	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (248,426)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,455,197	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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 29,746 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	Hyundai	$	$ 10,604	17
18					18
19					19
20					20
21	TOTAL		$	$ 10,604	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 And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

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	$		$ 338,047	$		$ 338,047	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			70,753			70,753	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			488,040			488,040	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				276,901		276,901	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						111,691		111,691	13
14	TOTAL			$		$ 896,840	$ 388,592		$ 1,285,432	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.

STATE OF ILLINOIS

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (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	$	$ 104,862	1
2	Cash-Patient Deposits	2,011	2,011	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,848,691	1,848,691	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	842,756	856,857	6
7	Other Prepaid Expenses	424,222	424,222	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	893,210	1,581,448	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,010,890	$ 4,818,091	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	791,170	1,605,283	15
16	Equipment, at Historical Cost	1,388,758	2,338,898	16
17	Accumulated Depreciation (book methods)	(1,991,156)	(7,224,738)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		126,523	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(20,785)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,333,639	3,333,639	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,522,411	$ 7,778,229	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,533,301	$ 12,596,320	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,309,206	$ 2,323,207	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,650,000	1,815,169	29
30	Accrued Salaries Payable	437,926	437,926	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,782	28,782	31
32	Accrued Real Estate Taxes(Sch.IX-B)		378,766	32
33	Accrued Interest Payable	3,526	28,847	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,666	1,666	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	132,346	148,933	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,563,452	$ 5,163,296	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,275,172	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		124,365	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,399,537	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,563,452	$ 13,562,833	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,969,849	$ (966,513)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,533,301	$ 12,596,320	48

*(See instructions.)

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,685,842	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,685,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	484,005	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	(200,000)	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)**	$ 284,005	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)**	$ 2,969,849	24 *

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 14,182,067	1
2	Discounts and Allowances for all Levels	(2,146,328)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,035,739	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,746,398	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,746,398	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	1,942	13
14	Non-Patient Meals	582	14
15	Telephone, Television and Radio	2,550	15
16	Rental of Facility Space		16
17	Sale of Drugs	452,921	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,451	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,661	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 560,107	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	152,682	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 152,682	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	97	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 97	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,495,023	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,374,906	31
32	Health Care	5,387,537	32
33	General Administration	3,394,677	33
	B. Capital Expense		
34	Ownership	1,218,281	34
	C. Ancillary Expense		
35	Special Cost Centers	1,387,527	35
36	Provider Participation Fee	248,090	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,011,018	40
41	**Income before Income Taxes (line 30 minus line 40)****	484,005	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 484,005	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,868,138	44
45	Private Pay - Net Inpatient Revenue	1,509,419	45
46	Medicare - Net Inpatient Revenue	1,636,246	46
47	Other-(specify) Insurance	518,833	47
48	Other-(specify) Veteran, MMAI	5,503,103	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,035,739	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.**

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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	1,160	1,360	$ 75,992	$ 55.88	1
2	Assistant Director of Nursing	1,677	2,405	95,063	39.53	2
3	Registered Nurses	34,641	39,041	1,157,254	29.64	3
4	Licensed Practical Nurses	44,222	48,081	1,259,367	26.19	4
5	CNAs & Orderlies	109,152	117,412	1,549,045	13.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,304	10,872	158,219	14.55	8
9	Activity Director	3,680	4,184	66,258	15.84	9
10	Activity Assistants	6,675	7,856	95,777	12.19	10
11	Social Service Workers	8,911	9,976	257,816	25.84	11
12	Dietician					12
13	Food Service Supervisor	4,865	5,927	115,253	19.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,663	34,717	414,895	11.95	15
16	Dishwashers					16
17	Maintenance Workers	4,045	4,301	69,219	16.09	17
18	Housekeepers	36,561	39,244	522,572	13.32	18
19	Laundry	5,324	6,531	89,012	13.63	19
20	Administrator	2,029	2,150	122,102	56.79	20
21	Assistant Administrator					21
22	Other Administrative	261	261	45,096	172.78	22
23	Office Manager					23
24	Clerical	11,468	12,240	222,065	18.14	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	1,911	2,076	31,841	15.34	31
32	Other Health Care(specify)					32
33	Other(specify)	4,528	5,087	141,094	27.74	33
34	TOTAL (lines 1 - 33)	323,077	353,721	$ 6,487,940 *	$ 18.34	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	$ 19,367	01-03	35
36	Medical Director	Monthly	193,283	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	12,420	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	6,926	11-03	44
45	Social Service Consultant	Monthly	1,408	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 286,204		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Allen Hollander	Administrator	0	$ 122,102
Ian Crook	VP Operations	0	45,096
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 167,198

B. Administrative - Other

Description	Amount
Management Fees - Mark Hollander	$ 63,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 63,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consultant	$ 1,263
AK Care	Bookkeeping	132,250
See Attached	Legal	56,404
Marcum LLP	Accounting	38,414
Ability Network	Data Processing	6,515
Netsmart Technologies	Data Processing	55,357
Paycom	Payroll Processing	17,263
AK Care	Data Processing	13,546
ML Enterprises	Purchasing Consultant	250
Great American	Payroll Clock Processing	3,552
2401 Incorporated	Architectural Services	1,880
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 326,694

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 253,232
Unemployment Compensation Insurance	38,359
FICA Taxes	487,191
Employee Health Insurance	308,169
Employee Meals	93,951
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	16,997
Employee Benefits	237
Pension Plan	46,848
Christmas Expense	11,370
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,256,354

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	3,600
Health Care Worker Background Check	1,457
(Indicate # of checks performed 145)	
Patient Background Checks	
Dues & Subscriptions	22,220
Licenses & Permits	3,472
Allocated from ITEX/AK Care	1,373
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,122

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,550
Allocated from ITEX/AK Care	925
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,475

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 $26,100**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,556** 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. $ **248,090**
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. $ **93,951** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **582**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **N/A**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees