

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: <u>0057828</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Harmony Palos</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> 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.																																															
Address: <u>11860 Southwest Hwy</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code																																																		
County: <u>Cook</u>																																																		
Telephone Number: <u>(708) 361-4555</u> Fax # <u>(701) 361-3777</u>																																																		
HFS ID Number: _____																																																		
Date of Initial License for Current Owners: <u>01/01/2023</u>			<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) _____</td><td></td></tr><tr><td colspan="2">(Signed) _____</td></tr><tr><td colspan="2">(Date) _____</td></tr><tr><td>(Print Name and Title) <u>John Epperson</u> <u>Principal</u></td><td></td></tr><tr><td colspan="2"></td><td>(Firm Name & Address) <u>Miller Cooper & Co., Ltd.</u> <u>3 Parkway North, Suite 200, Deerfield IL 60015</u></td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>(312) 344-2883</u></td><td>Fax # () _____</td></tr><tr><td colspan="3">In the event there are further questions about this report, please contact: Name: <u>John Epperson</u> Telephone Number: <u>(312) 344-2883</u> Email Address: _____</td><td colspan="3">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>John Epperson</u> <u>Principal</u>				(Firm Name & Address) <u>Miller Cooper & Co., Ltd.</u> <u>3 Parkway North, Suite 200, Deerfield IL 60015</u>				(Telephone) <u>(312) 344-2883</u>	Fax # () _____	In the event there are further questions about this report, please contact: Name: <u>John Epperson</u> Telephone Number: <u>(312) 344-2883</u> Email Address: _____			MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																			
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Type of Ownership:																																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>			☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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		☐	Other _____																																															

Facility Name & ID Number

Harmony Palos

#

0057828

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

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	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				313		3,707		4,020	8
9	SNF/PED									9
10	ICF	10,353	16,195	2,615		808			29,971	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	10,353	16,195	2,615	313	808	3,707		33,991	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

71.64%

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

01/01/2023

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

01/01/2023

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter certified beds.

number of certified beds

130

Medicare Intermediary

Novitas Solutions

IV. ACCOUNTING BASIS

ACCURAL

X

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

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

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	505,836	50,820	13,093	569,749		569,749	168	569,917			1
2	Food Purchase		258,112		258,112		258,112	(7,080)	251,032			2
3	Housekeeping	288,400	32,329	3,090	323,819		323,819	380	324,199			3
4	Laundry	92,905	33,688		126,593		126,593		126,593			4
5	Heat and Other Utilities			256,448	256,448		256,448	(23,547)	232,901			5
6	Maintenance	85,057	47,156	136,046	268,259		268,259	7,515	275,774			6
7	Other (specify):*							611	611			7
8	TOTAL General Services	972,198	422,105	408,677	1,802,980		1,802,980	(21,953)	1,781,027			8
	B. Health Care and Programs											
9	Medical Director			20,520	20,520		20,520	3,763	24,283			9
10	Nursing and Medical Records	2,969,726	61,296	1,141,394	4,172,416		4,172,416	63,418	4,235,834			10
10a	Therapy	662,982		57,932	720,914		720,914	1,707	722,621			10a
11	Activities	131,225	6,267	4,488	141,980		141,980	71	142,051			11
12	Social Services	151,757		6,477	158,234		158,234	1,394	159,628			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,677	10,677			15
16	TOTAL Health Care and Programs	3,915,690	67,563	1,230,811	5,214,064		5,214,064	81,030	5,295,094			16
	C. General Administration											
17	Administrative	234,029			234,029		234,029	31,902	265,931			17
18	Directors Fees											18
19	Professional Services			174,703	174,703		174,703	41,001	215,704			19
20	Dues, Fees, Subscriptions & Promotion			59,434	59,434		59,434	(30,757)	28,677			20
21	Clerical & General Office Expenses	386,322	3,105	480,789	870,216		870,216	(91,864)	778,352			21
22	Employee Benefits & Payroll Taxes			1,054,687	1,054,687		1,054,687		1,054,687			22
23	Inservice Training & Education											23
24	Travel and Seminars			1,025	1,025		1,025	565	1,590			24
25	Other Admin. Staff Transportation							2,145	2,145			25
26	Insurance-Prop.Liab.Malpractice			377,962	377,962		377,962	4,820	382,782			26
27	Other (specify):*							19,564	19,564			27
28	TOTAL General Administration	620,351	3,105	2,148,600	2,772,056		2,772,056	(22,624)	2,749,432			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,508,239	492,773	3,788,088	9,789,100		9,789,100	36,453	9,825,553			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

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			54,549	54,549		54,549	(10,985)	43,564			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,025	77,025		77,025	(6,804)	70,221			32
33	Real Estate Taxes			550,887	550,887		550,887	997	551,884			33
34	Rent-Facility & Grounds			1,431,303	1,431,303		1,431,303	10,648	1,441,951			34
35	Rent-Equipment & Vehicles							1,000	1,000			35
36	Other (specify):*											36
37	TOTAL Ownership			2,113,764	2,113,764		2,113,764	(5,144)	2,108,620			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		270,276	73,505	343,781		343,781		343,781			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* HPH Management			616,639	616,639		616,639	(616,639)				43
44	TOTAL Special Cost Centers		270,276	690,144	960,420		960,420	(616,639)	343,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,508,239	763,049	6,591,996	12,863,284		12,863,284	(585,330)	12,277,954			45

*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.)

	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 Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room:	(24,246)	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	(12,324)	30		9
10	Interest and Other Investment Income	(5,954)	32		10
11	Discounts, Allowances, Rebates & Refund:	(5,640)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,440)	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	(1,890)	21		18
19	Entertainment	(441)	21		19
20	Contributions	(15,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer:				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt	(211,104)	21		24
25	Fund Raising, Advertising and Promotiona	(5,568)	20		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees:				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	(675,543)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (959,150)		\$	30

BHF USE ONLY							
48		49		50		51	

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 ^a	\$		31
32	Donated Goods-Attach Schedule ^a			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	373,820		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 373,820		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (585,330)		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		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (11,310)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Expense	(616,639)	43	3
4	Bank Charges	(5,398)	21	4
5	Patient Personal Items	0	10	5
6	Sequestration Expense	(43,536)	21	6
7	Non-Allowable Legal	1,340	19	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
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(675,543)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	0	0	168	0	0	0	0	0	0	0	0	168	1
2	Food Purchase	(7,080)	0	0	0	0	0	0	0	0	0	0	(7,080)	2
3	Housekeeping	0	0	380	0	0	0	0	0	0	0	0	380	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(24,246)	0	394	305	0	0	0	0	0	0	0	(23,547)	5
6	Maintenance	0	0	7,214	383	(82)	0	0	0	0	0	0	7,515	6
7	Other (specify):*	0	0	611	0	0	0	0	0	0	0	0	611	7
8	TOTAL General Services	(31,326)	0	8,767	688	(82)	0	0	0	0	0	0	(21,953)	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,763	0	0	0	0	0	0	0	0	3,763	9
10	Nursing and Medical Records	0	0	65,002	0	0	0	(1,584)	0	0	0	0	63,418	10
10a	Therapy	0	0	1,707	0	0	0	0	0	0	0	0	1,707	10a
11	Activities	0	0	71	0	0	0	0	0	0	0	0	71	11
12	Social Services	0	0	1,394	0	0	0	0	0	0	0	0	1,394	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	10,677	0	0	0	0	0	0	0	0	10,677	15
16	TOTAL Health Care and Programs	0	0	82,614	0	0	0	(1,584)	0	0	0	0	81,030	16
	C. General Administration													
17	Administrative	0	0	31,902	0	0	0	0	0	0	0	0	31,902	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	1,340	0	45,327	30	0	(5,696)	0	0	0	0	0	41,001	19
20	Fees, Subscriptions & Promotions	(31,878)	0	1,121	0	0	0	0	0	0	0	0	(30,757)	20
21	Clerical & General Office Expenses	(262,369)	0	170,479	26	0	0	0	0	0	0	0	(91,864)	21
22	Employee Benefits & Payroll Taxe	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Educatior	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	565	0	0	0	0	0	0	0	0	565	24
25	Other Admin. Staff Transportatior	0	0	2,145	0	0	0	0	0	0	0	0	2,145	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,729	91	0	0	0	0	0	0	0	4,820	26
27	Other (specify):*	0	0	19,564	0	0	0	0	0	0	0	0	19,564	27
28	TOTAL General Administration	(292,907)	0	275,832	147	0	(5,696)	0	0	0	0	0	(22,624)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(324,233)	0	367,213	835	(82)	(5,696)	(1,584)	0	0	0	0	36,453	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(12,324)	0	0	1,339	0	0	0	0	0	0	0	(10,985) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(5,954)	0	(1,691)	841	0	0	0	0	0	0	0	(6,804) 32
33	Real Estate Taxes	0	0	0	997	0	0	0	0	0	0	0	997 33
34	Rent-Facility & Grounds	0	0	10,648	0	0	0	0	0	0	0	0	10,648 34
35	Rent-Equipment & Vehicles	0	0	1,000	0	0	0	0	0	0	0	0	1,000 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(18,278)	0	9,957	3,177	0	0	0	0	0	0	0	(5,144) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportatior	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shop:	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(616,639)	0	0	0	0	0	0	0	0	0	0	(616,639) 43
44	TOTAL Special Cost Centers	(616,639)	0	0	0	0	0	0	0	0	0	0	(616,639) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(959,150)	0	377,170	4,012	(82)	(5,696)	(1,584)	0	0	0	0	(585,330) 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 Ownership Listing-1		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: 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			
1	V		\$			\$		\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$	\$ *		14

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Astoria Place Living and Rehab	Chicago, IL	Bella Terra Streamwood	Streamwood, IL	Legacy HC & Financial	Lincolnwood	Home Office/Book	1
2	Avantara Arrowhead	Rapid City, SD	Bella Terra Wheeling	Wheeling, IL	CF St. Louis LLC	Skokie	Building Company	2
3	Avantara Aurora	Aurora, IL	Carlton at the Lake	Chicago, IL	ML Group Design & Interiors	Skokie	Asset Management	3
4	Avantara Chicago Ridge	Chicago Ridge, IL	Chalet Living and Rehab	Chicago, IL	ReMED Services LLC	Lincolnwood	Nursing Equipment	4
5	Avantara Clark City	Clark, SD	Cardinal Grove Independent & Assisted Living	Garner, IA	Propay HR	Evanston	Payroll Processing	5
6	Avantara of Elgin	Elgin, IL	Glenview Terrace	Glenview, IL				6
7	Avantara Evergreen Park	Evergreen Park, IL	Harmony Cedar Rapids	Cedar Rapids, IA				7
8	Avantara Groton	Groton, SD	Harmony Davenport	Davenport, IA				8
9	Avantara Huron	Huron, SD	Harmony Dubuque	Dubuque, IA				9
10	Avantara Lake Norden	Lake Norden, SD	Harmony Marshalltown	Marshalltown, IA				10
11	Avantara Lake Zurich	Lake Zurich, IL	Harmony Healthcare & Rehabilitation Center	Chicago, IL				11
12	Avantara Libertyville	Libertyville, IL	Harmony Palos	Palos Heights, IL				12
13	Avantara Lincoln Park	Chicago, IL	Harmony Utica Ridge	Davenport, IA				13
14	Avantara Long Grove	Long Grove, IL	Harmony Waterloo	Waterloo, IA				14
15	Avantara Milbank	Milbank, SD	Harmony West Des Moines	West Des Moines, IA				15
16	Avantara Mountain View	Rapid City, SD	Lakefront	Chicago, IL				16
17	Avantara North	Rapid City, SD	Peterson Park Health Care Center	Chicago, IL				17
18	Avantara Norton	Rapid City, SD	Grove at the Lake	Zion, IL				18
19	Avantara Palos Heights	Palos Heights, IL	Harmony House Care Center ICF	Waterloo, IA				19
20	Avantara Park Ridge	Park Ridge, IL	The Grove of Elmhurst	Elmhurst, IL				20
21	Avantara Pierre	Pierre, SD	The Grove of Evanston	Evanston, IL				21
22	Avantara Redfield	Redfield, SD	The Grove of Fox Valley	Aurora, IL				22
23	Avantara Saint Cloud	St. Cloud, MN	The Grove of La Grange Park	La Grange Park, IL				23
24	Avantara Watertown	Watertown, SD	The Grove of Northbrook	Northbrook, IL				24
25	Bella Terra Bloomingdale	Bloomington, IL	The Grove of Skokie	Skokie, IL				25
26	Bella Terra Elmhurst	Elmhurst, IL	Grove of St. Charles	St. Charles, IL				26
27	Bella Terra La Grange	La Grange, IL	Vistas Fox Valley	Aurora, IL				27
28	Bella Terra Lombard	Lombard, IL	Vistas of Lincoln Park	Chicago, IL				28
29	Bella Terra Morton Grove	Morton Grove, IL	Wellshire Morton Grove	Morton Grove, IL				29
30	Bella Terra Schaumburg	Schaumburg, IL	Warren Barr Buffalo Grove	Buffalo Grove, IL				30

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Warren Barr Gold Coast	Chicago, IL	Nora Springs Care Center	Nora Springs, IA				1
2	Warren Barr Lieberman	Skokie, IL	Grandview Care Center	Oelwein, IA				2
3	Warren Barr Lincoln Park	Chicago, IL	Oelwein Healthcare Center	Oelwein, IA				3
4	Warren Barr North Shore	Highland Park, IL	Park View Care Center	Sac City, IA				4
5	Whitehall	Deerfield, IL	Manor House Care Center	Sigourney, IA				5
6	Warren Barr Orland Park	Orland Park, IL	Main Street Manor	Swea City, IA				6
7	Warren Barr South Loop	Chicago, IL	Harmony House Care Center SNF	Waterloo, IA				7
8	Wellshire Huron	Huron, SD	Northgate Care Center	Waukon, IA				8
9	Wellshire Park Place	Milbank, SD	Southfield Wellness Community	Webster City, IA				9
10	Warren Barr Oak Lawn	Oak Lawn, IL	Avantara Joliet	Joliet, IL				10
11	Rehab Center Of Allison	Allison, IA	Harmony Park Ridge	Park Ridge, IL				11
12	Maple Manor Village	Aplington, IA	Mulberry Place Independent & Assisted Living	Bloomfield, IA				12
13	Valley Vue Care Center	Armstrong, IA	Afton Oaks Independent & Assisted Living	Apal Elma, IA				13
14	Willow Dale Wellness Village	Battle Creek, IA	Southfield Wellness Community Independent & Webster City, IA					14
15	Rehab Center Of Belmond	Belmond, IA	Emerald Oaks Independent & Assisted Living	A Emmetsburg, IA				15
16	Bloomfield Care Center	Bloomfield, IA	Eagle Ridge Assisted Living Apartments	Guttenberg, IA				16
17	Westview Care Center	Britt, IA	Cherry Ridge Independent & Assisted Living	Ap Mount Vernon, IA				17
18	Oakwood Care Center	Clear Lake, IA	Mills Harbor Assisted Living	Lake Mills, IA				18
19	Colonial Manor Of Elma	Elma, IA	Deer View Manor Independent & Assisted Living	Sigourney, IA				19
20	Emmetsburg Care Center	Emmetsburg, IA	Maple Manor Village Independent & Assisted Living	L Aplington, IA				20
21	Concord Care Center	Garner, IA	Summit Heights	Nora Springs, IA				21
22	Guttenberg Care Center	Guttenberg, IA	Southcrest Manor II Assisted Living	Waukon, IA				22
23	Rehab Center Of Hampton	Hampton, IA	The Courtyard	West Des Moines, IA				23
24	Rehab Center Of Independence-West	Independence, IA	Park Place Independent & Assisted Living	Apasac City, IA				24
25	Westview Of Indianola	Indianola, IA	Elm Springs	Arkansas, IA				25
26	Rehab Center Of Lisbon	Lisbon, IA	Belle Haven Independent & Assisted Living	Apblemond, IA				26
27	Lake Mills Care Center	Lake Mills, IA	Leahy Grove Independent & Assisted Living	Hampton, IA				27
28	Heritage Health & Rehab Center	Cedar Rapids, IA	Indian Creek Independent & Assisted Living	Ap Nevada , IA				28
29	Hallmark Care Center	Mt Vernon, IA	Spring Creek Independent & Assisted Living	Ap Armstrong, IA				29
30	Rolling Green Village	Nevada, IA	Clark SNF	Clark St, IL				30

