		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0040535

Facility Name: Harmony Nursing Rehab Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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) 05/26/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	180	Skilled (SNF)	180	65,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	38,027	5,095	7,674	50,796	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,027	5,095	7,674	50,796	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.10%

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 4,705

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number: Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	813,906	76,846		890,752		890,752	2,335	893,087			1
2	Food Purchase		504,123		504,123	(104,676)	399,447	(1,018)	398,429			2
3	Housekeeping	711,017	50,024		761,041		761,041	8,279	769,320			3
4	Laundry	118,693	33,913		152,606		152,606		152,606			4
5	Heat and Other Utilities			232,446	232,446		232,446	4,340	236,786			5
6	Maintenance	88,267	34,746	132,381	255,394		255,394	(618)	254,776			6
7	Other (specify):*											7
8	TOTAL General Services	1,731,883	699,652	364,827	2,796,362	(104,676)	2,691,686	13,318	2,705,004			8
	B. Health Care and Programs											
9	Medical Director			144,000	144,000		144,000		144,000			9
10	Nursing and Medical Records	4,567,429	765,356	210,755	5,543,540		5,543,540	(1,386)	5,542,154			10
10a	Therapy	174,890	148		175,038		175,038		175,038			10a
11	Activities	233,763	7,929	1,593	243,285		243,285		243,285			11
12	Social Services	167,400		3,153	170,553		170,553		170,553			12
13	CNA Training											13
14	Program Transportation			5,554	5,554		5,554		5,554			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,143,482	773,433	365,055	6,281,970		6,281,970	(1,386)	6,280,584			16
	C. General Administration											
17	Administrative	132,955			132,955		132,955		132,955			17
18	Directors Fees											18
19	Professional Services			1,121,326	1,121,326		1,121,326	(859,889)	261,437			19
20	Dues, Fees, Subscriptions & Promotions			157,393	157,393		157,393	(82,086)	75,307			20
21	Clerical & General Office Expenses	296,988	2,455	427,339	726,782		726,782	154,844	881,626			21
22	Employee Benefits & Payroll Taxes			1,111,465	1,111,465	104,676	1,216,141		1,216,141			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,101	1,101		1,101	1,313	2,414			24
25	Other Admin. Staff Transportation			1,951	1,951		1,951		1,951			25
26	Insurance-Prop.Liab.Malpractice			427,061	427,061		427,061	14,937	441,998			26
27	Other (specify):*							98,585	98,585			27
28	TOTAL General Administration	429,943	2,455	3,247,636	3,680,034	104,676	3,784,710	(672,296)	3,112,414			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,305,308	1,475,540	3,977,518	12,758,366		12,758,366	(660,364)	12,098,002			29

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

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

Facility Name & ID Number Harmony Nursing Rehab Center #0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,777	38,777		38,777	411,420	450,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,253	130,253		130,253	244,983	375,236			32
33	Real Estate Taxes							406,964	406,964			33
34	Rent-Facility & Grounds			1,028,000	1,028,000		1,028,000	(1,028,000)				34
35	Rent-Equipment & Vehicles			33,972	33,972		33,972	(8,991)	24,981			35
36	Other (specify):*							39,744	39,744			36
37	TOTAL Ownership			1,231,002	1,231,002		1,231,002	66,120	1,297,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	759,123	290,971		1,050,094		1,050,094		1,050,094			39
40	Barber and Beauty Shops			564	564		564		564			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			390,757	390,757		390,757		390,757			42
43	Other (specify):*	95,989		243,000	338,989		338,989	(338,989)				43
44	TOTAL Special Cost Centers	855,112	290,971	634,321	1,780,404		1,780,404	(338,989)	1,441,415			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,160,420	1,766,511	5,842,841	15,769,772		15,769,772	(933,233)	14,836,539			45

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(515)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	52,002	30		9
10	Interest and Other Investment Income	(18,104)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(503)	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	(16,407)	21		18
19	Entertainment				19
20	Contributions	(5,300)	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	(242,035)	21		24
25	Fund Raising, Advertising and Promotional	(228)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,387)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(577,931)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (814,408)		$	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)	(118,825)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (118,825)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (933,233)		37

