

Facility Name & ID Number Harmony Nursing And Rehab

0040535 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	Private Pay	4 Other	Total		
8	SNF	36,242	6,097	9,298	51,637	8	
9	SNF/PED					9	
10	ICF	7,450	192		7,642	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	43,692	6,289	9,298	59,279	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.23%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/25/1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 180 and days of care provided 5,944

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	422,350	88,256	19,945	530,551		530,551	4,607	535,158		1
2	Food Purchase		488,574		488,574	(89,535)	399,040	(1,027)	398,013		2
3	Housekeeping	417,566	50,066		467,632		467,632	6,457	474,089		3
4	Laundry	81,228	38,985		120,213		120,213		120,213		4
5	Heat and Other Utilities			232,669	232,669		232,669	(2,711)	229,958		5
6	Maintenance	98,939	54,819	179,720	333,478		333,478	6,694	340,172		6
7	Other (specify):*										7
8	TOTAL General Services	1,020,083	720,700	432,334	2,173,117	(89,535)	2,083,583	14,020	2,097,603		8
	B. Health Care and Programs										
9	Medical Director			144,627	144,627		144,627		144,627		9
10	Nursing and Medical Records	3,988,803	401,035	66,746	4,456,584		4,456,584	(36,911)	4,419,673		10
10a	Therapy	131,902			131,902		131,902		131,902		10a
11	Activities	148,840	9,427	7,539	165,806		165,806		165,806		11
12	Social Services	241,163		2,403	243,566		243,566		243,566		12
13	CNA Training										13
14	Program Transportation			14,607	14,607		14,607		14,607		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,510,708	410,462	235,922	5,157,092		5,157,092	(36,911)	5,120,181		16
	C. General Administration										
17	Administrative	126,905		85,100	212,005		212,005		212,005		17
18	Directors Fees										18
19	Professional Services			587,828	587,828	(2,614)	585,214	(436,248)	148,965		19
20	Dues, Fees, Subscriptions & Promotions			209,363	209,363		209,363	(114,455)	94,908		20
21	Clerical & General Office Expenses	226,274	20,213	452,303	698,790		698,790	115,551	814,341		21
22	Employee Benefits & Payroll Taxes			974,395	974,395	89,535	1,063,930		1,063,930		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,731	6,731		6,731	151	6,882		24
25	Other Admin. Staff Transportation			2,428	2,428		2,428		2,428		25
26	Insurance-Prop.Liab.Malpractice			354,458	354,458		354,458	2,006	356,464		26
27	Other (specify):*							114,676	114,676		27
28	TOTAL General Administration	353,179	20,213	2,672,606	3,045,998	86,920	3,132,918	(318,320)	2,814,598		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,883,970	1,151,375	3,340,862	10,376,207	(2,614)	10,373,593	(341,211)	10,032,382		29

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

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

Facility Name & ID Number

Harmony Nursing And Rehab

#0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			144,870	144,870		144,870	356,668	501,538			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			180,421	180,421		180,421	198,193	378,614			32
33	Real Estate Taxes					2,614	2,614	310,229	312,843			33
34	Rent-Facility & Grounds			851,700	851,700		851,700	(851,700)				34
35	Rent-Equipment & Vehicles			27,530	27,530		27,530	(4,624)	22,906			35
36	Other (specify):*							44,106	44,106			36
37	TOTAL Ownership			1,204,521	1,204,521	2,614	1,207,135	52,872	1,260,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		474,310	825,087	1,299,397		1,299,397		1,299,397			39
40	Barber and Beauty Shops			3,423	3,423		3,423	(3,423)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			368,442	368,442		368,442		368,442			42
43	Other (specify):*	118,904		2,591	121,495		121,495	(121,495)	0			43
44	TOTAL Special Cost Centers	118,904	474,310	1,199,543	1,792,757		1,792,757	(124,918)	1,667,839			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,002,874	1,625,685	5,744,926	13,373,485	0	13,373,485	(413,256)	12,960,229			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(511)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,455)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	166,531	30		9
10	Interest and Other Investment Income	(127,213)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(516)	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	(290)	21		18
19	Entertainment				19
20	Contributions	(16,200)	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	(223,089)	21		24
25	Fund Raising, Advertising and Promotional	(89,969)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(357,465)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (656,176)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	242,920		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 242,920		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (413,256)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Harmony Nursing And Rehab

