

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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>0026237</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Glenview Terrace Nsg. Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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>1511 Greenwood Road</u> <u>Glenview</u> <u>60025</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 729-9090</u> Fax # <u>(847) 729-9135</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>11/01/75</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☒ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</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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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Skilled (SNF)			1
2	314	Skilled Pediatric (SNF/PED)	314	114,610	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	314	TOTALS	314	114,610	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,061	20,655	33,330	64,046	8
9	SNF/PED					9
10	ICF	36,822	365		37,187	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,883	21,020	33,330	101,233	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.33%

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 12/01/1975

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 314 and days of care provided 26,080

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	798,928	139,120	52,324	990,372		990,372	5,597	995,969			1
2	Food Purchase		790,830		790,830	(127,312)	663,518	(5,746)	657,772			2
3	Housekeeping	626,221	114,514		740,735		740,735	11,599	752,334			3
4	Laundry	347,397	55,362		402,759		402,759		402,759			4
5	Heat and Other Utilities			390,855	390,855		390,855	6,013	396,868			5
6	Maintenance	248,028	98,439	301,437	647,904		647,904	3,298	651,202			6
7	Other (specify):*											7
8	TOTAL General Services	2,020,574	1,198,265	744,616	3,963,455	(127,312)	3,836,143	20,761	3,856,904			8
	B. Health Care and Programs											
9	Medical Director			98,100	98,100		98,100		98,100			9
10	Nursing and Medical Records	7,569,911	401,724	140,286	8,111,921		8,111,921	(3,450)	8,108,471			10
10a	Therapy	1,387,136		38,173	1,425,309		1,425,309		1,425,309			10a
11	Activities	356,371	47,452	12,026	415,849		415,849		415,849			11
12	Social Services	474,884		4,550	479,434		479,434		479,434			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,788,302	449,176	293,135	10,530,613		10,530,613	(3,450)	10,527,163			16
	C. General Administration											
17	Administrative	311,917		225,000	536,917		536,917	(213,889)	323,028			17
18	Directors Fees											18
19	Professional Services			655,005	655,005		655,005	(436,150)	218,855			19
20	Dues, Fees, Subscriptions & Promotions			301,180	301,180		301,180	(172,534)	128,646			20
21	Clerical & General Office Expenses	633,709	6,351	546,400	1,186,460		1,186,460	(41,589)	1,144,871			21
22	Employee Benefits & Payroll Taxes			2,378,091	2,378,091	127,312	2,505,403	(1,695)	2,503,708			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,865	10,865		10,865	(702)	10,163			24
25	Other Admin. Staff Transportation			5,703	5,703		5,703		5,703			25
26	Insurance-Prop.Liab.Malpractice			423,348	423,348		423,348	2,132	425,480			26
27	Other (specify):*							90,836	90,836			27
28	TOTAL General Administration	945,626	6,351	4,545,592	5,497,569	127,312	5,624,881	(773,592)	4,851,289			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,754,502	1,653,792	5,583,343	19,991,637		19,991,637	(756,281)	19,235,356			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			242,605	242,605		242,605	644,431	887,036			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			338,803	338,803		338,803	464,882	803,685			32
33	Real Estate Taxes							737,436	737,436			33
34	Rent-Facility & Grounds			2,294,000	2,294,000		2,294,000	(2,294,000)				34
35	Rent-Equipment & Vehicles			80,894	80,894		80,894	3,157	84,051			35
36	Other (specify):*							78,619	78,619			36
37	TOTAL Ownership			2,956,302	2,956,302		2,956,302	(365,474)	2,590,828			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,212,422	2,903,792		4,116,214		4,116,214		4,116,214			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			478,620	478,620		478,620		478,620			42
43	Other (specify):*	186,568		473,895	660,463		660,463	(660,463)	0			43
44	TOTAL Special Cost Centers	1,398,990	2,903,792	952,515	5,255,297		5,255,297	(660,463)	4,594,834			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	14,153,492	4,557,584	9,492,160	28,203,236		28,203,236	(1,782,217)	26,421,019			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 Programs	(4,110)	02		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	101,981	30		9
10	Interest and Other Investment Income	(306,807)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,636)	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	(970)	21		18
19	Entertainment				19
20	Contributions	(30,720)	20		20
21	Owner or Key-Man Insurance	(890)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(83,315)	21		24
25	Fund Raising, Advertising and Promotional	(24,889)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,431)	20		28
29	Other-Attach Schedule	(1,651,911)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,024,197)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	241,980		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 241,980		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,782,217)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:

Ending:

ID#0026237

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Driver's Salary	\$ (36,338)	43	1
2	Marketing Salary	(58,417)	43	2
3	Veteran Expenses	(3,450)	10	3
4	Bank Charges	(13,155)	21	4
5	Credit Card Fees	(36,248)	21	5
6	Public Relations	(111,261)	20	6
7	Trust Fees	(900)	21	7
8	COPE Dues	(7,972)	20	8
9	Net Expenses - Misc. Income	(121)	21	9
10	State of Illinois - Misc. Income	(140)	21	10
11	State WC Lawsuit Refund - Misc. Income	(805)	22	11
12	Fundraising Events - Misc. Income	(100)	21	12
13	Non-Allowable Interest	(123,062)	32	13
14	Non-Allowable Seminar	(607)	24	14
15	2012 Non-Allowable Seminar	(245)	24	15
16	Non-Allowable Legal	(14,040)	19	16
17	Non-Allowable Office Expense	(225,000)	21	17
18	Non-Allowable Fees	(450,000)	43	18
19	Non-Allowable Auto Expense	(23,895)	43	19
20	Non-Allowable Marketing Travel	(4,851)	43	20
21	Building Co. - Annual Report Fee	(250)	20	21
22	Building Co. - Legal	(39,308)	19	22
23	Building Co. - Accounting Fee	(14,443)	19	23
24	Building Co. - Licenses and Fees	(250)	20	24
25	Building Co. - Amortization	(4,515)	36	25
26	Non-Allowable Salary	(86,962)	43	26
27	Non-Allowable Rent	(384,000)	34	27
28	Capitalized R&M	(24,711)	06	28
29	Additional R&M	16,133	06	29
30	Non-Allowable Professional Fees	(3,000)	19	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	(1,651,911)		49

Glenview Terrace Nsg. Ctr

	ID#	0026237
Report Period Beginning:		01/01/11
Ending:		12/31/11

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				49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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 6-Supplemental		See 6-Supplemental		See 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	Rental Income	\$ 1,910,000	Glenview Terrace Property, LLC	100.00%	\$	\$ (1,910,000)	1
2	V	32	Interest Income	688	Glenview Terrace Property, LLC	100.00%		(688)	2
3	V	20	Annual Report Fee		Glenview Terrace Property, LLC	100.00%	250	250	3
4	V	19	Legal		Glenview Terrace Property, LLC	100.00%	39,308	39,308	4
5	V	19	Accounting Fees		Glenview Terrace Property, LLC	100.00%	14,443	14,443	5
6	V	20	Licenses and Fees		Glenview Terrace Property, LLC	100.00%	250	250	6
7	V	32	Mortgage Interest Expense		Glenview Terrace Property, LLC	100.00%	863,118	863,118	7
8	V	33	Real Estate Taxes		Glenview Terrace Property, LLC	100.00%	724,507	724,507	8
9	V	36	MIP Insurance		Glenview Terrace Property, LLC	100.00%	78,619	78,619	9
10	V	30	Depreciation		Glenview Terrace Property, LLC	100.00%	525,558	525,558	10
11	V	36	Loan Amortization		Glenview Terrace Property, LLC	100.00%	4,515	4,515	11
12	V								12
13	V								13
14	Total			\$ 1,910,688			\$ 2,250,568	\$ * 339,880	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	ITEX / AK CARE COMPANY	100.00%	\$ 5,597	\$ 5,597	15
16	V	3	HOUSEKEEPING				11,599	11,599	16
17	V	5	UTILITIES				6,013	6,013	17
18	V	6	REPAIRS AND MAINT.				11,876	11,876	18
19	V	19	PROFESSIONAL FEES				12,467	12,467	19
20	V	20	FEES, SUBSCRIPTIONS				4,738	4,738	20
21	V	21	CLERICAL AND GENERAL				48,344	48,344	21
22	V	24	EDUCATION/SEMINARS				150	150	22
23	V	26	INSURANCE				2,132	2,132	23
24	V	30	DEPRECIATION				16,892	16,892	24
25	V	32	INTEREST				32,321	32,321	25
26	V	33	REAL ESTATE TAXES				12,929	12,929	26
27	V	35	EQUIPMENT RENTAL				3,157	3,157	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES				286,475	286,475	32
33	V	27	GEN ADMIN. - EMP. BEN.				89,150	89,150	33
34	V								34
35	V	19	BOOKKEEPING	432,000				(432,000)	35
36	V	19	HOME OFFICE						36
37	V	19	DATA PROCESSING	133				(133)	37
38	V								38
39	Total			\$ 432,133			\$ 543,840	\$ * 111,707	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	17	J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 11,111	\$ 11,111	15
16	V	19	PROFESSIONAL FEES				556	556	16
17	V	21	OFFICE				2,040	2,040	17
18	V	27	EMPLOYEE BENEFITS				1,686	1,686	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	17	MANAGEMENT FEES	225,000				(225,000)	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			\$ 225,000			\$ 15,393	\$ * (209,607)	39

