

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0026237 Facility Name: Glenview Terrace Nsg Ctr Address: 1511 Greenwood Road Glenview 60025 County: Cook Telephone Number: (847) 729-9090 Fax #: (847) 729-9135 HFS ID Number: Date of Initial License for Current Owners: 11/01/75 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual X Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Noshir R. Daruwalla, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax #: (847) 236-1155 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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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nsg Ctr

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

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	<u>314</u>	Skilled (SNF)	<u>314</u>	<u>114,924</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>314</u>	TOTALS	<u>314</u>	<u>114,924</u>	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	<u>8,688</u>	<u>18,354</u>	<u>33,123</u>	<u>60,165</u>	8
9	SNF/PED					9
10	ICF	<u>38,035</u>	<u>121</u>		<u>38,156</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>46,723</u>	<u>18,475</u>	<u>33,123</u>	<u>98,321</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.55%

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 26,508

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

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

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

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	882,320	145,766	17,968	1,046,054		1,046,054	5,741	1,051,795			1
2	Food Purchase		876,568		876,568	(144,643)	731,925	(6,044)	725,881			2
3	Housekeeping	621,175	105,452		726,627		726,627	11,325	737,952			3
4	Laundry	347,244	50,174		397,418		397,418		397,418			4
5	Heat and Other Utilities			320,395	320,395		320,395	4,712	325,107			5
6	Maintenance	249,290	97,016	296,749	643,055		643,055	2,176	645,231			6
7	Other (specify):*											7
8	TOTAL General Services	2,100,029	1,274,976	635,112	4,010,117	(144,643)	3,865,474	17,910	3,883,384			8
	B. Health Care and Programs											
9	Medical Director			118,900	118,900		118,900		118,900			9
10	Nursing and Medical Records	7,496,399	348,005	117,189	7,961,593		7,961,593	(475)	7,961,118			10
10a	Therapy	1,538,852		42,000	1,580,852		1,580,852		1,580,852			10a
11	Activities	404,353	41,816	7,621	453,790		453,790		453,790			11
12	Social Services	522,118		4,500	526,618		526,618		526,618			12
13	CNA Training											13
14	Program Transportation			1,994	1,994		1,994		1,994			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,961,722	389,821	292,204	10,643,747		10,643,747	(475)	10,643,272			16
	C. General Administration											
17	Administrative	341,502		140,000	481,502		481,502	(127,755)	353,747			17
18	Directors Fees											18
19	Professional Services			985,588	985,588	(22,844)	962,744	(412,089)	550,655			19
20	Dues, Fees, Subscriptions & Promotions			306,173	306,173		306,173	(198,221)	107,952			20
21	Clerical & General Office Expenses	597,898	7,613	525,128	1,130,639		1,130,639	(64,725)	1,065,914			21
22	Employee Benefits & Payroll Taxes			2,490,808	2,490,808	144,643	2,635,451	(644)	2,634,808			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,179	14,179		14,179	30	14,209			24
25	Other Admin. Staff Transportation			4,205	4,205		4,205		4,205			25
26	Insurance-Prop.Liab.Malpractice			412,475	412,475		412,475	2,151	414,626			26
27	Other (specify):*							88,700	88,700			27
28	TOTAL General Administration	939,400	7,613	4,878,556	5,825,569	121,799	5,947,368	(712,552)	5,234,816			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	13,001,151	1,672,410	5,805,872	20,479,433	(22,844)	20,456,589	(695,118)	19,761,472			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			247,693	247,693		247,693	624,029	871,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			403,591	403,591		403,591	457,312	860,903			32
33	Real Estate Taxes			65,800	65,800	22,844	88,644	653,720	742,364			33
34	Rent-Facility & Grounds			2,339,000	2,339,000		2,339,000	(2,339,000)				34
35	Rent-Equipment & Vehicles			78,825	78,825		78,825	1,487	80,312			35
36	Other (specify):*							70,950	70,950			36
37	TOTAL Ownership			3,134,909	3,134,909	22,844	3,157,753	(531,502)	2,626,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,291,857	2,328,619		3,620,476		3,620,476		3,620,476			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			634,967	634,967		634,967	(37,743)	597,224			42
43	Other (specify):*	181,992		305,018	487,010		487,010	(487,010)	(0)			43
44	TOTAL Special Cost Centers	1,473,849	2,328,619	939,985	4,742,453		4,742,453	(524,753)	4,217,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	14,475,000	4,001,029	9,880,766	28,356,795	(0)	28,356,795	(1,751,373)	26,605,422			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,405)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	119,034	30		9
10	Interest and Other Investment Income	(315,095)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,639)	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	(2,830)	21		18
19	Entertainment				19
20	Contributions	(29,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(97,679)	21		24
25	Fund Raising, Advertising and Promotional	(28,343)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,769)	20		28
29	Other-Attach Schedule	(1,713,263)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,075,989)		\$	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)	324,616		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 324,616		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,751,373)		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

Report Period Beginning:

Ending:

ID#

0026237

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Driver's Salary	\$ (35,739)	43	1
2	Marketing Salary	(58,874)	43	2
3	Veteran Expenses	(458)	10	3
4	Bank Charges	(19,141)	21	4
5	Credit Card Fees	(26,243)	21	5
6	Public Relations	(122,741)	20	6
7	COPE Dues	(16,327)	20	7
8	Jury Duty Income	(17)	10	8
9	Misc. Income - State of Illinois	(180)	21	9
10	Miscellaneous Income	(153)	21	10
11	Non-Allowable Interest	(86,572)	32	11
12	2013 Seminar	(245)	24	12
13	2012 Seminar from Prior Year	245	24	13
14	Non-Allowable Legal	(19,218)	19	14
15	Non-Allowable Office Expense	(240,000)	21	15
16	Non-Allowable Fees	(280,000)	43	16
17	Non-Allowable Auto Expense	(25,018)	43	17
18	Non-Allowable Marketing Travel	(2,918)	43	18
19	Building Co. - Annual Report Fee	(250)	20	19
20	Building Co. - Prepayment Penalty	(79,944)	21	20
21	Building Co. - Office Expense	(12)	21	21
22	Building Co. - Legal	(865)	19	22
23	Building Co. - Amortization	(169,302)	36	23
24	Non-Allowable Salary	(84,461)	43	24
25	Non-Allowable Rent	(384,000)	34	25
26	Capitalized R&M	(11,435)	06	26
27	Additional R&M	4,363	06	27
28	Non-Allowable Professional Fees	(750)	19	28
29	Life Insurance	(644)	22	29
30	Prior Year Bed Tax Assessment	(37,743)	42	30
31	Building Co. - Accounting Fees	(14,621)	19	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	(1,713,263)		49

ID#

0026237

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

12/31/12

[illegible]

Summary B

12/31/12

[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	\$ 1,955,000	Glenview Terrace Property, LLC	100.00%	\$	\$ (1,955,000)	1
2	V	32	Interest Income	2,542	Glenview Terrace Property, LLC	100.00%		(2,542)	2
3	V	20	Annual Report Fee		Glenview Terrace Property, LLC	100.00%	250	250	3
4	V	21	Prepayment Penalty		Glenview Terrace Property, LLC	100.00%	79,944	79,944	4
5	V	21	Office Expense		Glenview Terrace Property, LLC	100.00%	12	12	5
6	V	19	Legal		Glenview Terrace Property, LLC	100.00%	865	865	6
7	V	19	Accounting Fees		Glenview Terrace Property, LLC	100.00%	14,621	14,621	7
8	V	32	Mortgage Interest Expense		Glenview Terrace Property, LLC	100.00%	829,718	829,718	8
9	V	33	Real Estate Taxes		Glenview Terrace Property, LLC	100.00%	640,496	640,496	9
10	V	36	MIP Insurance		Glenview Terrace Property, LLC	100.00%	70,950	70,950	10
11	V	30	Depreciation		Glenview Terrace Property, LLC	100.00%	488,608	488,608	11
12	V	36	Loan Amortization		Glenview Terrace Property, LLC	100.00%	169,302	169,302	12
13	V	19	RE Related Legal Fees		Glenview Terrace Property, LLC	100.00%	22,843	22,843	13
14	Total			\$ 1,957,542			\$ 2,317,609	\$ * 360,067	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.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 5,741	\$ 5,741	15
16	V	3	HOUSEKEEPING			100.00%	11,325	11,325	16
17	V	5	UTILITIES			100.00%	4,712	4,712	17
18	V	6	REPAIRS AND MAINT.			100.00%	9,248	9,248	18
19	V	19	PROFESSIONAL FEES			100.00%	16,424	16,424	19
20	V	20	FEES, SUBSCRIPTIONS			100.00%	959	959	20
21	V	21	CLERICAL AND GENERAL			100.00%	45,019	45,019	21
22	V	24	EDUCATION/SEMINARS			100.00%	30	30	22
23	V	26	INSURANCE			100.00%	2,151	2,151	23
24	V	30	DEPRECIATION			100.00%	16,387	16,387	24
25	V	32	INTEREST			100.00%	31,803	31,803	25
26	V	33	REAL ESTATE TAXES			100.00%	13,224	13,224	26
27	V	35	EQUIPMENT RENTAL			100.00%	1,487	1,487	27
28	V								28
29	V								29
30	V								30
31	V	21	CLERICAL SALARIES			100.00%	271,182	271,182	31
32	V	27	GEN ADMIN. - EMP. BEN.			100.00%	87,227	87,227	32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	432,000		100.00%		(432,000)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 432,000			\$ 516,919	\$ * 84,919	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 FINANCIAL SERVICES CORP.	100.00%	\$ 12,245	\$ 12,245	15
16	V	19	PROFESSIONAL FEES			100.00%	612	612	16
17	V	21	OFFICE			100.00%	5,300	5,300	17
18	V	27	EMPLOYEE BENEFITS			100.00%	1,473	1,473	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	140,000		100.00%		(140,000)	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			\$ 140,000			\$ 19,630	\$ * (120,370)	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

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.

YESNO

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

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%	CLARIDGE IMPERIAL, LTD.	CHICAGO	GLENVIEW TERRACE PROPER		BUILDING CO.	1
2	ADINA AARON	0.263%	HARMONY NURSING & REHAB.	CHICAGO	ITEX / A.K. CARE	LINCOLNWOOD	BOOKEEPING CO./MANA	2
3	AHUVA WEINREB	1.177%	THE CARLTON AT THE LAKE, INC.	CHICAGO	JLR FINANCIAL SERVICES CO	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	2.867%						9
10	DISCRETIONARY TRUST FOR JULIE T.Y.	2.867%						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	FEIGE C. KNOBEL DISCRETIONARY TRUST	6.020%						15
16	FREDA ROBINSON	1.279%						16
17	HENRY CHEN	1.976%						17
18	IRVING CUTLER	0.395%						18
19	J & J PARTNERSHIP	8.260%						19
20	JANET HARRIS	2.370%						20
21	JAY ROBINSON	0.393%						21
22	JOEL E. JACOBSON	0.263%						22
23	LAURENCE & CORALIE ZUNG	4.147%						23
24	LEAH FINK REPARATIONS TRUST	1.980%						24
25	LEONARD & MOLLY BOLNICK	0.790%						25
26	MARK HOLLANDER DISCRETIONARY TRUST	6.020%						26
27	MOSHE Y. DAVIS	1.177%						27
28	NAOMI FARKAS	3.950%						28
29	NESANEL B. DAVIS	1.177%						29
30	R & L ASSOCIATES	0.395%						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	RAJCHENBACH GLENVIEW TERRACE LLC	9.800%						1
2	ROBINSON-LEVITT FAMILY TRUST	0.296%						2
3	ROSLYN HAMER	1.580%						3
4	SANDI SPRECKMAN TRUST	0.393%						4
5	SHARON HOLLANDER DISCRETIONARY TRUST	6.020%						5
6	SHELDON AND FREDA ROBINSON	0.988%						6
7	SHELDON ROBINSON	0.395%						7
8	SHELDON ROBINSON DELTA TRUST	1.976%						8
9	SHELDON ROBINSON REVOCABLE TRUST	3.558%						9
10	SHOSHANA BRAUN	1.177%						10
11	SNYDER-MILSTEIN LLC	0.990%						11
12	SOREL SIMON TRUST	0.395%						12
13	STEVE AND BARBARA GELLER	0.296%						13
14	SUSAN MOESER	0.393%						14
15	YEHUDA SILVER	0.590%						15
16	YEHOShUA Y. DAVIS	1.177%						16
17	YISROEL M. DAVIS	1.177%						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