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

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

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

Harmony Nursing Rehab Center

ID# 0040535

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (16,831)	21	1
2	Marketing Salary	(95,989)	43	2
3	Patient Purchases	(1,386)	10	3
4	Bank Charges	(13,099)	21	4
5	Credit Card Fees	(6,310)	21	5
6	Public Relations/Marketing	(64,179)	20	6
7	Building Co. - Franchise Tax	(75)	21	7
8	Building Co. - Office Expense	(392)	21	8
9	Building Co. - Accounting	(16,313)	19	9
10	Building Co. - Amortization	(3,615)	36	10
11	Non-Allowable Auto Rental	(10,859)	35	11
12	PAC Dues	(12,728)	20	12
13	Non-Allowable Expense	(243,000)	43	13
14	Non-Allowable Legal	(85,777)	19	14
15	Capitalized R&M	(7,377)	06	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(577,931)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Harmony Nursing Rehab Center

ID# 0040535

Report Period Beginning: 01/01/20

Ending: 12/31/20

	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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
14	15	17	18	19	20	21	22	23	24	25	26	27

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS | Summary A

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			2,335									2,335	1
2	Food Purchase	(1,018)											(1,018)	2
3	Housekeeping			8,279									8,279	3
4	Laundry													4
5	Heat and Other Utilities			4,340									4,340	5
6	Maintenance	(7,377)		6,759									(618)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(8,395)		21,713									13,318	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,386)											(1,386)	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**	(1,386)											(1,386)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(102,091)	16,313	(774,111)									(859,889)	19
20	Fees, Subscriptions & Promotions	(82,435)		349									(82,086)	20
21	Clerical & General Office Expenses	(300,536)	(10,200)	465,580									154,844	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,313									1,313	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		13,826	1,111									14,937	26
27	Other (specify):*			98,585									98,585	27
28	**TOTAL General Administration**	(485,062)	19,939	(207,173)									(672,296)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(494,843)	19,939	(185,460)									(660,364)	29

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	52,002	319,977	39,441									411,420	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(18,104)	252,163	10,924									244,983	32
33	Real Estate Taxes		387,293	19,671									406,964	33
34	Rent-Facility & Grounds		(1,028,000)										(1,028,000)	34
35	Rent-Equipment & Vehicles	(10,859)		1,868									(8,991)	35
36	Other (specify):*	(3,615)	43,359										39,744	36
37	**TOTAL Ownership**	19,424	(25,208)	71,904									66,120	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(338,989)											(338,989)	43
44	**TOTAL Special Cost Centers**	(338,989)											(338,989)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(814,408)	(5,269)	(113,556)									(933,233)	45

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,028,000	Keiro Building LLC		$	$ (1,028,000)	1
2	V	32	Interest	112	Keiro Building LLC		252,275	252,163	2
3	V	36	MIP Insurance		Keiro Building LLC		39,744	39,744	3
4	V	21	Office Expense		Keiro Building LLC		392	392	4
5	V	19	Accounting		Keiro Building LLC		16,313	16,313	5
6	V	33	Real Estate Taxes		Keiro Building LLC		387,293	387,293	6
7	V	21	Franchise Tax/Limited Liab Co Fee		Keiro Building LLC		75	75	7
8	V	26	Insurance Expense		Keiro Building LLC		13,826	13,826	8
9	V	21	Miscellaneous Income	10,667	Keiro Building LLC			(10,667)	9
10	V	30	Depreciation		Keiro Building LLC		319,977	319,977	10
11	V	36	Amortization		Keiro Building LLC		3,615	3,615	11
12	V								12
13	V								13
14	Total			$ 1,038,779			$ 1,033,510	$ * (5,269)	14

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

STATE OF ILLINOIS

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	RAJCHENBACH FAMILY TRUST	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 Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	ITEX 6633 Bldg./ AK Care Bookkeeping Services		$ 2,335	$ 2,335	15
16	V	3	Housekeeping		ITEX 6633 Bldg./ AK Care Bookkeeping Services		8,279	8,279	16
17	V	5	Utilities		ITEX 6633 Bldg./ AK Care Bookkeeping Services		4,340	4,340	17
18	V	6	Repairs and Maintenance		ITEX 6633 Bldg./ AK Care Bookkeeping Services		6,759	6,759	18
19	V	19	Professional Fees	14,569	ITEX 6633 Bldg./ AK Care Bookkeeping Services		7,458	(7,111)	19
20	V	20	Fees, Subscriptions		ITEX 6633 Bldg./ AK Care Bookkeeping Services		349	349	20
21	V	21	Clerical and General		ITEX 6633 Bldg./ AK Care Bookkeeping Services		31,496	31,496	21
22	V	24	Education and Seminars		ITEX 6633 Bldg./ AK Care Bookkeeping Services		1,313	1,313	22
23	V	26	Insurance		ITEX 6633 Bldg./ AK Care Bookkeeping Services		1,111	1,111	23
24	V	30	Depreciation		ITEX 6633 Bldg./ AK Care Bookkeeping Services		39,441	39,441	24
25	V	32	Interest		ITEX 6633 Bldg./ AK Care Bookkeeping Services		10,924	10,924	25
26	V	33	Real Estate Taxes		ITEX 6633 Bldg./ AK Care Bookkeeping Services		19,671	19,671	26
27	V	33	RE Tax Protest Costs		ITEX 6633 Bldg./ AK Care Bookkeeping Services				27
28	V	35	Equipment Rental		ITEX 6633 Bldg./ AK Care Bookkeeping Services		1,868	1,868	28
29	V								29
30	V								30
31	V								31
32	V	21	Clerical Salaries		ITEX 6633 Bldg./ AK Care Bookkeeping Services		434,084	434,084	32
33	V	27	Gen. Admin. - Emp. Benefit		ITEX 6633 Bldg./ AK Care Bookkeeping Services		98,585	98,585	33
34	V								34
35	V								35
36	V	19	Bookkeeping Fees	767,000	ITEX 6633 Bldg./ AK Care Bookkeeping Services			(767,000)	36
37	V								37
38	V								38
39	Total			$ 781,569			$ 668,013	$ * (113,556)	39

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Arthur Hollander	Relative	Administrative	0.00%	See Attached	40	100.00%	Alloc Salary	87,932	17-01	1
2	Mark Hollander	Owner	Administrative	10.00%	See Attached	20	33.33%				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	$ 87,932		13

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 6633 Bldg./AK Care Bookkeeping Svcs.
Street Address: 6633 N. Lincoln Ave.
City / State / Zip Code: Lincolnwood, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Available Bed Days	271,572	3	$ 9,624	$	65,880	$ 2,335	1
2	3	Housekeeping	Available Bed Days	271,572	3	34,129		65,880	8,279	2
3	5	Utilities	Available Bed Days	271,572	3	17,889		65,880	4,340	3
4	6	Repairs and Maintenance	Available Bed Days	271,572	3	27,861		65,880	6,759	4
5	19	Professional Fees	Available Bed Days	271,572	3	30,745		65,880	7,458	5
6	20	Fees, Subscriptions	Available Bed Days	271,572	3	1,439		65,880	349	6
7	21	Clerical and General	Available Bed Days	271,572	3	129,832		65,880	31,496	7
8	24	Education and Seminars	Available Bed Days	271,572	3	5,414		65,880	1,313	8
9	26	Insurance	Available Bed Days	271,572	3	4,578		65,880	1,111	9
10	30	Depreciation	Available Bed Days	271,572	3	162,585		65,880	39,441	10
11	32	Interest	Available Bed Days	271,572	3	45,029		65,880	10,924	11
12	33	Real Estate Taxes	Available Bed Days	271,572	3	81,087		65,880	19,671	12
13	33	RE Tax Protest Costs	Available Bed Days	271,572	3			65,880		13
14	35	Equipment Rental	Available Bed Days	271,572	3	7,702		65,880	1,868	14
15										15
16										16
17										17
18	21	Clerical Salaries	Direct Allocation		4	1,069,154	1,069,154		434,084	18
19	27	Gen. Admin. - Emp. Benefit	Direct Allocation		4	242,817			98,585	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,869,885	$ 1,069,154		$ 668,013	25

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number ( )

Fax Number ( )

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	Mortgage	$49,971.00	10/1/2003	$ 9,295,200	$ 7,930,219	10/1/2038	5.5000	$ 252,275	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Citi Bank		X	Line of Credit							130,253	6
7												7
8												8
9	TOTAL Facility Related				$49,971.00		$ 9,295,200	$ 7,930,219			$ 382,528	9
	B. Non-Facility Related*											
10	Interest Income		X								(18,104)	10
11	Interest Income - Bldg Co		X								(112)	11
12	Allocated from ITEX/AK Care										10,924	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,292)	14
15	TOTALS (line 9+line14)						$ 9,295,200	$ 7,930,219			$ 375,236	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 39,744 Line # 36

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	416,807	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.)	$	421,721	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,914	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	402,050	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	406,964	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	330,079	8
	2016	360,729	9
	2017	387,689	10
	2018	395,251	11
	2019	402,050	12

2020 Accrual = 2019 Tax
Allocated from ITEX/AK Care: $19,671
*Beginning Accrual Adjusted

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	13-11-300-007-0000	Long Term Care Property	$ 402,050.18	402,050.18
2.	10-35-312-022-0000	Allocated from ITEX	$ 84,819.07	19,670.71
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 486,869.25	$ 421,720.89

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 319,977	20	$ 350,970	$ 30,993	$ 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	6	6	9,553	10
11	Various			1997	8,612		20			8,612	11
12	Various			1998	12,911		20	3	3	12,911	12
13	Various			1999	61,368		20	6	6	61,368	13
14	Various			2000	36,671		20	1,428	1,428	36,666	14
15	Various			2001	19,752		20	521	521	19,116	15
16	Various			2002	23,794		20	558	558	22,883	16
17	Various			2003	19,176		20			19,176	17
18	Various			2004	5,922		20	174	174	5,336	18
19	Various			2005	60,851		20	562	562	60,777	19
20	Various			2006	20,548		20			20,548	20
21	Various			2007	369,783		20	775	775	367,230	21
22	Various			2008	109,693		20			109,693	22
23	Various			2009	184,943		20	5,046	5,046	116,795	23
24	Various			2010	51,188		20	1,889	1,889	50,639	24
25	Various			2011	8,250		20	413	413	4,996	25
26	Various			2012	14,324		20	343	343	12,195	26
27	Various			2013	128,030		20	974	974	117,631	27
28	Various			2014	26,746		20	287	287	24,259	28
29	Various			2015	13,603		20	545	545	9,483	29
30	Various			2016	14,248		20	713	713	3,153	30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		852,173			41,621	41,621	208,838	67
68	Related Party Allocations (Pages 12H & 12I)		525,731	39,395		13,187	(26,208)	413,660	68
69	Financial Statement Depreciation			38,777			(38,777)		69
70	TOTAL (lines 4 thru 69)		$ 9,608,435	$ 398,149		$ 420,022	$ 21,873	$ 8,746,083	70