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Elmbrook SNF	Elmhurst, IL						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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Legacy Healthcare Financial Services		\$ 168	\$ 168	15
16	V	3	Housekeeping		Legacy Healthcare Financial Services		380	380	16
17	V	5	Heat and other Utilities		Legacy Healthcare Financial Services		394	394	17
18	V	6	Maintenece		Legacy Healthcare Financial Services		7,214	7,214	18
19	V	7	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		611	611	19
20	V	9	Medical Director		Legacy Healthcare Financial Services		3,763	3,763	20
21	V	10	Nursing and Medical Records		Legacy Healthcare Financial Services		65,002	65,002	21
22	V	10A	Therapy		Legacy Healthcare Financial Services		1,707	1,707	22
23	V	11	Activities		Legacy Healthcare Financial Services		71	71	23
24	V	12	Social Services		Legacy Healthcare Financial Services		1,394	1,394	24
25	V	15	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		10,677	10,677	25
26	V	17	Administrative		Legacy Healthcare Financial Services		31,902	31,902	26
27	V	19	Professional Services		Legacy Healthcare Financial Services		45,327	45,327	27
28	V	20	Dues, Fees, Subscriptions & Promotions		Legacy Healthcare Financial Services		1,121	1,121	28
29	V	21	Clerical & General Office Expenses		Legacy Healthcare Financial Services		170,479	170,479	29
30	V	24	Travel and Seminar		Legacy Healthcare Financial Services		565	565	30
31	V	25	Other Admin. Staff Transportation		Legacy Healthcare Financial Services		2,145	2,145	31
32	V	26	Insurance-Prop.Liab.Malpractice		Legacy Healthcare Financial Services		4,729	4,729	32
33	V	27	Other (specify):* Employee Benefits		Legacy Healthcare Financial Services		19,564	19,564	33
34	V	32	Interest		Legacy Healthcare Financial Services		(1,691)	(1,691)	34
35	V	34	Rent-Facility & Grounds		Legacy Healthcare Financial Services		10,648	10,648	35
36	V	35	Equipment Rental		Legacy Healthcare Financial Services		123	123	36
37	V	35	Auto Rental		Legacy Healthcare Financial Services		877	877	37
38	V								38
39	Total			\$			\$ 377,170	\$ * 377,170	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	5	Utilities	\$	CF St. Louis LLC		\$ 305	\$ 305	15
16	V	6	Repairs and Maintenance		CF St. Louis LLC		383	383	16
17	V	19	Real Estate Appraisal Fee		CF St. Louis LLC		30	30	17
18	V	20	Professional Fees		CF St. Louis LLC		0		18
19	V	21	Office Expense		CF St. Louis LLC		26	26	19
20	V	26	Insurance		CF St. Louis LLC		91	91	20
21	V	30	Depreciation		CF St. Louis LLC		1,339	1,339	21
22	V	32	Interest Expense		CF St. Louis LLC		841	841	22
23	V	33	Real Estate Taxes		CF St. Louis LLC		997	997	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			\$			\$ 4,012	\$ * 4,012	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	6	Maintenance	\$ 6,000	ML Group Design and Development		\$ 5,918	\$ (82)	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			\$ 6,000			\$ 5,918	\$ * (82)	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	19	Payroll Service	\$25,003	ProPay HR LLC		\$19,307	\$(5,696)	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			\$25,003			\$19,307	\$*(5,696)	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	10	Medical Supplies	\$ 23,394	ReMED Services		\$ 21,810	\$ (1,584)	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			\$ 23,394			\$ 21,810	\$ * (1,584)	39

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

STATE OF ILLINOIS				Ownership Listing-1			
Harmony Palos							
ID#		0057828					
Report Period Beginning:		01/01/2025		Legacy Healthcare FS			
Ending:		12/31/2025		N/A			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Operator/Licensee		Building Co.	Management
-Owners of companies must be listed instead of company names.							Co./Home Office
-Names of trust beneficiaries must be listed.				Place of Residence		Ownership Percentage	Ownership Percentage
	First Name	M.L.	Last Name	City	State	Ownership Percentage	Ownership Percentage
1	GPN Family Trust						1
2	Beneficiary						2
3	Rivka	Rajchenbach	Chicago	IL	14.87500		3
4	Bella	Rajchenbach	Chicago	IL	14.87500		4
5	Vitzchok	Rajchenbach	Chicago	IL	14.87500		5
6	Ziskind	Rajchenbach	Chicago	IL	14.87500		6
7							7
8	Oakway Operations LLC						8
9	Daniel	Garden	Chicago	IL	4.90000		9
10	Rebecca	Garden	Chicago	IL	2.60000		10
11	Mordechay	Ninio	Chicago	IL	4.90000		11
12	Sherie	Ninio	Chicago	IL	2.60000		12
13							13
14	Doros Generation Trust						14
15	Beneficiary						15
16	Ahuva	Shabat	Lincolnwood	IL	5.10000		16
17	Eliana	Shabat	Lincolnwood	IL	5.10000		17
18	Ayalet	Shabat	Lincolnwood	IL	5.10000		18
19	Ashira	Shabat	Lincolnwood	IL	5.10000		19
20	Leora	Shabat	Lincolnwood	IL	5.10000		20
21							21
22	Legacy Healthcare Financial Service						22
23	Chaim	Rajchenbach	Chicago	IL			50.00000
24	Menachem	Shabat	Lincolnwood	IL			50.00000
25							25
26	Note: Building Owner is Not Related Party in 2025						26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
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72							72
73							73
74							74
75							75

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 Legacy Healthcare Financial Services
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 683-2900

	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	Census Days / Direct Allocation		121	\$ 17,417	\$ 188,860		\$ 168	1
2	3	Housekeeping	Census Days / Direct Allocation		121	39,313			380	2
3	5	Heat and other Utilities	Census Days / Direct Allocation		121	40,732			394	3
4	6	Maintenece	Census Days / Direct Allocation		121	1,086,339			7,214	4
5	7	Other (specify):*Employee Benefi	Census Days / Direct Allocation		121	115,823			611	5
6	9	Medical Director	Census Days / Direct Allocation		121	389,400	1,007,031		3,763	6
7	10	Nursing and Medical Records	Census Days / Direct Allocation		121	7,945,861	12,523,114		65,002	7
8	10A	Therapy	Census Days / Direct Allocation		121	176,684	152,483		1,707	8
9	11	Activities	Census Days / Direct Allocation		121	7,371			71	9
10	12	Social Services	Census Days / Direct Allocation		121	144,309	144,309		1,394	10
11	15	Other (specify):*Employee Benefi	Census Days / Direct Allocation		121	1,241,625			10,677	11
12	17	Administrative	Census Days / Direct Allocation		121	5,453,317			31,902	12
13	19	Professional Services	Census Days / Direct Allocation		121	4,691,102	5,453,317		45,327	13
14	20	Dues, Fees, Subscriptions & Prom	Census Days / Direct Allocation		121	116,052			1,121	14
15	21	Clerical & General Office Expens	Census Days / Direct Allocation		121	20,639,396	19,821,678		170,479	15
16	24	Travel and Seminar	Census Days / Direct Allocation		121	58,495			565	16
17	25	Other Admin. Staff Transportatio	Census Days / Direct Allocation		121	221,955			2,145	17
18	26	Insurance-Prop.Liab.Malpractice	Census Days / Direct Allocation		121	489,395			4,729	18
19	27	Other (specify):* Employee Benef	Census Days / Direct Allocation		121	2,646,369			19,564	19
20	32	Interest	Census Days / Direct Allocation		121	(175,042)			(1,691)	20
21	34	Rent-Facility & Grounds	Census Days / Direct Allocation		121	1,102,008			10,648	21
22	35	Equipment Rental	Census Days / Direct Allocation		121	12,712			123	22
23	35	Auto Rental	Census Days / Direct Allocation		121	90,802			877	23
24										24
25	TOTALS					\$ 46,551,435	\$ 39,290,792		\$ 377,170	25

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 CF St. Louis LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	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	5	Utilities	Census Days	3,517,851	121	\$ 31,540	\$	33,991	\$ 305	1
2	6	Repairs and Maintenance	Census Days	3,517,851	121	39,680		33,991	383	2
3	19	Real Estate Appraisal Fee	Census Days	3,517,851	121	3,155		33,991	30	3
4	20	Professional Fees	Census Days	3,517,851	121			33,991		4
5	21	Office Expense	Census Days	3,517,851	121	2,733		33,991	26	5
6	26	Insurance	Census Days	3,517,851	121	9,443		33,991	91	6
7	30	Depreciation	Census Days	3,517,851	121	138,584		33,991	1,339	7
8	32	Interest Expense	Census Days	3,517,851	121	87,057		33,991	841	8
9	33	Real Estate Taxes	Census Days	3,517,851	121	103,201		33,991	997	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					\$ 415,393	\$		\$ 4,012	25

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ML Group Design and Development
City / State / Zip Code 3424 Oakton St
Phone Number (847) 676-5300
Fax Number (847) 676-5300

	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	6	Maintenance	Direct			\$	\$		\$ 5,918	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					\$	\$		\$ 5,918	25

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ProPay HR LLC
Street Address 2201 W. Main St.
City / State / Zip Code Evanston, IL 60202
Phone Number (847) 905-3268
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	19	Payroll Services	Direct			\$	\$		\$ 19,307	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					\$	\$		\$ 19,307	25

Facility Name & ID Number Harmony Palos # 0057828 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 ReMED Services LLC
Street Address 3424 Oakton Street, Suite 102
City / State / Zip Code Skokie, IL
Phone Number (847) 440-2600
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	10	Medical Supplies	Direct			\$	\$		\$ 21,810	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					\$	\$		\$ 21,810	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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
	Working Capital											
6	Forbright		X	Revolving Line of Credit - Interest Only				2,548,362			76,132	6
7	IPFS Corporation		X	Prepaid Insurance - Interest Only							893	7
8												8
9	TOTAL Facility Related						\$	2,548,362			\$ 77,025	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,954)	10
11												11
12												12
13	Allocated from CF St. Louis	X									841	13
14	TOTAL Non-Facility Related						\$				\$ (5,113)	14
15	TOTALS (line 9+line14)						\$	2,548,362			\$ 71,912	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

* 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.)

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

B. Real Estate Taxes

[illegible]

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Harmony Palos

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0057828

CONTACT PERSON REGARDING THIS REPORT

John Epperson

TELEPHONE

(312) 344-2883

FAX #:

()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	23-24-300-341-0000	Long Term Care Property	\$ 550,887.05	\$ 550,887.05
2.	10-23-406-034-0000	Home Office Allocation	\$ 758,833.99	\$ 997.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 1,309,721.04	\$ 551,884.05

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,757B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories2

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 groun (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. List the bed capacity for the building if it differs from the licensed tota N/A
G. Have you properly capitalized all major repairs and equipment purchases Yes
H. Are you presently operating under a sale and leaseback arrangement' No

If YES, give effective date of lease N/A
I. Are you presently operating under a sublease agreement' No

J. 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 ove: N/A

K. 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	Allocated from CF St. Louis LLC			\$854	1
2					2
3	TOTALS			\$854	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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											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

XL OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

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

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		\$	\$		\$	\$	\$	1
2									2
3	Paint 10 resident rooms on 2nd Floor (\$2,500	2023	24,185		20	1,209	1,209	3,628	3
4	Harmony Palos Heights Wsest Monument Sign (\$8,335)	2023	8,063		20	403	403	1,209	4
5	Install New Rooftop Unit Servicing Kitchen & Back Area (\$25,000)	2023	24,185		20	1,209	1,209	3,628	5
6	Replace 14 Sprinkler Heads (\$10,910)	2023	10,554		20	528	528	1,583	6
7	Paint 10 Resident Rooms On 2Nd Floor (\$25,000)	2023	24,185		20	1,209	1,209	3,628	7
8	Paint Room 224 And 2 Hallway Restrooms (\$3,569)	2023	3,453		20	173	173	518	8
9	Install New Hot Water Boiler (\$30,000)	2023	29,022		20	1,451	1,451	4,353	9
10	Install Domestic Circulating Pump In Water Heater Room (\$4,978	2023	4,816		20	241	241	722	10
11	Set Up Zone 5 And Zone 6 Smoke Detectors (\$9,410	2023	9,103		20	455	455	1,365	11
12	Installation Of 27 Cameras (\$13,574	2023	13,131		20	657	657	1,970	12
13	Installation Of 2 Ptacs (\$2,680)	2023	2,592		20	130	130	389	13
14	Replace Variable Frequency Drive And Fuses On Rtu #2 (\$5,449	2023	5,271		20	264	264	791	14
15	Replace Heat Exchanger, Gas Valve On Rtu #1 (\$5,207	2023	5,037		20	252	252	756	15
16	Phone System (\$9,886)	2023	9,564		20	478	478	1,435	16
17	Phone System Software & Licensing (\$4,800	2023	4,644		20	232	232	697	17
18	2nd floor painting (10 rooms and hallway)	2024	28,700		20	1,435	1,435	1,435	18
19	Kitchen drop ceiling installation	2024	4,000		20	200	200	400	19
20	1st and 2nd floor Medical and Utility room, Ice Room paint furnitu	2024	11,900		20	595	595	1,190	20
21	Kitchen and Dish room tile repair	2024	4,496		20	225	225	450	21
22	Electrical, keypad install, and patio door installations	2024	4,006		20	200	200	401	22
23	Kitchen tile replacement and repair	2024	4,496		20	225	225	450	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Current year depreciation			15,541			(15,541)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 235,403	\$ 15,541		\$ 11,770	\$ (3,771)	\$ 30,996	34