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM SHOSHANA	0.590%	THE CARLTON AT THE LAKE, INC.	CHICAGO	GLENVIEW TERRACE PROPER		BUILDING CO.	1
2	ADINA AARON	0.263%	CLARIDGE IMPERIAL, LTD.	CHICAGO	ITEX / A.K. CARE	LINCOLNWOOD	BOOKEEPING CO./MAN/	2
3	AHUVA WEINREB	1.177%	HARMONY NURSING & REHAB.	CHICAGO	JLR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	3
4	ALBERT MILSTEIN	2.170%	WHITEHALL NORTH	DEERFIELD	SEASONS HOSPICE	PARK RIDGE	HOSPICE	4
5	DARRIN CHAN	1.976%						5
6	DAVIS GLENVIEW TERRACE LLC	9.820%						6
7	DENISE CHAN	1.976%						7
8	DEVORAH SHOSHANA	0.590%						8
9	DISCRETIONARY TRUST FOR JENNIFER	3.557%						9
10	DISCRETIONARY TRUST FOR JULIE T.Y.	3.557%						10
11	ELIEZER LEON SILVER	0.590%						11
12	ELIYAHU DAVIS	1.177%						12
13	ELLIOTT ROBINSON	1.877%						13
14	ESTHER V. STEIN	0.263%						14
15	FREDA ROBINSON	1.279%						15
16	HENRY CHEN	1.976%						16
17	IRVING CUTLER	0.395%						17
18	J & J PARTNERSHIP	8.260%						18
19	JANET HARRIS	2.370%						19
20	JAY ROBINSON	0.393%						20
21	JOEL E. JACOBSON	0.263%						21
22	LAURENCE & CORALIE ZUNG	2.767%						22
23	LEONARD & MOLLY BOLNICK	0.790%						23
24	MOSHE Y. DAVIS	1.177%						24
25	NAOMI FARKAS	3.950%						25
26	NESANEL B. DAVIS	1.177%						26
27	R & L ASSOCIATES	0.395%						27
28	RAJCHENBACH GLENVIEW TERRACE LLC	9.800%						28
29	ROBINSON -LEVITT FAMILY TRUST	0.296%						29
30	ROSLYN HAMER	1.580%						30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SANDI SPRECKMAN TRUST	0.393%						1
2	SHELDON AND FRED A ROBINSON	0.988%						2
3	SHELDON ROBINSON	0.395%						3
4	SHELDON ROBINSON DELTA TRUST	1.976%						4
5	SHELDON ROBINSON REVOCABLE TRUST	3.558%						5
6	SHOSHANA BRAUN	1.177%						6
7	SNYDER -MILSTEIN LLC	0.990%						7
8	SOREL SIMON TRUST	0.395%						8
9	STEVE AND BARBARA GELLER	0.296%						9
10	SUSAN MOESER	0.393%						10
11	YEHO SHUA Y. DAVIS	1.177%						11
12	YEHUDA SILVER	0.590%						12
13	YISROEL M. DAVIS	1.177%						13
14	LEAH FINK REPARATIONS TRUST	1.980%						14
15	MARK HOLLANDER DISCRETIONARY TRUST	6.020%						15
16	SHARON HOLLANDER DISCRETIONARY TRUST	6.020%						16
17	FEIGE C. KNOBEL DISCRETIONARY TRUST	6.020%						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)

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	9.80%	See Attached	6.00	9.23%	Alloc. Salary	\$ 11,111	17-7	1
2	Mark Hollander	Relative	Administrative	0.00%	See Attached	27.00	45.00%	Salary	145,900	17-1	2
3	Aber Hollander	Relative	Administrative	0.00%	See Attached	24.64	61.60%	Salary/Al. Sal	56,728	17-1, 17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs										10
11	to reflect only amount anticipated to be considered allowable by the IL. Dept. of HFS										11
12											12
13								TOTAL	\$ 213,739		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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Ending: 12/31/11

(847) 679-1820

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 JLR MANAGEMENT CORP.
Street Address 6633 NORTH LINCOLN
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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	54	9	\$ 100,000	\$ 100,000	6	\$ 11,111	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	54	9	5,000		6	556	2
3	21	OFFICE	AVG. HOURS WORKED	54	9	18,359	18,359	6	2,040	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	54	9	15,176		6	1,686	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					\$ 138,535	\$ 118,359		\$ 15,393	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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	HUD		X	Mortgage			\$	15,636,461			\$	863,118	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	MB Financial		X	Line of Credit				3,500,000				153,930	6
7	INAC		X	Insurance Financing								11,745	7
8	See Supplemental Schedule							486,586				205,448	8
9	TOTAL Facility Related						\$	19,623,047			\$	1,234,242	9
	B. Non-Facility Related*												
10	Interest Income		X									(306,807)	10
11	Interest Income - Bldg. Co.		X									(688)	11
12													12
13	See Supplemental Schedule											(123,062)	13
14	TOTAL Non-Facility Related						\$				\$	(430,556)	14
15	TOTALS (line 9+line14)						\$	19,623,047			\$	803,685	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,619 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.) 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 - 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	Omnicare		X				\$		\$ 486,586			\$ 50,066	8
9	Related Parties	X										69,483	9
10	Shareholder Loan	X										53,578	10
11	Allocated from ITEX		X									32,321	11
12													12
13													13
14	TOTAL Working Capital								486,586			205,448	14
	B. Non-Facility Related*												
15	Shareholder/Rel. Party Int.	X					\$					\$ (123,062)	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											(123,062)	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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	661,780	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.)				\$	689,167	2
3. Under or (over) accrual (line 2 minus line 1).				\$	27,387	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	710,049	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	737,436	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	498,058	8		
		2007	609,463	9		
		2008	626,952	10		
		2009	630,272	11		
		2010	676,238	12		
Beginning Accrual Adjusted						
2011 Accrual = \$676,238 x 1.05 = \$710,049						
Allocation from ITEX = \$12,929						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Glenview Terrace Nsg. Ctr</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0026237</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-1111	FAX #:	(847) 236-1155

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Glenview Terrace Nsg. Ctr</u>	COUNTY	<u>Cook</u>
---------------	----------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,000

B. General Construction Type: Exterior Brick Frame Steel & Concrete Number of Stories 3

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>1978</u>	<u>\$ 167,502</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 167,502</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	314			1975	\$ 2,750,940	\$ 525,558	40	\$ 68,774	\$ (456,785)	\$ 2,431,998	4
5				1989	1,453,936		40	36,348	36,348	806,348	5
6				2002	4,266,341		40	106,659	106,659	106,659	6
7				2004	37,074		40	927	927	927	7
8											8
	Improvement Type**										
9	Various			1975	28,890		20			28,890	9
10	Various			1977	11,520		20			6,484	10
11	Various			1978	1,209		20			1,209	11
12	Various			1979	4,832		20			4,832	12
13	Various			1980	6,097		20			6,097	13
14	Various			1981	2,004		20			1,610	14
15	Various			1982	6,604		20			2,943	15
16	Various			1983	5,607		20			5,607	16
17	Various			1984	4,233		20			4,233	17
18	Various			1985	10,997		20			9,125	18
19	Various			1986	2,080		20			2,071	19
20	Various			1987	2,375		20			1,655	20
21	Various			1988	4,955		20			4,169	21
22	Various			1989	111,464		20			107,016	22
23	Various			1990	98,033		20			85,773	23
24	Various			1991	2,229		20	46	46	2,008	24
25	Various			1992	3,024		20	151	151	2,816	25
26	Various			1993	103,239		20	4,695	4,695	96,142	26
27	Various			1994	23,033		20	1,152	1,152	19,376	27
28	Various			1995	44,266		20	2,213	2,213	36,339	28
29	Various			1996	93,171		20	4,659	4,659	72,559	29
30	Various			1997	102,244		20	3,703	3,703	54,038	30
31	Various			1998	103,389		20	4,025	4,025	75,585	31
32	Various			1999	150,958		20	3,531	3,531	125,148	32
33	Various			2000	37,198		20	1,860	1,860	20,972	33
34	Various			2001	217,477		20	10,874	10,874	115,181	34
35	Various			2002	5,478,038		20	288,838	288,838	3,041,073	35
36	Various			2003	1,988,331		20	97,228		1,023,625	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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2004	\$ 154,078	\$	20	\$ 11,943	\$ 11,943	\$ 120,331	37
38	Various	2005	112,565		20	9,117	9,117	67,718	38
39	Various	2006	43,728		20	4,093	4,093	30,353	39
40	Various	2007	78,768		20	7,114	7,114	31,999	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		664,334	15,798		21,945	6,147	380,114	68
69	Financial Statement Depreciation			242,605			(242,605)		69
70	TOTAL (lines 4 thru 69)		\$ 18,209,260	\$ 783,961		\$ 689,894	\$ (191,295)	\$ 8,933,021	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/11

Ending:

12/31/11

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		\$ 18,209,260	\$ 783,961		\$ 689,894	\$ (94,067)	\$ 8,933,021	1
2	Carpeting Hallways & Patient Rooms	2008	99,922		20	19,984	19,984	66,615	2
3	Carpeting	2008	3,952		20	790	790	2,569	3
4	Wallcovering	2008	6,224		20	1,245	1,245	4,253	4
5	Wallcovering	2008	2,142		20	428	428	1,463	5
6	Draperies & Cornice Boards	2008	9,522		20	1,904	1,904	6,348	6
7	Window Treatments	2008	9,218		20	1,844	1,844	5,685	7
8	Parking Lot Seal & Paint	2008	4,000		20	267	267	933	8
9	Electric Wall Heaters	2008	1,840		20	368	368	1,410	9
10	Electric Wall Heaters	2008	2,436		20	487	487	1,827	10
11	Conversion Of Resident Rooms / Bathrooms	2008	89,640		20	8,964	8,964	34,362	11
12	Kitchen Shelves	2008	2,633		20	527	527	2,106	12
13	Aquabath Shower Unit	2008	10,231		20	2,046	2,046	8,185	13
14	Doors And Installation	2008	5,200		20	520	520	1,950	14
15	Sprinkler Heads	2008	2,795		20	186	186	652	15
16	Carpet Rooms 102 & 100	2009	3,272		20	218	218	545	16
17	Tree Cutting & Asphalt	2009	12,000		20	300	300	800	17
18	7 New Private Baths	2009	50,000		20	1,250	1,250	3,750	18
19	9 New Private Baths	2009	45,000		20	1,125	1,125	3,375	19
20	9 New Private Baths	2009	52,466		20	1,312	1,312	2,733	20
21	Fireproofing Spray	2009	2,500		20	63	63	177	21
22	2 Aquabath Shower Units	2009	8,020		20	201	201	434	22
23	Remove Cabinets From 2008 Bill	2009	(9,000)		20	(225)	(225)	(675)	23
24	Canvas Wall Panels	2009	3,450		20	86	86	259	24
25	Repiping And New Valves	2009	3,475		20	87	87	203	25
26	5 New Smoke Dampers	2009	4,035		20	807	807	2,219	26
27	New Maxton Valve & Packing	2009	4,900		20	980	980	2,777	27
28	Alarm Repair	2009	2,909		20	145	145	376	28
29	Damper Installation	2009	2,977		20	149	149	323	29
30	Topographic Survey	2009	3,039		20	152	152	355	30
31	Ho Smith 670000 Btu Boiler	2010	8,500		20	1,700	1,700	3,400	31
32	Flate Plate Heat Exchanger	2010	4,590		20	918	918	1,071	32
33	Demolition & Repair Of Bathroom	2010	14,747		20	1,475	1,475	2,458	33
34	TOTAL (lines 1 thru 33)		\$ 18,675,895	\$ 783,961		\$ 740,197	\$ (43,764)	\$ 9,095,958	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 12B, Carried Forward		\$ 18,675,895	\$ 783,961		\$ 740,197	\$ (43,764)	\$ 9,095,958	1
2	Aquabath Shower Units	2010	8,350		20	835	835	1,461	2
3	Aquabath Shower Units	2010	5,795		20	580	580	966	3
4	Built In Footboards & Headboards	2010	4,300		20	860	860	1,075	4
5	Inline Chiller	2010	5,501		20	1,100	1,100	1,559	5
6	Parking Lot Seal Coat	2010	2,800		20	140	140	245	6
7	Hvac Repair - Condenser	2010	3,166		20	158	158	237	7
8	Hvac Repair - Pump & Valve	2010	2,596		20	130	130	195	8
9	Generator Repair	2010	2,816		20	141	141	246	9
10	Carpet For Office	2011	3,049		20	254	254	254	10
11	Carpet 2Nd Floor Hallway	2011	15,000		20	893	893	893	11
12	Carpet 2Nd Floor Hallway	2011	19,850		20	945	945	945	12
13	Carpet 24 Rooms 1St Floor	2011	13,000		20	155	155	155	13
14	Ac Repair	2011	4,574		20	457	457	457	14
15	Boiler Work	2011	6,654		20	222	222	222	15
16	Air Conditioning System	2011	3,339		20	668	668	668	16
17	Wallcoverings	2011	2,708		20	542	542	542	17
18	Cornice Boards And Draperies	2011	3,023		20	504	504	504	18
19	Wallcoverings	2011	5,669		20	736	736	736	19
20	Wallcoverings	2011	3,163		20	422	422	422	20
21	Wallcoverings	2011	3,703		20	62	62	62	21
22	Computer Cubbies And Walls	2011	9,500		20	1,425	1,425	1,425	22
23	Bearing And Housing Repair	2011	3,108		20	518	518	518	23
24	Concrete Repair	2011	3,760		20	167	167	167	24
25	Ceramic Wall Tile	2011	3,400		20	283	283	283	25
26	French Door	2011	3,500		20	175	175	175	26
27	Airconditioning System For Elevator Room	2011	10,243		20	683	683	683	27
28	Roof Air Unit	2011	21,350		20	1,068	1,068	1,068	28
29	Roof Air Unit	2011	3,439		20	172	172	172	29
30	Roof Air Unit	2011	19,782		20	659	659	659	30
31	Repaired Heating/Cooling Units	2011	2,913		20	146	146	146	31
32	Repaired Boilers	2011	6,654		20	333	333	333	32
33	Replaced Heating/Cooling Units	2011	3,339		20	167	167	167	33
34	TOTAL (lines 1 thru 33)		\$ 18,885,939	\$ 783,961		\$ 755,795	\$ (28,166)	\$ 9,113,597	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Totals from Page 12C, Carried Forward		\$ 18,885,939	\$ 783,961		\$ 755,795	\$ (28,166)	\$ 9,113,597	1
2 Replaced Sprinkler Heads	2011	3,457		20	173	173	173	2
3 Repaired Elevator Pit	2011	5,241		20	262	262	262	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)		\$ 18,894,636	\$ 783,961		\$ 756,230	\$ (27,731)	\$ 9,114,031	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Totals from Page 12D, Carried Forward	\$ 18,894,636	\$ 783,961		\$ 756,230	\$ (27,731)	\$ 9,114,031	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)	\$ 18,894,636	\$ 783,961		\$ 756,230	\$ (27,731)	\$ 9,114,031	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									34

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4	Allocation from ITEX	1993	510,824	13,098	35	14,595	1,497	271,222	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from ITEX	1993	64,276	378	20	3,213	2,835	60,120	9
10	Allocation from ITEX	1994	34,524	898	20	1,726	828	29,831	10
11	Allocation from ITEX	1995	5,884	16	20	294	278	4,764	11
12	Allocation from ITEX	1996	333		20	17	17	268	12
13	Allocation from ITEX	1997	9,926	255	20	496	241	7,196	13
14	Allocation from ITEX	1999	1,102	28	20	55	27	716	14
15	Allocation from ITEX	2005	4,826		20	241	241	1,538	15
16	Allocation from ITEX	2007	5,975	202	20	299	97	1,272	16
17	Allocation from ITEX	2008	22,773	584	20	752	168	2,695	17
18	Allocation from ITEX	2009	1,241	32	20	124	92	310	18
19	Allocation from ITEX	2010	2,650	307	20	133	(174)	182	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Related Party Information Continued								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
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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 (12H & 12I lines 1 thru 33)		\$ 664,334	\$ 15,798		\$ 21,945	\$ 6,147	\$ 380,114	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$1,742,604	\$1,094	\$126,130	\$125,036	10	\$1,454,543	71
72	Current Year Purchases	65,394		4,483	4,483	10	4,483	72
73	Fully Depreciated Assets	2,352,503		194	194	10	2,352,503	73
74								74
75	TOTALS	\$4,160,501	\$1,094	\$130,806	\$129,712		\$3,811,528	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$23,222,640
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$785,055
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$887,036
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$101,981
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$12,925,560

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$50,256
- 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	Residential Use	Ford Vans	\$ Various	\$ 26,980	17
18	Residential Use	Chrysler Jeep	805.00	6,815	18
19					19
20					20
21	TOTAL		\$ 805.00	\$ 33,795	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 544,555		\$	\$		\$ 544,555	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	190,246			11,010		201,256	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	358,125			409,774		767,899	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				2,172,200		2,172,200	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			119,496			310,808		430,304	13
14	TOTAL			\$ 1,212,422		\$	\$ 2,903,792		\$ 4,116,214	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 23,194	\$ 379,870	1
2	Cash-Patient Deposits	42,841	42,841	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,142,538	6,142,538	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	481,641	481,641	6
7	Other Prepaid Expenses	15,339	47,029	7
8	Accounts Receivable (owners or related parties)	6,151,579	6,151,579	8
9	Other(specify): See Attached Schedule	864,840	1,290,302	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 13,721,972	\$ 14,535,800	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		198,820	13
14	Buildings, at Historical Cost		8,932,843	14
15	Leasehold Improvements, at Historical Cost	1,079,442	8,680,719	15
16	Equipment, at Historical Cost	1,616,373	5,050,375	16
17	Accumulated Depreciation (book methods)	(1,729,957)	(14,168,184)	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 Schedule	252,047	1,150,442	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,217,905	\$ 9,845,015	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,939,877	\$ 24,380,815	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,827,343	\$ 3,839,843	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,341	41,341	28
29	Short-Term Notes Payable	3,947,836	3,947,836	29
30	Accrued Salaries Payable	716,151	716,151	30
31	Accrued Taxes Payable (excluding real estate taxes)	96,262	96,262	31
32	Accrued Real Estate Taxes(Sch.IX-B)		710,049	32
33	Accrued Interest Payable	19,396	91,063	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,625	227,432	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,655,954	\$ 9,669,977	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	38,750	38,750	39
40	Mortgage Payable		15,636,461	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 38,750	\$ 15,675,211	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,694,704	\$ 25,345,188	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,245,173	\$ (964,373)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,939,877	\$ 24,380,815	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,826,940	1
2	Restatements (describe):		2
3	Rounding Adjustment	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,826,946	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,193,227	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	(775,000)	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)	\$ 1,418,227	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,245,173	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 26,997,337	1
2	Discounts and Allowances for all Levels	(7,453,589)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,543,748	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,245,547	6
7	Oxygen	191	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,245,738	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	4,110	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,743,881	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	287,454	19
20	Radiology and X-Ray		20
21	Other Medical Services	257,370	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,292,815	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	306,807	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 306,807	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,355	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,355	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 30,396,463	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,963,455	31
32	Health Care	10,530,613	32
33	General Administration	5,497,569	33
	B. Capital Expense		
34	Ownership	2,956,302	34
	C. Ancillary Expense		
35	Special Cost Centers	4,776,677	35
36	Provider Participation Fee	478,620	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,203,236	40
41	Income before Income Taxes (line 30 minus line 40)**	2,193,227	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,193,227	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,509	2,764	\$ 128,375	\$ 46.45	1
2	Assistant Director of Nursing	6,394	7,068	261,814	37.04	2
3	Registered Nurses	76,872	86,859	2,625,518	30.23	3
4	Licensed Practical Nurses	46,512	51,337	1,366,955	26.63	4
5	CNAs & Orderlies	213,811	241,348	3,086,698	12.79	5