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,608,435	$ 398,149		$ 420,022	$ 21,873	$ 8,746,083	1
2	Interior Signs - 3Rd Floor	2017	3,793		20	190	190	648	2
3	Switches And Lights - 3Rd Floor	2017	6,100		20	305	305	966	3
4	7 Thru The Wall Ac Units	2017	3,202		20	160	160	574	4
5	Wallpaper For 2Nd Floor Hallway & Patient Rooms	2017	4,139		20	207	207	811	5
6	Elevator Work On Elvator 1 & 3	2017	7,381		20	369	369	1,261	6
7	Hvac Repair	2017	3,868		20	193	193	773	7
8	Repairs To Door	2017	2,505		20	125	125	490	8
9	Sprinkler System Repair	2017	3,549		20	177	177	635	9
10	Sprinkler System Repair	2017	3,715		20	186	186	635	10
11	Fill Station Installation	2020	3,200		20	160	160	160	11
12	Repair Fresh Air Damper, Actuator, Freeze Stat And Coil	2020	10,375		20	519	519	519	12
13	Tampering Valve Installation And Gate Valve Repairs	2020	4,880		20	244	244	244	13
14	New Fire Protection System	2020	72,134		20	3,607	3,607	3,607	14
15	Elevator Upgrade - Installation Of 3 Units	2020	87,583		20	4,379	4,379	4,379	15
16	Elevator Repair - Replace Bad Door Edge	2020	3,402		20	170	170	170	16
17	Fire Alarrm System - Main Fire Panel	2020	3,975		20	199	199	199	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,832,236	$ 398,149		$ 431,211	$ 33,063	$ 8,762,154	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2,886	10
11	Design/Install Roman Shades in Resident Rooms	2016	21,803		20	1,090	1,090	5,450	11
12	Wallpapaer in Hallways and Resident Rooms/3rd floor	2016	40,767		20	2,038	2,038	10,191	12
13	Wallpaper lobby & 1st floor	2016	42,129		20	2,106	2,106	10,531	13
14	Design & Install Roman shades Halls & Rooms	2016	25,437		20	1,272	1,272	6,360	14
15	Lighting Fixtures and Sconces Patient/Toilet Room Ortho Wing	2016	40,991		20	2,050	2,050	10,249	15
16	Handrails throughout Facility/Patient/1st Floor Hallways	2016	32,600		20	1,630	1,630	8,150	16
17	Shades, Privacy Curtains, Tile, Cabinets in Dining/Patient/Spa/To	2016	61,560		20	3,078	3,078	15,390	17
18	Tile for Offices	2016	15,200		20	760	760	3,800	18
19	Create temp/perm shower room w/toilet on 2nd/3rd floor	2016	8,400		20	420	420	2,100	19
20	Tile,Counter, Fixtures in Bathrooms, Drywall, Partitions, Lights	2016	21,000		20	1,050	1,050	5,250	20
21	Demolish/Install new plumbing, lighting, flooring in bathrooms	2016	87,500		20	4,375	4,375	21,875	21
22	Corridors & Nurses Stations/ new tile, doors, drywall, electrical, li	2016	112,900		20	5,645	5,645	28,225	22
23	Wallpaper lobby & 1st floor	2016	35,000		20	1,750	1,750	8,750	23
24	Window Replacements	2016	3,700		20	185	185	925	24
25	Install Cove Base/Wallpaper/Quartz Counter in computer room	2016	3,800		20	190	190	950	25
26	Replacement of Fire Dumper & Actuator	2016	5,121		20	256	256	1,280	26
27	Repair of water leak in Boiler	2016	8,982		20	449	449	2,245	27
28	Install electric outlet in server room/relocate outlets/time clock	2016	3,073		20	154	154	769	28
29	Wall Base 1st and 3rd Floor	2017	3,000		20	150	150	600	29
30	Parking Lot Repair	2017	4,374		20	219	219	875	30
31	Interior/Exterior Existing Lighting	2017	49,689		20	2,484	2,484	9,937	31
32	Security System Entire Building	2017	6,400		20	320	320	1,287	32
33	1st FL Dining Rm-Outlets,Drywall,Cabinets,Counter/Backsplash	2017	6,470		20	324	324	1,295	33
34	TOTAL (lines 1 thru 33)		$ 671,183	$		$ 32,572	$ 32,572	$ 179,113	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 32,572	$ 179,113	1
2	3rd FL Dining Rm-Outlets,Drywall,Cabinets,Counters,Fixtures	2017	12,450		20	623	623	2,491	2
3	3rd Floor Wallpaper & Paint,Switches, Blinds	2017	8,550		20	428	428	1,711	3
4	Men's & Woman's Spa Grout & Tile Work, Mirrors	2017	7,375		20	369	369	1,476	4
5	1st FL Therapy Rm-Wallpaper,Mouldings,Outlets,Cabinetry,Pantry	2017	17,000		20	850	850	3,400	5
6	Wall Prep,Lights,Outlets,Bathroom Fixtures in 3rd Floor Resident Rm	2017	9,070		20	454	454	1,815	6
7	Commercial Chiller Repair	2017	6,384		20	319	319	1,276	7
8	Chiller Pump Replacement	2017	6,938		20	347	347	1,388	8
9	Boiler Repair	2017	6,315		20	316	316	1,264	9
10	Carrier hot water coil repair	2018	12,300		20	615	615	1,845	10
11	Repair all windows & doors 2nd and 3rd floor	2018	10,780		20	539	539	1,617	11
12	Wall mount kitchen exhaust fan	2018	3,500		20	175	175	525	12
13	Wall prep, cove base, remodeling in 3rd flr rooms	2018	5,000		20	250	250	750	13
14	Physician lounge tile, cabinets, wall repair, countertops	2018	16,000		20	800	800	2,400	14
15	1st floor therapy countertops and remodel	2018	4,500		20	225	225	675	15
16	Wall prep, cove base, remodeling in 3rd flr rooms	2018	9,200		20	460	460	1,380	16
17	City required plumbing corrections	2018	9,400		20	470	470	1,410	17
18	Lochinvar boiler and installation	2018	13,618		20	681	681	2,043	18
19	Parking Lot Repairs - Asphalt and Patching	2019	3,400		20	170	170	340	19
20	Elevator Repair - Pistons/Jacks	2019	13,810		20	691	691	1,381	20
21	Commercial Chiller Repair	2019	5,400		20	270	270	540	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)		$ 852,173	$		$ 41,621	$ 41,621	$ 208,838	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 from Itex 6633 Bldg.	1993	389,123	36,316	20	11,118	(25,198)	306,665	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Itex 6633 Bldg.	1993	48,963	662	20		(662)	48,963	9
10	Allocated from Itex 6633 Bldg.	1994	26,299	684	20		(684)	26,297	10
11	Allocated from Itex 6633 Bldg.	1995	4,482	30	20		(30)	4,482	11
12	Allocated from Itex 6633 Bldg.	1996	254		20			254	12
13	Allocated from Itex 6633 Bldg.	1997	7,561	425	20		(425)	7,561	13
14	Allocated from Itex 6633 Bldg.	1999	840	43	20		(43)	840	14
15	Allocated from Itex 6633 Bldg.	2005	3,676		20	184	184	2,826	15
16	Allocated from Itex 6633 Bldg.	2007	4,551	160	20	228	68	3,017	16
17	Allocated from Itex 6633 Bldg.	2008	17,347	663	20	573	(90)	7,209	17
18	Allocated from Itex 6633 Bldg.	2009	945	35	20		(35)	945	18
19	Allocated from Itex 6633 Bldg.	2010	2,019		20	101	101	1,047	19
20	Allocated from Itex 6633 Bldg.	2014	8,428		20	421	421	2,751	20
21	Allocated from Itex 6633 Bldg.	2016	965	33	20	48	15	201	21
22	Allocated from Itex 6633 Bldg.	2018	858	29	20	43	14	93	22
23	Allocated from Itex 6633 Bldg.	2019	9,421	314	20	471	157	510	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)		$ 525,731	$ 39,395		$ 13,187	$ (26,208)	$ 413,660	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 525,731	$ 39,395		$ 13,187	$ (26,208)	$ 413,660	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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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)		$ 525,731	$ 39,395		$ 13,187	$ (26,208)	$ 413,660	34

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 223,631	$ 46	$ 18,544	$ 18,498	10	$ 135,231	71
72	Current Year Purchases	3,850		385	385	10	385	72
73	Fully Depreciated Assets	965,831		56	56	10	965,817	73
74								74
75	TOTALS	$ 1,193,312	$ 46	$ 18,986	$ 18,939		$ 1,101,432	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,625,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 398,195	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 450,197	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,002	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,863,586	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 24,455 Description: See Attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Honda	$	$ 526	17
18					18
19					19
20					20
21	TOTAL		$	$ 526	21

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

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

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

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

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 248,561		$	$		$ 248,561	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	86,841					86,841	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	423,721					423,721	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				209,106		209,106	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached						81,865		81,865	13
14	TOTAL			$ 759,123		$	$ 290,971		$ 1,050,094	14

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 3,617,251	$ 4,067,803	1
2	Cash-Patient Deposits	2,011	2,011	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,690,545	2,690,545	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,256	73,256	6
7	Other Prepaid Expenses	823,878	823,878	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	10,440	501,531	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,217,381	$ 8,159,024	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	969,343	1,846,146	15
16	Equipment, at Historical Cost	1,392,608	2,404,955	16
17	Accumulated Depreciation (book methods)	(2,144,609)	(8,326,107)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		126,523	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(31,630)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	7,058,450	7,007,946	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,275,792	$ 10,647,242	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,493,173	$ 18,806,266	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 672,943	$ 686,945	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,589,048	1,589,048	28
29	Short-Term Notes Payable		171,214	29
30	Accrued Salaries Payable	593,083	593,083	30
31	Accrued Taxes Payable (excluding real estate taxes)	381,351	381,351	31
32	Accrued Real Estate Taxes(Sch.IX-B)		402,050	32
33	Accrued Interest Payable		17,777	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,591,250	1,591,250	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,827,675	$ 5,432,718	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,759,005	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	3,015,098	3,058,206	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,015,098	$ 10,817,211	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,842,773	$ 16,249,929	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,650,400	$ 2,556,337	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,493,173	$ 18,806,266	48

*(See instructions.)