ID# 0040535

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Expense	\$ (2,591)	43	1
2	Barber and Beauty Shop Income	(3,423)	40	2
3	Telephone Commissions	(4,170)	21	3
4	State of Illinois Income	(60)	21	4
5	Blue Cross Blue Shield Refund	(292)	21	5
6	Veterans Expense	(12,330)	10	6
7	Patient Purchases	(24,582)	10	7
8	Bank Charges	(17,176)	21	8
9	Franchise Tax	(100)	21	9
10	Building Company - Franchise Tax	(250)	21	10
11	Building Company - Office Expense	(243)	21	11
12	Building Company - Accounting	(16,654)	19	12
13	Building Company - Amortization of Loan Costs	(3,615)	36	13
14	Building Company - Legal Fees	(2,614)	19	14
15	Non-Allowable Fees	(109,988)	21	15
16	Non-Allowable Auto Lease	(6,179)	35	16
17	PAC Dues	(9,537)	20	17
18	Non-Allowable Legal	(24,759)	19	18
19	Marketing Salary	(98,514)	43	19
20	Collections Salary	(20,390)	43	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	(357,465)		49

Harmony Nursing And Rehab

Report Period Beginning: ID# 0040535
 Ending: 01/01/15
 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harmony Nursing And Rehab# 0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			4,607									4,607	1
2	Food Purchase	(1,027)											(1,027)	2
3	Housekeeping			6,457									6,457	3
4	Laundry													4
5	Heat and Other Utilities	(7,455)		4,744									(2,711)	5
6	Maintenance			6,694									6,694	6
7	Other (specify):*													7
8	TOTAL General Services	(8,482)		22,502									14,020	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(36,911)											(36,911)	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	(36,911)											(36,911)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(44,026)	19,268	(411,490)									(436,248)	19
20	Fees, Subscriptions & Promotions	(115,706)		1,251									(114,455)	20
21	Clerical & General Office Expenses	(355,657)	(10,174)	481,382									115,551	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			151									151	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			2,006									2,006	26
27	Other (specify):*			114,676									114,676	27
28	TOTAL General Administration	(515,390)	9,094	187,976									(318,320)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(560,783)	9,094	210,478									(341,211)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing And Rehab# 0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	166,531	180,072	10,065									356,668	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(127,213)	316,398	9,008									198,193	32
33	Real Estate Taxes		300,954	9,275									310,229	33
34	Rent-Facility & Grounds		(851,700)										(851,700)	34
35	Rent-Equipment & Vehicles	(6,179)		1,555									(4,624)	35
36	Other (specify):*	(3,615)	47,721										44,106	36
37	TOTAL Ownership	29,524	(6,555)	29,903									52,872	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(3,423)											(3,423)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(121,495)											(121,495)	43
44	TOTAL Special Cost Centers	(124,918)											(124,918)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(656,176)	2,539	240,381									(413,256)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Rent	\$ 851,700	Keiro Building LLC	100.00%	\$	(851,700)	1	
2	V	32 Interest	1,187	Keiro Building LLC	100.00%	317,585	316,398	2	
3	V	21 Miscellaneous Income	10,667	Keiro Building LLC	100.00%		(10,667)	3	
4	V	21 Franchise Tax		Keiro Building LLC	100.00%	250	250	4	
5	V	36 MIP Insurance		Keiro Building LLC	100.00%	44,106	44,106	5	
6	V	21 Office Expense		Keiro Building LLC	100.00%	243	243	6	
7	V	19 Accounting		Keiro Building LLC	100.00%	16,654	16,654	7	
8	V	33 Real Estate Taxes		Keiro Building LLC	100.00%	300,954	300,954	8	
9	V	30 Depreciation		Keiro Building LLC	100.00%	180,072	180,072	9	
10	V	36 Amortization of Loan Costs		Keiro Building LLC	100.00%	3,615	3,615	10	
11	V	19 Legal Fees		Keiro Building LLC	100.00%	2,614	2,614	11	
12	V							12	
13	V							13	
14	Total		\$ 863,554			\$ 866,093	\$ *	2,539	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>ITEX / AK CARE COMPANY</u>	100.00%	\$ 4,607	\$ 4,607
16	V	<u>3</u> <u>HOUSEKEEPING</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	6,457	6,457
17	V	<u>5</u> <u>UTILITIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	4,744	4,744
18	V	<u>6</u> <u>REPAIRS AND MAINT.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	6,694	6,694
19	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	5,510	5,510
20	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	1,251	1,251
21	V	<u>21</u> <u>CLERICAL AND GENERAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	33,620	33,620
22	V	<u>24</u> <u>EDUCATION AND SEMINARS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	151	151
23	V	<u>26</u> <u>INSURANCE</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	2,006	2,006
24	V	<u>30</u> <u>DEPRECIATION</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	10,065	10,065
25	V	<u>32</u> <u>INTEREST</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	9,008	9,008
26	V	<u>33</u> <u>REAL ESTATE TAXES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	9,275	9,275
27	V	<u>35</u> <u>EQUIPMENT RENTAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	1,555	1,555
28	V						
29	V						
30	V						
31	V						
32	V	<u>21</u> <u>CLERICAL SALARIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	447,762	447,762
33	V	<u>27</u> <u>GEN ADMIN. - EMP. BEN.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	114,676	114,676
34	V						
35	V	<u>19</u> <u>CENTRALIZED BOOKKEEPING</u>	417,000	<u>ITEX / AK CARE COMPANY</u>	100.00%		(417,000)
36	V						
37	V						
38	V						
39	Total		\$ 417,000			\$ 657,381	\$ * 240,381

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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 And Rehab

#

0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Jack Rajchenbach	Owner	Administrative	30.00%	See Attached	5.00	8.33%		\$		1	
2	Mark Hollander	Owner	Administrative	10.00%	See Attached	20.00	33.33%	Mgmt Fees	85,100	17-03	2	
3	Allen Hollander	Relative	Administrative	0.00%	See Attached	40.00	100.00%	Salary	91,817	17-01	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	\$ 176,917		13	

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

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	359,890	4	\$ 25,233	\$ 65,700	\$ 4,607	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	359,890	4	35,372	65,700	6,457	2
3	5	UTILITIES	AVAILABLE BED DAYS	359,890	4	25,988	65,700	4,744	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	359,890	4	36,670	65,700	6,694	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	359,890	4	30,182	65,700	5,510	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	359,890	4	6,855	65,700	1,251	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	359,890	4	184,161	65,700	33,620	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	359,890	4	828	65,700	151	8
9	26	INSURANCE	AVAILABLE BED DAYS	359,890	4	10,991	65,700	2,006	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	359,890	4	55,133	65,700	10,065	10
11	32	INTEREST	AVAILABLE BED DAYS	359,890	4	49,344	65,700	9,008	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	359,890	4	50,804	65,700	9,275	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	359,890	4	8,519	65,700	1,555	13
14									14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	1,244,148	1,244,148	447,762	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	318,638		114,676	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,082,866	\$ 1,244,148	\$ 657,381	25

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

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										
										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	\$ 8,753,389	10/1/2038	5.5000	\$ 317,585	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	City Bank		X	Line of Credit				2,700,000			180,421	6							
7	Allocated from ITEX/AK Care		X								9,008	7							
8												8							
9	TOTAL Facility Related				\$49,971.00		\$ 9,295,200	\$ 11,453,389			\$ 507,014	9							
B. Non-Facility Related*																			
10	Interest Income		X								(127,213)	10							
11	Interest Income - Bldg Co.		X								(1,187)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (128,400)	14							
15	TOTALS (line 9+line14)						\$ 9,295,200	\$ 11,453,389			\$ 378,614	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,106 Line # 36