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

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		\$ 235,403	\$ 15,541		\$ 11,770	\$ (3,771)	\$ 30,996	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
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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)		\$ 235,403	\$ 15,541		\$ 11,770	\$ (3,771)	\$ 30,996	34

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

XL 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		\$ 235,403	\$ 15,541		\$ 11,770	\$ (3,771)	\$ 30,996	1
2									2
3									3
4	Related Party								4
5	Buildings:								5
6	Allocated from CF St. Louis, LLC	2016	4,599	91	35	131	40	1,314	6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	63,750	438	20	3,188	2,750	31,875	9
10	Allocated from CF St. Louis, LLC	2017	1,480	38	20	74	36	666	10
11	Allocated from CF St. Louis, LLC	2019	13,411	344	20	671	327	4,694	11
12	Allocated from CF St. Louis, LLC	2020	705	18	20	35	17	212	12
13	Allocated from CF St. Louis, LLC	2021	2,504	64	20	125	61	626	13
14	Allocated from CF St. Louis, LLC	2022	4,140	106	20	207	101	828	14
15	Allocated from CF St. Louis, LLC	2023	577	15	20	29	14	87	15
16									16
17	Allocated from Legacy HC	2018	76		20	4	4	30	17
18	Allocated from Legacy HC	2020	57		20	3	3	17	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)		\$ 326,702	\$ 16,655		\$ 16,237	\$ (418)	\$ 71,345	34

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

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	\$172,811	\$32,410	\$17,281	\$(15,129)	10	\$22,206	71
72	Current Year Purchases	100,391	6,816	10,039	3,223	10	10,039	72
73	Fully Depreciated Assets	2,580				10	2,580	73
74								74
75	TOTALS	\$275,782	\$39,226	\$27,320	\$(11,906)		\$34,825	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	2	
	Reference	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)	\$603,338	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$55,881	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$43,557	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(12,324)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$106,170	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.

Harmony Palos
0057828
Moveable Equipment Schedule
01/01/2025
12/31/2025

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Harmony Palos	168,600	32,192	16,860	(15,332)	19,666
Allocated from Legacy HC	32	3	3	0	9
Allocated from CF St. Louis, LLC	4,179	215	418	203	2,531
Total	172,811	32,410	17,281	(15,129)	22,206

Line 29: Current Year

Harmony Palos	100,391	6,816	10,039	3,223	10,039
Allocated from Legacy HC	-	-	-	-	
Allocated from CF St. Louis, LLC	-	-	-	-	
			-	-	
Total	100,391	6,816	10,039	3,223	10,039

Line 30: Fully Depreciated

Harmony Palos	-	-	-	-	
Allocated from Legacy HC	2,580	-	-	-	2,580
Allocated from CF St. Louis, LLC	-	-	-	-	
Total	2,580	-	-	-	2,580

Total (Should tie to page 13)

Harmony Palos	268,991	39,008	26,899	(12,109)	29,705
Allocated from Legacy HC	2,612	3	3	0	2,589
Allocated from CF St. Louis, LLC	4,179	215	418	203	2,531
	-	-	-	-	-
Total	275,782	39,226	27,320	(11,906)	34,825

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Integra WIP Tenant LLC
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:				\$1,431,303			3
4	Additions							4
5	Storage/Parking Rent Expense				0			5
6	Allocated from Legacy HC				10,648			6
7	TOTAL				\$1,441,951			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: \$123Description: Allocated from Legacy HC
- (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	Allocated from Legacy HC		\$	\$877	17
18					18
19					19
20					20
21	TOTAL		\$	\$877	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. /2026	\$
13. /2027	\$
14. /2028	\$

* 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

☒ 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.)

12345678											
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A-1	hrs	\$ 74,173		\$	\$		\$ 74,173	1	
2	Licensed Speech and Language Development Therapist	10A-1	hrs	43,231					43,231	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A-1	hrs	147,047					147,047	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				191,539		191,539	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		18,816		73,505	78,737		171,058	13	
14	TOTAL			\$ 283,267		\$ 73,505	\$ 270,276		\$ 627,048	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.

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE

Special Services - Supplies (Column 6 - Other)		Amount	Special Services - Salary (Column 3 - Staff)		Amount
13A	Supplies - Medical	39-259,389	13U		
13B	Supplies - G-Tube	39-214,448	13V	Therapy Concierge - Regular	10A-118,816
13C	Oxygen	39-24,900	13W		
13D			13X		
13E			13Y		
13F			13Z		
13G					18,816
13 H					
13I					
13J					
		78,737			
Special Services - Outside (Column 5 - Other)					
13K	Durable Medical Equipment	39-331,438			
13L	Radiology	39-39,687			
13M	Laboratory	39-332,380			
13N					
13O					
13P					
13Q					
13R					
13S					
13T					
		73,505			

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	\$ 42,464	\$	1
2	Cash-Patient Deposits	750		2
3	Accounts & Short-Term Notes Receivable Patients (less allowance)	1,166,717		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,923		6
7	Other Prepaid Expenses	1,788		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	(7,069)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,215,573	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	155,412		15
16	Equipment, at Historical Cost	268,991		16
17	Accumulated Depreciation (book methods)	(117,214)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify): See Attached	12,959,080		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,266,269	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,481,842	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 239,754	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,708		28
29	Short-Term Notes Payable	103,537		29
30	Accrued Salaries Payable	411,346		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,656		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	348,396		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,176,397	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	16,847,720		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,847,720	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 18,024,117	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,542,275)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,481,842	\$	48

*(See instructions.)

Other Current Assets		Amount	Amount	Other Current Liabilities		Amount	Amount
09A	Refund	(112,470)		36A	Prepaid - Legal Fees	130,000	
09B	Exchange	143,210		36B	Accrued Accounting Fees	13,458	
09C	Insurance Refund Exchange	434		36C	Accrued Monthly Assessment Fee	199,717	
09D	Accounts Receivable - Quality Incentive	(229,705)		36D	Union Dues Payable	2,017	
09E	C.N.A. Tenure Program	354,599		36E	Due To/From Medicare	(1,705)	
09F	Employee Loans	(2,810)		36F	Due To BCBS - UPP	4,909	
09G	Accrued Rent	(160,327)		36G			
09H				36H			
09I				36I			
09J				36J			
		(7,069)	-			348,396	-
Other Non-Current Assets:		Amount	Amount	Other Non-Current Liabilities		Amount	Amount
23A	Right Of Use Asset	13,156,474		43A	Due To/From - Peterson Park & Promedica	-	
23B	Finance Right Of Use Asset	77,991		43B	Due To/From - 10 Pack Forbright Interco	3,221,450	
23C	Right Of Use Asset Acc Amortization	(1,115,975)		43C	Due To/From Prior Owner	244,199	
23D	Finance Right Of Use Asset Acc Amortization	(45,495)		43D	Right Of Use Lease Liability	13,347,530	
23E	Option/Rent Deposit	878,011		43E	Finance Lease Liability	34,541	
23F	Due To/From - Harmony Palos & Management Company	(33,452)		43F			
23G	Accrued Management Fees Entities	41,526		43G			
23H				43H			
23I				43I			
23J				43J			
		12,959,080	-			16,847,720	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,592,044)	1
2	Restatements (describe)		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,592,044)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(901,080)	7
8	Aquisitions of Pooled Companie:		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 Owner:	(49,151)	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (950,231)	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)	\$ (3,542,275)	24 *

* This must agree with page 17, line 47

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,912,248	1
2	Discounts and Allowances for all Levels	(4,912,371)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,999,877	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,980,587	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,980,587	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	155,865	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,574	19
20	Radiology and X-Ray	6,377	20
21	Other Medical Services	178,912	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 364,728	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**:	5,954	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,954	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Discounts Earned & Rebates (adj on pg 5)	5,640	28
28a	Quality Incentive	206,231	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 211,871	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,563,017	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,802,980	31
32	Health Care	5,214,064	32
33	General Administration	2,772,056	33
	B. Capital Expense		
34	Ownership	2,113,764	34
	C. Ancillary Expense		
35	Special Cost Centers	960,420	35
36	Provider Participation Fee	600,813	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,464,097	40
41	Income before Income Taxes (line 30 minus line 40)**	(901,080)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (901,080)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,796,310.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,374,215.00	45
46	MMAI-Medicaid is the Primary Payer	706,303.00	46
47	MMAI-Medicare is the Primary Payer	71,452.00	47
48	Private Pay	736,432.00	48
49	Medicare Part A	846,237.00	49
50	Other-(specify) Insurance	468,928.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,999,877	56

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	2,064	2,282	\$ 133,882	\$ 58.67	1
2	Assistant Director of Nursing	1,781	1,997	91,580	45.86	2
3	Registered Nurses	22,157	27,374	1,188,151	43.40	3
4	Licensed Practical Nurses	3,002	3,780	124,203	32.86	4
5	CNAs & Orderlies	38,979	47,262	1,394,259	29.50	5
6	CNA Trainees					6
7	Licensed Therapist	6,831	7,844	397,225	50.64	7
8	Rehab/Therapy Aides	7,024	8,272	265,757	32.13	8
9	Activity Director	1,976	2,080	50,911	24.48	9
10	Activity Assistants	3,920	4,307	80,314	18.65	10
11	Social Service Workers	4,403	4,899	151,757	30.98	11
12	Dietician	1,025	1,059	29,752	28.09	12
13	Food Service Supervisor	1,848	2,120	66,131	31.19	13
14	Head Cook	5,458	6,409	167,507	26.14	14
15	Cook Helpers/Assistants	11,671	12,896	242,446	18.80	15
16	Dishwashers					16
17	Maintenance Workers	2,285	2,448	85,057	34.75	17
18	Housekeepers	13,042	14,269	288,400	20.21	18
19	Laundry	4,441	4,961	92,905	18.73	19
20	Administrator	1,832	2,080	192,255	92.43	20
21	Assistant Administrator	904	972	41,774	42.98	21
22	Other Administrative					22
23	Office Manager	1,720	2,080	58,788	28.26	23
24	Clerical	11,944	12,993	327,534	25.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,436	1,488	37,651	25.30	31
32	Other Health Care(specify)					32
33	Other(specify)			0		33
34	TOTAL (lines 1 - 33)	149,743	173,872	\$ 5,508,239 *	\$ 31.68	34

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	\$ 13,093	01-03	35
36	Medical Director	Monthly	20,520	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	899	10-03	38
39	Pharmacist Consultant	Monthly	16,224	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	4,488	11-03	44
45	Social Service Consultant	Monthly	6,477	12-03	45
46	Other(specify)				46
47	Rehabilitation Consultant	Monthly	48,000	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 109,701		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	13,693	\$ 696,314	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	17,187	422,293	10-03	52
53	TOTAL (lines 50 - 52)	30,880	\$ 1,118,607		53