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	Relative	Administrative	0.00%	See Attached	6.00	10.00%	Alloc. Salary	\$ 12,245	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	40.00	100.00%	Salary	129,052	17-1	3
4	Allen Hollander	Relative	Clerical	0.00%	N/A	18.05	100.00%	Salary	13,165	21-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 300,362		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 12/31/12

(847) 679-1820

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

(847) 679-1820

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 01/01/12 Ending: 12/31/12

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: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 01/01/12 Ending: 12/31/12

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: 12/31/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

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			\$	15,930,000			\$	829,718	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	MB Financial		X	Line of Credit				6,175,000				222,813	6
7	INAC		X	Insurance Financing								8,468	7
8	See Supplemental Schedule							992,615				85,738	8
9	TOTAL Facility Related						\$	23,097,615			\$	1,146,737	9
	B. Non-Facility Related*												
10	Interest Income		X									(315,095)	10
11	Interest Income - Bldg. Co.		X									(2,542)	11
12	Allocated from ITEX		X									31,803	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(285,834)	14
15	TOTALS (line 9+line14)						\$	23,097,615			\$	860,903	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 70,950 Line # 36

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$		\$ 992,615			\$ 45,765	8
9	Related Parties	X											9
10	Shareholder Loan	X										39,974	10
11	Allocated from ITEX		X										11
12													12
13													13
14	TOTAL Working Capital								992,615			85,738	14
	B. Non-Facility Related*												
15							\$		\$			\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Glenview Terrace Nsg Ctr</u>	COUNTY	<u>Cook</u>
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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 2011 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 2011.

(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.	<u>04-28-401-042-0000</u>	<u>Long Term Property Care</u>		\$	<u>690,900.70</u>	\$	<u>690,900.70</u>
2.	<u>10-35-312-022-0000</u>	<u>Allocation from ITEX/AK Care</u>		\$	<u>50,627.24</u>	\$	<u>15,413.27</u>
3.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
4.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
5.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
6.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
7.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
8.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
9.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
10.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
TOTALS				\$	<u><u>741,527.94</u></u>	\$	<u><u>706,313.97</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	710,049	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.)		\$	704,125	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(5,924)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	725,446	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.)		\$	22,844	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 \$ 65,800 For 08,09 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.		\$	742,365	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	609,463	8	
		2008	626,952	9	
		2009	630,272	10	
		2010	676,238	11	
		2011	690,901	12	
2012 Accrual: \$690,901 x 1.05 = \$725,446					
Allocation from ITEX = \$13,224					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Glenview Terrace Nsg Ctr

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0026237

CONTACT PERSON REGARDING THIS REPORT

TELEPHONEFAX #:

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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

Facility Name & ID Number Glenview Terrace Nsg Ctr

#

0026237

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	\$ 488,608	40	\$ 68,774	\$ (419,834)	\$ 2,500,772	4
5				1989	1,453,936		40	36,348	36,348	842,696	5
6				2002	4,266,341		40	106,659	106,659	213,318	6
7											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			2,008	24
25	Various			1992	3,024		20	113	113	2,929	25
26	Various			1993	103,239		20	4,466	4,466	100,608	26
27	Various			1994	23,033		20	1,152	1,152	20,527	27
28	Various			1995	44,266		20	2,213	2,213	38,552	28
29	Various			1996	93,171		20	4,659	4,659	77,217	29
30	Various			1997	102,244		20	3,567	3,567	57,605	30
31	Various			1998	103,389		20	4,025	4,025	79,611	31
32	Various			1999	150,958		20	3,531	3,531	128,679	32
33	Various			2000	37,198		20	1,860	1,860	22,832	33
34	Various			2001	217,477		20	10,874	10,874	126,054	34
35	Various			2002	5,478,038		20	276,141	276,141	3,317,214	35
36	Various			2003	1,988,331		20	97,228		1,120,853	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:

01/01/12

Ending:

12/31/12

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	\$ 132,273	37
38	Various	2005	112,565		20	8,177	8,177	75,894	38
39	Various	2006	43,728		20	3,147	3,147	33,500	39
40	Various	2007	78,768		20	7,114	7,114	39,113	40
41	Various	2008	249,755		20	39,561	39,561	177,920	41
42									42
43									43
44									44
45									45
46									46
47									47
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65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		664,334	15,643		21,944	6,301	402,058	68
69	Financial Statement Depreciation			247,693			(247,693)		69
70	TOTAL (lines 4 thru 69)		\$ 18,421,941	\$ 751,944		\$ 713,495	\$ (135,677)	\$ 9,783,948	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:

01/01/12

Ending:

12/31/12

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		\$ 18,421,941	\$ 751,944		\$ 713,495	\$ (38,449)	\$ 9,783,948	1
2	<u>Carpet Rooms 102 & 100</u>	2009	3,272		20	218	218	764	2
3	<u>Tree Cutting & Asphalt</u>	2009	12,000		20	300	300	1,100	3
4	<u>7 New Private Baths</u>	2009	50,000		20	1,250	1,250	5,000	4
5	<u>9 New Private Baths</u>	2009	45,000		20	1,125	1,125	4,500	5
6	<u>9 New Private Baths</u>	2009	52,466		20	1,312	1,312	4,044	6
7	<u>Fireproofing Spray</u>	2009	2,500		20	63	63	240	7
8	<u>2 Aquabath Shower Units</u>	2009	8,020		20	201	201	635	8
9	<u>Remove Cabinets From 2008 Bill</u>	2009	(9,000)		20	(225)	(225)	(900)	9
10	<u>Canvas Wall Panels</u>	2009	3,450		20	86	86	345	10
11	<u>Repiping And New Valves</u>	2009	3,475		20	87	87	290	11
12	<u>5 New Smoke Dampers</u>	2009	4,035		20	807	807	3,026	12
13	<u>New Maxton Valve & Packing</u>	2009	4,900		20	980	980	3,757	13
14	<u>Alarm Repair</u>	2009	2,909		20	145	145	521	14
15	<u>Damper Installation</u>	2009	2,977		20	149	149	471	15
16	<u>Ho Smith 670000 Btu Boiler</u>	2010	8,500		20	1,700	1,700	5,100	16
17	<u>Flate Plate Heat Exchanger</u>	2010	4,590		20	918	918	1,989	17
18	<u>Demolition & Repair Of Bathroom</u>	2010	14,747		20	1,475	1,475	3,933	18
19	<u>Aquabath Shower Units</u>	2010	8,350		20	835	835	2,296	19
20	<u>Aquabath Shower Units</u>	2010	5,795		20	580	580	1,545	20
21	<u>Built In Footboards & Headboards</u>	2010	2,700		20	540	540	1,215	21
22	<u>Inline Chiller</u>	2010	5,501		20	1,100	1,100	2,659	22
23	<u>Parking Lot Seal Coat</u>	2010	2,800		20	140	140	385	23
24	<u>Hvac Repair - Condenser</u>	2010	3,166		20	158	158	396	24
25	<u>Hvac Repair - Pump & Valve</u>	2010	2,596		20	130	130	325	25
26	<u>Generator Repair</u>	2010	2,816		20	141	141	387	26
27	<u>Carpet For Office</u>	2011	3,049		20	436	436	690	27
28	<u>Carpet 2Nd Floor Hallway</u>	2011	15,000		20	2,143	2,143	3,036	28
29	<u>Carpet 2Nd Floor Hallway</u>	2011	19,850		20	2,836	2,836	3,781	29
30	<u>Carpet 24 Rooms 1St Floor</u>	2011	13,000		20	1,857	1,857	2,012	30
31	<u>Ac Repair</u>	2011	4,574		20	915	915	1,372	31
32	<u>Boiler Work</u>	2011	6,654		20	1,331	1,331	1,553	32
33	<u>Air Conditioning System</u>	2011	3,339		20	668	668	1,336	33
34	TOTAL (lines 1 thru 33)		\$ 18,734,971	\$ 751,944		\$ 737,893	\$ (14,051)	\$ 9,841,748	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:

01/01/12

Ending:

12/31/12**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		\$ 18,734,971	\$ 751,944		\$ 737,893	\$ (14,051)	\$ 9,841,748	1
2	Wallcoverings	2011	2,708		20	542	542	1,083	2
3	Cornice Boards And Draperies	2011	3,023		20	605	605	1,109	3
4	Wallcoverings	2011	5,669		20	1,134	1,134	2,079	4
5	Wallcoverings	2011	3,163		20	633	633	1,054	5
6	Wallcoverings	2011	3,703		20	741	741	802	6
7	Computer Cubbies And Walls	2011	9,500		20	1,900	1,900	3,325	7
8	Bearing And Housing Repair	2011	3,108		20	622	622	1,140	8
9	Concrete Repair	2011	3,760		20	251	251	418	9
10	Ceramic Wall Tile	2011	3,400		20	340	340	623	10
11	French Door	2011	3,500		20	350	350	525	11
12	Airconditioning System For Elevator Room	2011	10,243		20	1,024	1,024	1,707	12
13	Roof Air Unit	2011	21,350		20	2,135	2,135	3,203	13
14	Roof Air Unit	2011	3,439		20	344	344	516	14
15	Roof Air Unit	2011	19,782		20	1,978	1,978	2,638	15
16	Repaired Heating / Cooling Unit	2011	2,913		20	146	146	279	16
17	Repaired Boiler	2011	6,654		20	333	333	388	17
18	Replaced Heating / Cooling Unit	2011	3,339		20	167	167	334	18
19	Replace Sprinkler Heads	2011	3,457		20	173	173	187	19
20	Repaired Elevator Pit	2011	5,241		20	262	262	502	20
21	Asphalt Coating	2012	3,200		20	89	89	89	21
22	Carpet 24 Rooms 1St Floor	2012	16,750		20	1,954	1,954	1,954	22
23	Carpeting First Floor Hallway	2012	18,480		20	2,156	2,156	2,156	23
24	Carpeting First Floor Hallway	2012	18,480		20	1,232	1,232	1,232	24
25	Asphalt Paving	2012	11,850		20	329	329	329	25
26	3Rd Floor Dining Room - Wallcovering	2012	6,158		20	1,232	1,232	1,232	26
27	First Floor Resident Room - Wallcovering 330 Yards	2012	3,705		20	494	494	494	27
28	First Floor Resident Room - Wallcovering 660 Yards	2012	7,410		20	988	988	988	28
29	First Floor Resident Room - Wallcovering 300 Yards	2012	3,382		20	395	395	395	29
30	Room Heaters	2012	3,214		20	54	54	54	30
31	Baseboards	2012	4,160		20	832	832	832	31
32	Replace Water Heater	2012	8,974		20	823	823	823	32
33	Remove & Replace Taco Pump	2012	6,400		20	427	427	427	33
34	TOTAL (lines 1 thru 33)		\$ 18,965,086	\$ 751,944		\$ 762,574	\$ 10,630	\$ 9,874,663	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		\$ 18,965,086	\$ 751,944		\$ 762,574	\$ 10,630	\$ 9,874,663	1
2 Ao Smith Boiler	2012	6,253		20	365	365	365	2
3 Install Sprinklers; Extend Sprinklers With Two Piece Escutcheon	2012	4,685		20	234	234	234	3
4 Replaced 2Nd Flat Plate Heat Exchanger	2012	6,750		20	338	338	338	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
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15								15
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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)		\$ 18,982,774	\$ 751,944		\$ 763,510	\$ 11,566	\$ 9,875,599	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	Totals from Page 12D, Carried Forward		\$ 18,982,774	\$ 751,944		\$ 763,510	\$ 11,566	\$ 9,875,599	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 18,982,774	\$ 751,944		\$ 763,510	\$ 11,566	\$ 9,875,599	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
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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		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 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:

01/01/12

Ending:

12/31/12

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	285,817	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from ITEX	1993	64,276	378	20	3,212	2,834	63,333	9
10	Allocation from ITEX	1994	34,524	898	20	1,726	828	31,557	10
11	Allocation from ITEX	1995	5,884	16	20	294	278	5,058	11
12	Allocation from ITEX	1996	333		20	17	17	284	12
13	Allocation from ITEX	1997	9,926	255	20	496	241	7,692	13
14	Allocation from ITEX	1999	1,102	28	20	55	27	771	14
15	Allocation from ITEX	2005	4,826		20	241	241	1,779	15
16	Allocation from ITEX	2007	5,975	170	20	299	129	1,571	16
17	Allocation from ITEX	2008	22,773	584	20	752	168	3,447	17
18	Allocation from ITEX	2009	1,241	32	20	124	92	434	18
19	Allocation from ITEX	2010	2,650	184	20	133	(51)	315	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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party 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 (12H & 12I lines 1 thru 33)		\$ 664,334	\$ 15,643		\$ 21,944	\$ 6,301	\$ 402,058	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	\$ 1,574,477	\$ 744	\$ 102,642	\$ 101,898	10	\$ 1,326,319	71
72	Current Year Purchases	91,819		5,050	5,050	10	5,050	72
73	Fully Depreciated Assets	2,587,626		520	520	10	2,588,666	73
74								74
75	TOTALS	\$ 4,253,922	\$ 744	\$ 108,212	\$ 107,468		\$ 3,920,035	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
		Reference	Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 23,404,198
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 752,688
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 871,722
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 119,034
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,795,634

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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: \$46,894
- 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	\$ 22,951	17
18	Residential Use	Chrysler Jeep	805.00	10,467	18
19					19
20					20
21	TOTAL		\$ 805.00	\$ 33,418	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 631,569		\$	\$		\$ 631,569	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	193,895			10,960		204,855	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	348,772			445,822		794,594	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				1,570,746		1,570,746	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			117,621			301,091		418,712	13
14	TOTAL			\$ 1,291,857		\$	\$ 2,328,619		\$ 3,620,476	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 39,106	\$ 302,712	1
2	Cash-Patient Deposits	40,172	40,172	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,621,261	7,621,261	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	580,211	580,211	6
7	Other Prepaid Expenses	17,313	135,210	7
8	Accounts Receivable (owners or related parties)	7,001,152	7,001,152	8
9	Other(specify): See Attached Schedule	972,373	1,249,831	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 16,271,588	\$ 16,930,549	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	1,198,478	8,799,755	15
16	Equipment, at Historical Cost	1,711,935	5,145,937	16
17	Accumulated Depreciation (book methods)	(1,977,650)	(14,904,485)	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	275,816	1,517,351	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,208,579	\$ 9,690,221	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,480,167	\$ 26,620,770	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,758,019	\$ 2,785,971	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,672	38,672	28
29	Short-Term Notes Payable	6,569,801	6,569,801	29
30	Accrued Salaries Payable	761,983	761,983	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,815	67,815	31
32	Accrued Real Estate Taxes(Sch.IX-B)		725,446	32
33	Accrued Interest Payable	29,380	71,196	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,508	42,509	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,233,178	\$ 11,063,393	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	597,814	597,814	39
40	Mortgage Payable		15,930,000	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)	\$ 597,814	\$ 16,527,814	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,830,992	\$ 27,591,207	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,649,175	\$ (970,437)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,480,167	\$ 26,620,770	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,245,173	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,245,174	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	894,293	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	(490,292)	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)	\$ 404,001	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)	\$ 6,649,175	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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 26,558,379	1
2	Discounts and Allowances for all Levels	(8,301,448)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,256,931	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,098,951	6
7	Oxygen	13,893	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,112,844	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	293	13
14	Non-Patient Meals	4,405	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,031,877	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	249,343	19
20	Radiology and X-Ray		20
21	Other Medical Services	207,975	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,493,893	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	315,095	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 315,095	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	72,325	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 72,325	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 29,251,088	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,010,117	31
32	Health Care	10,643,747	32
33	General Administration	5,825,569	33
	B. Capital Expense		
34	Ownership	3,134,909	34
	C. Ancillary Expense		
35	Special Cost Centers	4,107,486	35
36	Provider Participation Fee	634,967	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,356,795	40
41	Income before Income Taxes (line 30 minus line 40)**	894,293	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 894,293	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,724,950	44
45	Private Pay - Net Inpatient Revenue	3,659,017	45
46	Medicare - Net Inpatient Revenue	6,071,851	46
47	Other-(specify) Insurance	519,151	47
48	Other-(specify) Veterans/Isolation	281,962	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,256,931	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

		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	2,524	2,780	\$ 129,140	\$ 46.45	1
2	Assistant Director of Nursing	5,447	6,311	211,649	33.54	2
3	Registered Nurses	84,122	100,425	2,689,227	26.78	3
4	Licensed Practical Nurses	42,370	47,401	1,230,966	25.97	4
5	CNAs & Orderlies	218,153	244,912	3,133,773	12.80	5
6	CNA Trainees					6
7	Licensed Therapist	40,910	48,964	1,291,857	26.38	7
8	Rehab/Therapy Aides	37,621	44,088	1,538,852	34.90	8
9	Activity Director	1,784	2,080	40,084	19.27	9
10	Activity Assistants	29,641	33,642	364,269	10.83	10
11	Social Service Workers	25,554	29,174	522,118	17.90	11
12	Dietician					12
13	Food Service Supervisor	3,804	4,264	121,092	28.40	13
14	Head Cook	5,601	6,451	95,722	14.84	14
15	Cook Helpers/Assistants	49,769	56,023	665,506	11.88	15
16	Dishwashers					16
17	Maintenance Workers	12,823	15,118	249,290	16.49	17
18	Housekeepers	47,118	54,065	621,175	11.49	18
19	Laundry	26,353	30,667	347,244	11.32	19
20	Administrator	4,249	4,356	129,052	29.63	20
21	Assistant Administrator					21
22	Other Administrative	3,072	3,160	212,450	67.23	22
23	Office Manager	1,851	2,147	54,742	25.50	23
24	Clerical	34,771	38,659	543,156	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	5,790	6,622	101,644	15.35	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,980	6,240	181,992	29.17	33
34	TOTAL (lines 1 - 33)	689,307	787,549	\$ 14,475,000 *	\$ 18.38	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	\$ 17,968	01-03	35
36	Medical Director	Monthly	118,900	09-03	36
37	Medical Records Consultant	47,401	4,533	10-03	37
38	Nurse Consultant	Monthly	83,846	10-03	38
39	Pharmacist Consultant	Monthly	28,810	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	7,621	11-03	44
45	Social Service Consultant	Monthly	4,500	12-03	45
46	Other(specify)				46
47	<u>Rehab Nursing Consultant</u>	Monthly	42,000	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	47,401	\$ 308,178		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.

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

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													
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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 - \$28,652.50

(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. \$ 15,234 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. \$ 597,224
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. \$ 144,643 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,405

(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?
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