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

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

Facility Name & ID Number

Harmony Nursing And Rehab

0040535

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

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

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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.			
1. Real Estate Tax accrual used on 2014 report.		\$	303,450		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	304,100		2
3. Under or (over) accrual (line 2 minus line 1).		\$	650		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	309,579		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.)		\$	2,614		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>6,893</u> For <u>2011</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	312,843		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>257,624</u>	8	FOR BHF USE ONLY	
	2011	<u>256,553</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>284,101</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>288,999</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>294,825</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
*Beginning Accrual Adjusted for Rounding					
2015 Accrual: \$294,825 x 1.05 = \$309,566					
Allocated from ITEX/AK Care: \$9,275					

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.

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X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180		1993	\$ 7,019,409	\$ 180,072	20	\$ 350,970	\$ 170,898	\$ 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	478	478	9,447	10
11	Various		1997	8,612		20	431	431	8,089	11
12	Various		1998	12,911		20	646	646	11,365	12
13	Various		1999	61,368		20	3,068	3,068	51,347	13
14	Various		2000	36,671		20	1,834	1,834	27,904	14
15	Various		2001	19,752		20	988	988	14,644	15
16	Various		2002	23,793		20	560	560	20,086	16
17	Various		2003	19,176		20	389	389	19,176	17
18	Various		2004	5,922		20	337	337	3,895	18
19	Various		2005	60,851		20	1,267	1,267	57,100	19
20	Various		2006	20,548		20	1,650	1,650	19,524	20
21	Various		2007	369,784		20	22,472	22,472	327,381	21
22	Various		2008	109,693		20	7,190	7,190	94,369	22
23	Various		2009	184,944		20	9,525	9,525	79,985	23
24	Various		2010	124,422		20	12,997	12,997	92,159	24
25	Various		2011	8,250		20	550	550	2,383	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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0040535

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		19,743			424	424	19,743	67
68		387,170	10,000		10,029	29	262,415	68
69			144,870			(144,870)		69
70		\$ 8,513,729	\$ 334,942		\$ 425,803	\$ 90,861	\$ 8,151,580	70

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,513,729	\$ 334,942		\$ 425,803	\$ 90,861	\$ 8,151,580	1
2	A & J Paving - Sewer & Concrete	2012	3,200		20	213	213	818	2
3	Water Heater For Kitchen/ Laundry	2012	7,474		20	1,495	1,495	5,855	3
4	Installed New Pump Motor On Elevator	2012	3,650		20	365	365	1,247	4
5	Parking Lot Paving	2013	5,600		20	373	373	809	5
6	Nurse Call System	2013	41,000		20	8,200	8,200	19,133	6
7	Vinyl Flooring - 2Nd & 4Th Floor Dayrooms	2013	33,635		20	6,727	6,727	17,378	7
8	Monument Sign In Brick Base	2013	10,979		20	732	732	1,952	8
9	Custom Built In Cabinetry - 2Nd & 4Th Floor Dining Rooms	2013	7,000		20	1,400	1,400	3,967	9
10	Kitchen Cabinets And Counter Top	2013	3,900		20	780	780	2,080	10
11	Cable In Walls For New Mds System	2013	16,410		20	3,282	3,282	8,205	11
12	Kitchen Hood Suppression System Updates	2013	6,614		20	1,323	1,323	3,197	12
13	Fire Alarm System Panel Connection To Kitchen Hood System	2013	2,892		20	145	145	337	13
14	A/C Chiller	2014	3,976		20	795	795	1,259	14
15	Laundry Water Heater	2014	5,575		20	1,115	1,115	2,230	15
16	New Condensing Unit	2014	3,676		20	735	735	1,041	16
17	Wet Sprinkler Repair	2014	5,739		20	574	574	670	17
18	Wiring And Cable Wiring For Better Cable Signal	2014	7,780		20	1,556	1,556	1,945	18
19	Outlets And Panel Work	2015	5,555		20	93	93	93	19
20	Circulating Pump	2015	3,926		20	654	654	654	20
21	Pressure Pump	2015	4,122		20	687	687	687	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	34

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

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

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	34

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

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

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 8,696,432	\$ 334,942		\$ 457,047	\$ 122,105	\$ 8,225,136	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Keiro Building LLC	1995	19,743		20	424	424	19,743	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,743	\$		\$ 424	\$ 424	\$ 19,743	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,743	\$		\$ 424	\$ 424	\$ 19,743	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 19,743	\$		\$ 424	\$ 424	\$ 19,743	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party								1
2	Buildings:								2
3	Allocated ITEX/AK Care	1993	292,829	7,509	20	8,366	857	188,944	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ITEX/AK Care	1993	36,846	217	20		(217)	36,846	9
10	Allocated from ITEX/AK Care	1994	19,791	515	20		(515)	19,789	10
11	Allocated from ITEX/AK Care	1995	3,373	9	20	134	125	3,372	11
12	Allocated from ITEX/AK Care	1996	191		20	9	9	191	12
13	Allocated from ITEX/AK Care	1997	5,690	146	20	284	138	5,263	13
14	Allocated from ITEX/AK Care	1999	632	16	20	32	16	537	14
15	Allocated from ITEX/AK Care	2005	2,767		20	138	138	1,435	15
16	Allocated from ITEX/AK Care	2007	3,425	80	20	171	91	1,414	16
17	Allocated from ITEX/AK Care	2008	13,054	335	20	431	96	3,270	17
18	Allocated from ITEX/AK Care	2009	711	18	20	71	53	462	18
19	Allocated from ITEX/AK Care	2010	1,519	32	20	76	44	408	19
20	Allocated from ITEX/AK Care	2014	6,342	1,123	20	317	(806)	484	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 387,170	\$ 10,000		\$ 10,029	\$ 29	\$ 262,415	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 387,170	\$ 10,000		\$ 10,029	\$ 29	\$ 262,415	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)	\$ 387,170	\$ 10,000		\$ 10,029	\$ 29	\$ 262,415	34

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

Facility Name & ID Number Harmony Nursing And Rehab

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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	\$ 281,137	\$ 66	\$ 43,656	\$ 43,590	10	\$ 187,916	71
72	Current Year Purchases	8,682		827	827	10	827	72
73	Fully Depreciated Assets	1,627,855		10	10	10	1,627,769	73
74								74
75	TOTALS	\$ 1,917,674	\$ 66	\$ 44,492	\$ 44,426		\$ 1,816,512	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)	\$ 11,214,107	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 335,008	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 501,539	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 166,531	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,041,648	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Parking Lot & Bath Remodel	\$ 110,000	92
93			93
94			94
95		\$ 110,000	95

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

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

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: _____ *

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: \$ 20,128

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Admin Car</u>	<u>Honda</u>	\$ <u>550.00</u>	\$ <u>2,778</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>550.00</u>	\$ <u>2,778</u>	21

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. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 321,806	\$			\$ 321,806	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					82,934				82,934	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs					420,347				420,347	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						383,069			383,069	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>See Supplemental</u>								91,241			91,241	13
14	TOTAL			\$				\$ 825,087	\$	474,310		\$ 1,299,397	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 And Rehab**# **0040535**Report Period Beginning: **01/01/15**

Ending:

12/31/15**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(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	\$ 59,651	\$ 397,005	1
2	Cash-Patient Deposits	2,011	2,011	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,157,809	3,157,809	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	331,592	346,212	6
7	Other Prepaid Expenses	233,344	233,344	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	794,010	2,150,308	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,578,417	\$ 6,286,689	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		7,019,409	14
15	Leasehold Improvements, at Historical Cost	785,070	788,470	15
16	Equipment, at Historical Cost	1,350,798	2,274,281	16
17	Accumulated Depreciation (book methods)	(1,751,371)	(6,462,878)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		126,523	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(13,556)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	2,067,460	1,972,288	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,451,957	\$ 6,304,537	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,030,374	\$ 12,591,226	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,481,541	\$ 1,495,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,700,000	2,843,048	29
30	Accrued Salaries Payable	385,727	385,727	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,881	22,881	31
32	Accrued Real Estate Taxes(Sch.IX-B)		309,579	32
33	Accrued Interest Payable	4,585	30,845	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,000	1,000	35
Other Current Liabilities(specify):				
36	See Attached Schedule	4,181	89,957	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,599,915	\$ 5,178,577	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,610,341	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43			10,667	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,621,008	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,599,915	\$ 13,799,585	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,430,459	\$ (1,208,359)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,030,374	\$ 12,591,226	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,444,692	1
2	Restatements (describe):		2
3	Bad Debt Expense	(150,000)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,294,691	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	375,768	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(240,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 135,768	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,430,459	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning: 01/01/15

Ending:

12/31/15

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,164,179	1
2	Discounts and Allowances for all Levels	(2,079,955)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,084,224	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,874,762	6
7	Oxygen	180	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,874,942	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,766	13
14	Non-Patient Meals	511	14
15	Telephone, Television and Radio	4,170	15
16	Rental of Facility Space		16
17	Sale of Drugs	540,337	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,131	19
20	Radiology and X-Ray		20
21	Other Medical Services	72,582	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 662,497	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	127,213	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 127,213	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	377	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 377	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,749,253	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,173,117	31
32	Health Care	5,157,092	32
33	General Administration	3,045,998	33
B. Capital Expense			
34	Ownership	1,204,521	34
C. Ancillary Expense			
35	Special Cost Centers	1,424,315	35
36	Provider Participation Fee	368,442	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,373,485	40
41	Income before Income Taxes (line 30 minus line 40)**	375,768	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 375,768	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,886,681	44
45	Private Pay - Net Inpatient Revenue	1,181,930	45
46	Medicare - Net Inpatient Revenue	1,521,392	46
47	Other-(specify) <u>Insurance</u>	362,565	47
48	Other-(specify) <u>Veterans</u>	131,656	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,084,224	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 And Rehab**

0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,784	2,080	\$ 109,271	\$ 52.53	1
2	Assistant Director of Nursing	1,904	2,080	76,533	36.79	2
3	Registered Nurses	48,085	56,412	1,592,935	28.24	3
4	Licensed Practical Nurses	25,429	31,422	702,769	22.37	4
5	CNAs & Orderlies	95,263	112,770	1,480,929	13.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,405	10,499	131,902	12.56	8
9	Activity Director	3,496	4,160	65,892	15.84	9
10	Activity Assistants	6,298	7,306	82,948	11.35	10
11	Social Service Workers	11,182	12,420	241,163	19.42	11
12	Dietician					12
13	Food Service Supervisor	4,664	5,349	91,956	17.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,583	33,236	330,394	9.94	15
16	Dishwashers					16
17	Maintenance Workers	5,267	5,755	98,939	17.19	17
18	Housekeepers	35,062	39,487	417,566	10.57	18
19	Laundry	6,178	6,839	81,228	11.88	19
20	Administrator	1,920	2,080	91,817	44.14	20
21	Assistant Administrator					21
22	Other Administrative	832	889	35,088	39.47	22
23	Office Manager	2,940	3,278	47,370	14.45	23
24	Clerical	10,303	11,485	178,904	15.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,863	2,080	26,366	12.68	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,821	3,014	118,904	39.45	33
34	TOTAL (lines 1 - 33)	305,279	352,641	\$ 6,002,874 *	\$ 17.02	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 19,945	01-03	35
36	Medical Director	Monthly	144,627	09-03	36
37	Medical Records Consultant	Monthly	4,706	10-03	37
38	Nurse Consultant	Monthly	48,000	10-03	38
39	Pharmacist Consultant	Monthly	14,040	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	7,539	11-03	44
45	Social Service Consultant	44	2,403	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	\$ 241,260		49

C. CONTRACT NURSES

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

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/15

Ending:

12/31/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC \$28,900
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,811 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. \$ 368,442
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. \$ 89,535 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 511
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.