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

** See instructions.

Facility Name & ID Number		Harmony Palos		STATE OF ILLINOIS		Report Period Beginning:		01/01/2025		Page 21	
#		0057828				Ending:		12/31/2025			
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership	Amount	Description		Amount	Description		Amount	
Patricia Davis		Administrator		\$ 234,029	Workers' Compensation Insurance		\$ 81,124	IDPH License Fee		\$ 1,990	
Damien Berrios		Assistant Administrator			Unemployment Compensation Insurance		74,947	Advertising: Employee Recruitment			
					FICA Taxes		406,494	Health Care Worker Background Check			
					Employee Health Insurance		384,656	(Indicate # of checks performed 247)		2,928	
					Employee Meals			Patient Background Checks		414	3,429
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		22,620	
					Other Employee Benefits		28,711	Other Dues & Subscriptions		4,770	
					Employee Physical Exams		18,759	Licenses & Permits		3,129	
					Voluntary Benefit Contribution		17,315	Allocation from Legacy Healthcare Financial		1,121	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 234,029							
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							
See Attached		Legal		\$ 22,497							
Legacy Healthcare Financial Services		Accounting		31,600							
Propay HR LLC		Payroll Processing		25,003							
Onyx Procurement Solutions		Procurement Services		6,120							
People Powered Nursing		Labor Management Consultant		38,639							
Achieve Accreditation LLC		Accreditation Services		8,678							
AR Proactive Workflows		Billing Consultant		5,364							
Apploi Corp		Labor Management Consultant		6,595							
Compliagent		Compliance		2,939							
Personnel Planners		Unemployment Consultant		7,094							
HCCI		Data Analytics		10,638							
See Supplemental Schedule				9,535							
TOTAL (agree to Schedule V, line 19, column 3)											
(For legal fee disclosure, see page 39 of instructions)				\$ 174,703							

AIX. SUPPORT SCHEDULES									
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
			\$	Workers' Compensation Insurance		\$	IDPH License Fee		\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment		
				FICA Taxes			Health Care Worker Background Check		
				Employee Health Insurance			(Indicate # of checks performed)		
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount				Less: Public Relations Expense	()	
			\$				PAC and Lobbying payments	()	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services									
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description		Amount
Optum	Claims Management	\$ 517				\$	Out-of-State Travel		\$
IIT/Sourcetek	Hospitality Solutions	600							
CertiSurv, LLC	Survey Services	1,000							
Sogolytics, LLC	Data Analytics	670					In-State Travel		
Collaborative Healthcare Urgency G	Restore Services	314							
TAP Innovations, LLC	Data Analytics	66							
Huron Consulting Group	Strategy Consultant	504							
Language Line Services, Inc.	Interpreting Services	50					Seminar Expense		
Aida Healthcare	Placement Solutions	496							
Legacy Healthcare Financial Service	Consulting Services	5,319							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense ()		
(For legal fee disclosure, see page 39 of instructions)			\$ 9,535				(agree to Sch. V, line 24, col. 8)		

* Attach copy of IMRF notifications

**See instructions.

HARMONY PALOS
0057828
Legal Schedule
01/01/2025 - 12/31/2025

Date	G/L Account No.	Payee/Vendor	Type of Service Provided	Amount	Adjustment	Adjusted Amount
8/25/2025	580063	Law Hesselbaum	General Counsel	85	-	85
2/13/2026	580063	Meyer Magence	General Counsel	175	-	175
4/28/2026	580063	Meyer Magence	General Counsel	88	-	88
5/12/2026	580063	Meyer Magence	General Counsel	263	-	263
6/17/2026	580063	Meyer Magence	General Counsel	88	-	88
7/16/2026	580063	Meyer Magence	General Counsel	88	-	88
11/13/2026	580063	Meyer Magence	General Counsel	88	-	88
12/8/2026	580063	Meyer Magence	General Counsel	88	-	88
5/27/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	7,612	-	7,612
7/1/2026	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	(122)	(122)	-
7/29/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	460	-	460
10/28/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	7,967	-	7,967
11/21/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	38	-	38
12/17/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	420	-	420
1/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	75	75	-
3/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	495	495	-
4/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	780	780	-
5/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	612	612	-
6/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	757	757	-
7/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	709	709	-
8/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,658	1,658	-
9/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	554	554	-
10/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	637	637	-
11/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	698	698	-
12/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	93	93	-
4/30/2025	580063	Forbright Bank	Retainage Fee	50	50	-
1/22/2025	580063	von Briesen & Roper s.c.	General Counsel	840	-	840
1/31/2025	580063	Skidelsky & Associates	Real Estate Tax Assesment	2,500	-	2,500
2/26/2025	580063	von Briesen & Roper s.c.	General Counsel	37	-	37
3/31/2025	580063		Statutory Representation / Matter Management / Annual Report	104	-	104
		Corporation Service Company				
4/30/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	48	-	48
8/1/2025	580063	Briana Mariano-Cacho	Reversal of settlement	(5,853)	(5,853)	-
9/30/2025	580063	Meyer Magence	General Counsel	175		175
10/31/2025	580063		Statutory Representation / Matter Management / Annual Report	198	198	-
		Corporation Service Company				
						-
						-
						-
						-
Total				22,497	1,340	21,158

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the associatio

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	11,310
	11,310 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATION OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	11,310
	11,310 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	22,620
	22,620 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expens and the location of this expense on Sch. V.

44,580

Line

10
- (6) Have all costs reported on this form been determined using accounting procedure consistent with prior reports?

Yes

If NO, attach a complete explanation
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme during this cost report period.

600,813

This amount is to be recorded on line 42 of Schedule V
- (8) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee?

No

If YES, attach an explanation of the allocation
- (9) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V?

Yes
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

None

Has any meal income been offset agains related costs?

N/A

Indicate the amount

\$
- (12) 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 program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients

100% LN1

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all othe times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing sucl transportation during this reporting period.

\$

N/A
- (13) Has an audit been performed by an independent certified public accounting firm

Firm Name:

N/A

No
- (14) Have all costs which do not relate to the provision of long term care been adjusted or out of Schedule V?

Yes
- (15) 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 fee



Prepared

With open item (general) - see below

Open (specific item)