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,517,630	1
2	Restatements (describe):		2
3	Depreciation	39,496	3
4	Rounding	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,557,127	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,093,273	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,093,273	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)**	$ 6,650,400	24 *

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,539,436	1
2	Discounts and Allowances for all Levels	(1,614,832)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,924,604	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,980,453	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,980,453	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	510	13
14	Non-Patient Meals	515	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205,082	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,238	19
20	Radiology and X-Ray	11,755	20
21	Other Medical Services	3,007	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 254,107	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,104	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,104	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	4,685,777	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,685,777	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,863,045	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,796,362	31
32	Health Care	6,281,970	32
33	General Administration	3,680,034	33
	B. Capital Expense		
34	Ownership	1,231,002	34
	C. Ancillary Expense		
35	Special Cost Centers	1,389,647	35
36	Provider Participation Fee	390,757	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,769,772	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,093,273	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,093,273	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,142,339	44
45	Private Pay - Net Inpatient Revenue	1,159,484	45
46	Medicare - Net Inpatient Revenue	1,886,040	46
47	Other-(specify) Insurance	177,810	47
48	Other-(specify) Veteran, MMAI	5,558,931	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,924,604	49

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

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

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

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

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,806	1,982	$ 120,947	$ 61.02	1
2	Assistant Director of Nursing	1,912	2,080	88,622	42.61	2
3	Registered Nurses	26,030	30,197	992,925	32.88	3
4	Licensed Practical Nurses	37,487	43,731	1,325,599	30.31	4
5	CNAs & Orderlies	94,460	111,076	1,964,038	17.68	5
6	CNA Trainees					6
7	Licensed Therapist	18,302	19,713	759,123	38.51	7
8	Rehab/Therapy Aides	6,652	8,045	174,890	21.74	8
9	Activity Director	3,463	4,095	67,994	16.60	9
10	Activity Assistants	9,200	10,289	165,769	16.11	10
11	Social Service Workers	6,841	7,743	167,400	21.62	11
12	Dietician					12
13	Food Service Supervisor	4,728	5,331	154,634	29.01	13
14	Head Cook	1,770	2,098	33,561	16.00	14
15	Cook Helpers/Assistants	35,052	39,577	625,711	15.81	15
16	Dishwashers					16
17	Maintenance Workers	4,468	5,150	88,267	17.14	17
18	Housekeepers	34,945	40,542	711,017	17.54	18
19	Laundry	5,394	6,389	118,693	18.58	19
20	Administrator	2,016	2,040	87,932	43.10	20
21	Assistant Administrator					21
22	Other Administrative	239	239	45,023	188.38	22
23	Office Manager	5,281	5,954	155,235	26.07	23
24	Clerical	8,882	9,425	141,753	15.04	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	183	195	3,445	17.67	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	4,457	5,681	167,842	29.54	33
34	TOTAL (lines 1 - 33)	313,567	361,572	$ 8,160,420 *	$ 22.57	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		$		35
36	Medical Director	Monthly	144,000	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	48,000	10-03	38
39	Pharmacist Consultant	Monthly	11,258	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	1,593	11-03	44
45	Social Service Consultant	Monthly	3,153	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 209,604		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,998	$ 149,897	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,998	$ 149,897		53

Facility Name & ID Number Harmony Nursing Rehab Center # 0040535 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arthur Hollander	Administrator	0	$ 87,932
Ian Crook	VP Operations	0	45,023
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 132,955

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consultant	$ 1,659
Consonus	Data Anaytics	5,997
AK Care Inc.	Administrative Consultant	1,667
AK Care Inc.	Bookkeeping	767,000
AK Care Inc.	Data Processing	12,902
Paylocity	Payroll Processing	13,361
Ability Network	Data Processing	8,567
Fully Managed, Inc.	IT Support	750
Information Controls Inc.	Data Processing	2,435
LexisNexis Risk Solutions	Data Processing	3,270
See Attached	Legal	161,855
See Supplemental Schedule		141,865
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 1,121,327

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,128
Unemployment Compensation Insurance	48,586
FICA Taxes	520,345
Employee Health Insurance	298,135
Employee Meals	104,676
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	17,670
Employee Benefits	13,953
Pension Plan	61,212
Christmas Expense	6,436
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,216,141

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	39,705
Health Care Worker Background Check (Indicate # of checks performed 51)	514
Patient Background Checks	
Dues & Subscriptions	30,261
Licenses & Fees	4,478
See Supplemental Schedule	349
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 75,307

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,101
See Supplemental Schedule	1,313
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,414

**See instructions.

Facility Name & ID Number **Harmony Nursing Rehab Center** **# 0040535** **Report Period Beginning: 01/01/20 Ending: 12/31/20**

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. **HCCI - $25,455**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **43,793** 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. $ **390,757**
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. $ **104,676** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **515**

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

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

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

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