6	CNA Trainees					6
7	Licensed Therapist	38,825	46,405	1,212,422	26.13	7
8	Rehab/Therapy Aides	39,978	48,930	1,387,136	28.35	8
9	Activity Director	1,808	2,160	41,502	19.21	9
10	Activity Assistants	25,049	27,780	314,869	11.33	10
11	Social Service Workers	20,699	23,470	474,884	20.23	11
12	Dietician					12
13	Food Service Supervisor	2,312	2,680	86,512	32.28	13
14	Head Cook	5,549	6,364	94,108	14.79	14
15	Cook Helpers/Assistants	47,825	53,628	618,308	11.53	15
16	Dishwashers					16
17	Maintenance Workers	12,990	15,187	248,028	16.33	17
18	Housekeepers	48,708	54,936	626,221	11.40	18
19	Laundry	26,129	29,507	347,397	11.77	19
20	Administrator	4,203	4,309	128,894	29.91	20
21	Assistant Administrator	1,849	1,849	37,123	20.08	21
22	Other Administrative	1,404	1,404	145,900	103.92	22
23	Office Manager	1,890	2,170	55,044	25.37	23
24	Clerical	37,052	41,195	578,665	14.05	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	5,616	6,567	100,551	15.31	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,972	6,140	186,568	30.39	33
34	TOTAL (lines 1 - 33)	673,956	764,057	\$ 14,153,492 *	\$ 18.52	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	\$ 52,324	01-03	35
36	Medical Director	Monthly	98,100	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	103,342	10-03	38
39	Pharmacist Consultant	Monthly	32,432	10-03	39
40	Physical Therapy Consultant	Monthly	173	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	12,026	11-03	44
45	Social Service Consultant	Monthly	4,550	12-03	45
46	Other(specify)				46
47	<u>Rehab Nursing Consultant</u>	Monthy	38,000	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 345,459		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Glenview Terrace Nsg. Ctr		STATE OF ILLINOIS		Report Period Beginning:		01/01/11		Page 21	
				# 0026237				Ending:		12/31/11	
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	
Ian Crook		Administrator	0.00%	\$ 64,419	Workers' Compensation Insurance		\$ 348,738	IDPH License Fee		\$	
Tom McClean		Administrator	0.00%	7,747	Unemployment Compensation Insurance		94,371	Advertising: Employee Recruitment		68,002	
Aber Hollander		Administrator	0.00%	56,728	FICA Taxes		1,052,666	Health Care Worker Background Check		12,115	
Mark Hollander		Executive Director	0.00%	145,900	Employee Health Insurance		704,794	(Indicate # of checks performed 1212)			
Tom McClean		Asst. Admin.	0.00%	37,123	Employee Meals		127,312	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions		20,216	
					401K Expense		32,622	Licenses		3,179	
					Pension Plan		122,830	Association Dues		20,396	
					Other Employee Benefits		6,446	Advertising and Public Relations		27,320	
					Christmas Expense		13,928	See Supplemental Schedule		4,738	
								Less: Public Relations Expense (			
								Non-allowable advertising		(24,889)	
								Yellow page advertising		(2,431)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 311,917	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,503,707	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 128,646	
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Description				Amount	Description		Line #	Amount	Description		Amount
JLR - Management Fees				\$ 225,000					Out-of-State Travel		\$
									In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 225,000							
C. Professional Services									Seminar Expense		10,013
Vendor/Payee		Type		Amount					Allocated from ITEX		150
Frost, Ruttenberg, & Rothblatt		Accounting		\$ 44,311							
Personnel Planners		Unemployment Consulting		1,868							
AK Care		Centralized Bookkeeping		432,000							
LTC Consulting, LLC		Admin. Consult. (Adj.5A)		3,000							
E-Health Data Solutions		Data Processing		7,260							
Am Ex		Data Processing		28,677							
ADL Data Systems		Data Processing		8,788							
Singer Networks		Data Processing		5,613							
AK Care		Data Processing		133							
Verizon Data		Data Processing		1,095							
Achieve Accreditation		Joint Commission Consult		3,215							
See Supplemetal Schedule				119,046					Entertainment Expense (		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 655,004	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 10,163
						* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT					
						**See instructions.					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. ILCTC - \$20,396.44

(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? _____

(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. \$ 15,685 Line 10-2

(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? X YES _____ 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. \$ 478,620
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? N/A 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. \$ 127,312 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,110

(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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT