

		FOR BHF USE					

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

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 Nursing Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</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.	
Address: <u>1511 Greenwood Road</u> <u>Glenview</u> <u>60025</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>			
Telephone Number: <u>(847) 729-9090</u> Fax # <u>(847) 729-9135</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/1/1975</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ 05/27/2021	
		* Subject to the attached Accountants' Consulting Report (Date)	
		Paid Preparer	
		(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</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	

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	314	Skilled (SNF)	314	114,924	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	314	TOTALS	314	114,924	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	42,441	21,076	13,257	76,774	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,441	21,076	13,257	76,774	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.80%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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 12/1/1975

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 11,014

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	1,246,848	18,843		1,265,691		1,265,691	4,073	1,269,764			1
2	Food Purchase		1,037,379		1,037,379	(209,059)	828,320	(3,430)	824,890			2
3	Housekeeping	780,210	120,741		900,951		900,951	14,443	915,394			3
4	Laundry	209,349	382,388		591,737		591,737		591,737			4
5	Heat and Other Utilities			253,599	253,599		253,599	7,570	261,169			5
6	Maintenance	290,056	62,335	323,158	675,549		675,549	2,497	678,046			6
7	Other (specify):*											7
8	TOTAL General Services	2,526,463	1,621,686	576,757	4,724,906	(209,059)	4,515,847	25,153	4,541,000			8
	B. Health Care and Programs											
9	Medical Director			156,900	156,900		156,900		156,900			9
10	Nursing and Medical Records	9,059,405	1,207,407	363,704	10,630,516		10,630,516	(21,480)	10,609,036			10
10a	Therapy	275,699			275,699		275,699		275,699			10a
11	Activities	443,522	7,710	975	452,207		452,207		452,207			11
12	Social Services	331,026		2,166	333,192		333,192		333,192			12
13	CNA Training											13
14	Program Transportation			14,481	14,481		14,481		14,481			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	10,109,652	1,215,117	538,226	11,862,995		11,862,995	(21,480)	11,841,515			16
	C. General Administration											
17	Administrative	278,002			278,002		278,002		278,002			17
18	Directors Fees											18
19	Professional Services			1,511,164	1,511,164	(67,944)	1,443,220	(967,450)	475,770			19
20	Dues, Fees, Subscriptions & Promotions			256,759	256,759		256,759	(157,962)	98,797			20
21	Clerical & General Office Expenses	383,121	6,447	467,799	857,367		857,367	229,327	1,086,694			21
22	Employee Benefits & Payroll Taxes			2,042,910	2,042,910	209,059	2,251,969	(380)	2,251,589			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,529	14,529		14,529	2,291	16,820			24
25	Other Admin. Staff Transportation			2,244	2,244		2,244		2,244			25
26	Insurance-Prop.Liab.Malpractice			441,058	441,058		441,058	1,937	442,995			26
27	Other (specify):*							104,069	104,069			27
28	TOTAL General Administration	661,123	6,447	4,736,463	5,404,033	141,115	5,545,148	(788,168)	4,756,980			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	13,297,238	2,843,250	5,851,446	21,991,934	(67,944)	21,923,990	(784,495)	21,139,495			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			75,985	75,985		75,985	616,934	692,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			274,197	274,197		274,197	(200,863)	73,334			32
33	Real Estate Taxes			49,337	49,337	67,944	117,281	1,379,582	1,496,863			33
34	Rent-Facility & Grounds			2,049,000	2,049,000		2,049,000	(1,989,000)	60,000			34
35	Rent-Equipment & Vehicles			33,140	33,140		33,140	(13,485)	19,655			35
36	Other (specify):*							71,184	71,184			36
37	TOTAL Ownership			2,481,659	2,481,659	67,944	2,549,603	(135,648)	2,413,955			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,331,451	752,186		3,083,637		3,083,637		3,083,637			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			586,141	586,141		586,141		586,141			42
43	Other (specify):*	208,195		9,052	217,247		217,247	(217,247)				43
44	TOTAL Special Cost Centers	2,539,646	752,186	595,193	3,887,025		3,887,025	(217,247)	3,669,778			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	15,836,884	3,595,436	8,928,298	28,360,618		28,360,618	(1,137,391)	27,223,227			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				3
4	Non-Patient Meals	(595)	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	32,220	30		9
10	Interest and Other Investment Income	(520,931)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,835)	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	(4,343)	21		18
19	Entertainment				19
20	Contributions	(11,500)	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	(196,420)	21		24
25	Fund Raising, Advertising and Promotional	(49,797)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(718,116)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,482,317)		\$	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)	344,926		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 344,926		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,137,391)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (700)	21	1
2	Driver Salaries	(20,929)	43	2
3	Marketing Salary	(62,702)	43	3
4	Veteran Expense	(21,480)	10	4
5	Life Insurance	(380)	22	5
6	Bank Charges	(23,168)	21	6
7	Credit Card Fees	(49,062)	21	7
8	Franchise Tax	(150)	21	8
9	Public Relations/Marketing	(69,799)	20	9
10	Building Co. - Bank Charges	(899)	21	10
11	Building Co. - Annual Report	(75)	20	11
12	Building Co. - Professional Fees	(16,132)	19	12
13	Building Co. - State Replacement Tax	(771)	21	13
14	Non-Allowable Auto Lease	(16,744)	35	14
15	Marketing Expense	(9,052)	43	15
16	PAC Dues	(27,475)	20	16
17	Non-Allowable Legal	(118,616)	19	17
18	Capitalized R&M	(9,293)	06	18
19	Building Co. - Penalties	(77)	21	19
20	Non-Allowable Wages	(124,564)	43	20
21	Non-Allowable Interest	(146,047)	32	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(718,116)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			4,073									4,073	1
2	Food Purchase	(3,430)											(3,430)	2
3	Housekeeping			14,443									14,443	3
4	Laundry													4
5	Heat and Other Utilities			7,570									7,570	5
6	Maintenance	(9,293)		11,790									2,497	6
7	Other (specify):*													7
8	TOTAL General Services	(12,723)		37,876									25,153	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(21,480)											(21,480)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(21,480)											(21,480)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(134,748)	32,576	(865,278)									(967,450)	19
20	Fees, Subscriptions & Promotions	(158,646)	75	609									(157,962)	20
21	Clerical & General Office Expenses	(285,590)	1,747	513,170									229,327	21
22	Employee Benefits & Payroll Taxes	(380)											(380)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,291									2,291	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,937									1,937	26
27	Other (specify):*			104,069									104,069	27
28	TOTAL General Administration	(579,364)	34,398	(243,202)									(788,168)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(613,567)	34,398	(205,326)									(784,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	32,220	515,911	68,803									616,934	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(666,978)	447,059	19,056									(200,863)	32
33	Real Estate Taxes		1,345,268	34,314									1,379,582	33
34	Rent-Facility & Grounds		(1,989,000)										(1,989,000)	34
35	Rent-Equipment & Vehicles	(16,744)		3,259									(13,485)	35
36	Other (specify):*		71,184										71,184	36
37	TOTAL Ownership	(651,502)	390,422	125,432									(135,648)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(217,247)											(217,247)	43
44	TOTAL Special Cost Centers	(217,247)											(217,247)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,482,317)	424,820	(79,894)									(1,137,391)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,989,000	Glenview Terrace Property, LLC		\$	(1,989,000)	1
2	V	32	Interest	1,414	Glenview Terrace Property, LLC		448,473	447,059	2
3	V	21	Bank Service Charges		Glenview Terrace Property, LLC		899	899	3
4	V	19	Accounting		Glenview Terrace Property, LLC		16,132	16,132	4
5	V	33	Real Estate Tax Expense		Glenview Terrace Property, LLC		1,345,268	1,345,268	5
6	V	36	MIP Insurance		Glenview Terrace Property, LLC		71,184	71,184	6
7	V	20	Annual Report Fee		Glenview Terrace Property, LLC		75	75	7
8	V	21	Penalties		Glenview Terrace Property, LLC		77	77	8
9	V	19	Appraisal		Glenview Terrace Property, LLC		16,444	16,444	9
10	V	30	Depreciation		Glenview Terrace Property, LLC		515,911	515,911	10
11	V	21	State Replacement Tax		Glenview Terrace Property, LLC		771	771	11
12	V								12
13	V								13
14	Total			\$ 1,990,414			\$ 2,415,234	\$ * 424,820	14

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

Facility Name & ID Number

Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM SHOSHANA	0.59%	CLARIDGE IMPERIAL, LTD.	CHICAGO	GLENVIEW TERRACE PROPERTY, LLC		BUILDING CO.	1
2	ADINA AARON	0.26%	HARMONY NURSING & REHAB.	CHICAGO	ITEX / A.K. CARE	LINCOLNWOOD	BOOKKEEPING	2
3	AHUYA WEINREB	1.18%	WHITEHALL NORTH	DEERFIELD	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	ALBERT MILSTEIN	2.17%						4
5	BARBARA GELLER	0.13%						5
6	BARBARA J GELLER DELTA DISC TRUST	0.49%						6
7	DAVIS GLENVIEW TERRACE LLC	9.82%						7
8	DENISE CHAN	3.95%						8
9	DEVORAH SHOSHANA	0.59%						9
10	DISCRETIONARY TRUST FOR JENNIFER T.W. CHOW	2.87%						10
11	DISCRETIONARY TRUST FOR JULIE T.Y. BRUM	2.87%						11
12	ELIEZER LEON SILVER	0.59%						12
13	ELIYAHU DAVIS	1.18%						13
14	ELLIOTT ROBINSON	1.88%						14
15	Elliott Robinson Delta Disc. Trust	0.63%						15
16	ESTHER V. STEIN	0.26%						16
17	FEIGE C. KNOBEL DISCRETIONARY TRUST	7.14%						17
18	FREDA ROBINSON	1.28%						18
19	FREDA ROBINSON DELTA DISC TRUST	0.49%						19
20	FREDA ROBINSON REVOCABLE TRUST	4.94%						20
21	Gail Levitt Delta Disc. Trust	0.63%						21
22	HENRY CHEN	1.98%						22
23	IRVING CUTLER	0.40%						23
24	J & J PARTNERSHIP	8.26%						24
25	JACK RAJCHENBACH FAMILY TRUST	3.35%						25
26	JANET HARRIS	2.37%						26
27	JOEL E. JACOBSON	0.26%						27
28	LAURENCE & CORALIE ZUNG	4.15%						28
29	LEAH FINK REPARATIONS TRUST	1.98%						29
30	LEONARD & MOLLY BOLNICK	0.79%						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	MARK HOLLANDER DISCRETIONARY TRUST	7.14%						1
2	MOSHE Y. DAVIS	1.18%						2
3	NESANEL B. DAVIS	1.18%						3
4	RAJCHENBACH GLENVIEW TERRACE LLC	9.80%						4
5	ROBINSON - LEVITT FAMILY TRUST	0.30%						5
6	SHARON HOLLANDER DISCRETIONARY TRST	7.14%						6
7	SHOSHANA BRAUN	1.18%						7
8	SNYDER - MILSTEIN LLC	0.99%						8
9	SOREL SIMON TRUST	0.40%						9
10	STEVE AND BARBARA GELLER	0.30%						10
11	SUSAN MOESER	0.39%						11
12	YEHOShUA Y. DAVIS	1.18%						12
13	YEHUDA SILVER	0.59%						13
14	YISROEL M. DAVIS	1.18%						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	ITEX 6633 Bldg./ AK Care Bookkeeping Services		\$ 4,073	\$ 4,073	15
16	V	3	Housekeeping		ITEX 6633 Bldg./ AK Care Bookkeeping Services		14,443	14,443	16
17	V	5	Utilities		ITEX 6633 Bldg./ AK Care Bookkeeping Services		7,570	7,570	17
18	V	6	Repairs and Maintenance		ITEX 6633 Bldg./ AK Care Bookkeeping Services		11,790	11,790	18
19	V	19	Professional Fees	21,289	ITEX 6633 Bldg./ AK Care Bookkeeping Services		13,011	(8,278)	19
20	V	20	Fees, Subscriptions		ITEX 6633 Bldg./ AK Care Bookkeeping Services		609	609	20
21	V	21	Clerical and General		ITEX 6633 Bldg./ AK Care Bookkeeping Services		54,942	54,942	21
22	V	24	Education and Seminars		ITEX 6633 Bldg./ AK Care Bookkeeping Services		2,291	2,291	22
23	V	26	Insurance		ITEX 6633 Bldg./ AK Care Bookkeeping Services		1,937	1,937	23
24	V	30	Depreciation		ITEX 6633 Bldg./ AK Care Bookkeeping Services		68,803	68,803	24
25	V	32	Interest		ITEX 6633 Bldg./ AK Care Bookkeeping Services		19,056	19,056	25
26	V	33	Real Estate Taxes		ITEX 6633 Bldg./ AK Care Bookkeeping Services		34,314	34,314	26
27	V	33	RE Tax Protest Costs		ITEX 6633 Bldg./ AK Care Bookkeeping Services				27
28	V	35	Equipment Rental		ITEX 6633 Bldg./ AK Care Bookkeeping Services		3,259	3,259	28
29	V								29
30	V								30
31	V								31
32	V	21	Clerical Salaries		ITEX 6633 Bldg./ AK Care Bookkeeping Services		458,228	458,228	32
33	V	27	Gen. Admin. - Emp. Benefit		ITEX 6633 Bldg./ AK Care Bookkeeping Services		104,069	104,069	33
34	V								34
35	V								35
36	V	19	Bookkeeping Fees	857,000	ITEX 6633 Bldg./ AK Care Bookkeeping Services			(857,000)	36
37	V								37
38	V								38
39	Total			\$ 878,289			\$ 798,395	\$ * (79,894)	39

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

VII. RELATED PARTIES (continued)

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

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	34	Storage	\$ 60,000	Itex Glenview Realty, LLC		\$ 60,000	\$	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			\$ 60,000			\$ 60,000	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

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.

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

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.

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.

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.

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.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 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	Mark Hollander	Relative	Administrative	0%	See Attached	27	45.00%	Alloc Salary	\$ 75,000	17-01	1
2	Allen Hollander	Relative	Administrative	0%	See Attached	40	100.00%	Alloc Salary	135,401	17-01	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 210,401		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 Nursing Ctr# 0026237

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Itex 6633 Bldg./AK Care Bookkeeping Svcs.

Street Address

6633 N. Lincoln Ave.

City / State / Zip Code

Lincolnwood, IL. 60712

Phone Number

(847) 679-9141

Fax Number

(847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Available Bed Days	271,572	3	\$ 9,624	\$	114,924	\$ 4,073	1
2	3	Housekeeping	Available Bed Days	271,572	3	34,129		114,924	14,443	2
3	5	Utilities	Available Bed Days	271,572	3	17,889		114,924	7,570	3
4	6	Repairs and Maintenance	Available Bed Days	271,572	3	27,861		114,924	11,790	4
5	19	Professional Fees	Available Bed Days	271,572	3	30,745		114,924	13,011	5
6	20	Fees, Subscriptions	Available Bed Days	271,572	3	1,439		114,924	609	6
7	21	Clerical and General	Available Bed Days	271,572	3	129,832		114,924	54,942	7
8	24	Education and Seminars	Available Bed Days	271,572	3	5,414		114,924	2,291	8
9	26	Insurance	Available Bed Days	271,572	3	4,578		114,924	1,937	9
10	30	Depreciation	Available Bed Days	271,572	3	162,585		114,924	68,803	10
11	32	Interest	Available Bed Days	271,572	3	45,029		114,924	19,056	11
12	33	Real Estate Taxes	Available Bed Days	271,572	3	81,087		114,924	34,314	12
13	33	RE Tax Protest Costs	Available Bed Days	271,572	3			114,924		13
14	35	Equipment Rental	Available Bed Days	271,572	3	7,702		114,924	3,259	14
15										15
16										16
17										17
18	21	Clerical Salaries	Direct Allocation		4	1,069,154	1,069,154		458,228	18
19	27	Gen. Admin. - Emp. Benefit	Direct Allocation		4	242,817			104,069	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,869,885	\$ 1,069,154		\$ 798,395	25

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Itex Glenview Realty, LLC.

Street Address

6633 N. Lincoln Ave.

City / State / Zip Code

Lincolnwood, IL. 60712

Phone Number

()

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Storage	Direct			\$	\$		\$ 60,000	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					\$	\$		\$ 60,000	25

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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 Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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: 12/31/20

Name of Related Organization

Fax Number

(_____)

(_____)

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

Ending: 12/31/20

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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 Nursing Ctr # 0026237 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD		X	Mortgage			\$	14,126,164			\$	448,473	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Fifth Third Bank		X	Line of Credit								128,150	6
7													7
8													8
9	TOTAL Facility Related						\$	14,126,164			\$	576,623	9
	B. Non-Facility Related*												
10	Interest Income		X									(520,931)	10
11	Interest Income - Bldg Co.		X									(1,414)	11
12	Allocated from ITEX/AK Care		X									19,056	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(503,289)	14
15	TOTALS (line 9+line14)						\$	14,126,164			\$	73,334	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 71,184 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	962,507	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.)				\$	1,212,870	2
3. Under or (over) accrual (line 2 minus line 1).				\$	250,363	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	1,178,556	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.)				\$	67,944	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>49,337</u> For <u>2015</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	1,496,863	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	<u>930,933</u>	8		
		2016	<u>932,278</u>	9		
		2017	<u>930,638</u>	10		
		2018	<u>956,116</u>	11		
		2019	<u>1,178,556</u>	12		
2020 Accrual = 2019 Tax						
Allocated from ITEX/AK Care: \$34,314						
*Beginning Accrual Adjusted						

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Glenview Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Glenview Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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

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

C. **Tax Bills**

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

Page 10B

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	Facility		1978	\$ 167,502	1
2					2
3	TOTALS			\$ 167,502	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	314			1975	\$ 2,750,940	\$ 515,911	35	\$ 78,598	\$ (437,313)	\$ 2,750,940	4
5				1989	1,453,936		35	41,541	41,541	1,143,867	5
6				2002	4,266,341		35	121,895	121,895	1,097,062	6
7											7
8											8
	Improvement Type**										
9	Various			1975	28,890		20			28,890	9
10	Various			1977	11,520		20	310	310	6,794	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	100	100	1,710	14
15	Various			1982	6,604		20	330	330	3,273	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	440	440	9,565	18
19	Various			1986	2,080		20	9	9	2,080	19
20	Various			1987	2,375		20	119	119	1,774	20
21	Various			1988	4,955		20	248	248	4,417	21
22	Various			1989	111,464		20	3,699	3,699	110,714	22
23	Various			1990	98,033		20	4,224	4,224	89,998	23
24	Various			1991	2,229		20	111	111	2,119	24
25	Various			1992	3,024		20	95	95	3,024	25
26	Various			1993	103,239		20	1,333	1,333	103,239	26
27	Various			1994	23,033		20	409	409	23,033	27
28	Various			1995	44,266		20	383	383	44,266	28
29	Various			1996	93,171		20	7	7	93,171	29
30	Various			1997	102,244		20	2,978	2,978	79,986	30
31	Various			1998	103,389		20	1,203	1,203	103,086	31
32	Various			1999	150,958		20	5	5	150,958	32
33	Various			2000	37,198		20	1,385	1,385	37,197	33
34	Various			2001	217,477		20	10,874	10,874	213,050	34
35	Various			2002	5,478,039		20	190,949	190,949	5,168,169	35
36	Various			2003	1,988,331		20	54,525		1,638,969	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2004	\$ 154,078	\$	20	\$ 170	\$ 170	\$ 153,526	37
38	Various	2005	112,564		20	866	866	110,540	38
39	Various	2006	43,728		20			43,728	39
40	Various	2007	78,767		20	1,144	1,144	76,679	40
41	Various	2008	249,755		20	340	340	248,510	41
42	Various	2009	186,004		20	9,079	9,079	67,995	42
43	Various	2010	61,561		20	1,463	1,463	56,227	43
44	Various	2011	183,418		20	4,355	4,355	164,529	44
45	Various	2012	129,851		20	2,407	2,407	112,678	45
46	Various	2013	16,374		20	639	639	11,503	46
47	Various	2014	167,372		20	7,275	7,275	105,642	47
48	Various	2015	79,069		20	3,855	3,855	37,425	48
49	Various	2016	493,683		20	24,686	24,686	110,650	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)		57,396			2,870	2,870	5,740	67
68	Related Party Allocations (Pages 12H & 12I)		917,109	68,722		23,004	(45,718)	721,608	68
69	Financial Statement Depreciation			75,985			(75,985)		69
70	TOTAL (lines 4 thru 69)		\$ 20,049,444	\$ 660,618		\$ 597,923	\$ (117,220)	\$ 14,960,308	70

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	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		\$ 20,049,444	\$ 660,618		\$ 597,923	\$ (62,695)	\$ 14,960,308	1
2	Blacktop Paving	2017	3,475		20	174	174	637	2
3	Switch Replacement	2017	3,146		20	157	157	498	3
4	Compressor Replacement	2017	3,735		20	187	187	732	4
5	Roof Top Compressor Replacement	2017	4,545		20	227	227	776	5
6	Kitchen Blower Replacement	2017	4,106		20	205	205	701	6
7	Compressor Replacement - Heat Pump	2017	3,245		20	162	162	554	7
8	Condensor Fan Motor	2017	4,113		20	206	206	634	8
9	Wiring Elevator	2017	5,698		20	285	285	1,140	9
10	Fire Alarm Repairs	2017	9,853		20	493	493	1,971	10
11	Tower Pump Repairs	2017	3,107		20	155	155	582	11
12	Add More Switch Position Contacts To Elevator Contacts	2017	2,863		20	143	143	572	12
13	Elevator	2017	21,723		20	1,086	1,086	4,344	13
14	Cast Iron Replacement For Back Stairs	2018	2,795		20	140	140	408	14
15	Generator Repair	2018	4,314		20	216	216	629	15
16	Cooler Repair & Water Tank In Basement	2018	3,371		20	169	169	464	16
17	Roof Repair	2018	2,625		20	131	131	350	17
18	Compressor Repair In 2Nd Floor	2018	3,871		20	194	194	500	18
19	Installed On 3Rd Floor Room - Honeywell Control Panel/Electrical	2018	2,540		20	127	127	328	19
20	Repaired Heat Pump Pipes In Basement Boiler Room	2018	5,487		20	274	274	686	20
21	Compressor Repair In Basement	2018	3,264		20	163	163	394	21
22	Installed Wall Mount Stopper Station At 2Nd Floor, 3Rd Floor Elevator	2018	2,818		20	141	141	329	22
23	Seal Coating - Installed Stones/Asphalt	2018	2,900		20	145	145	314	23
24	Patched Driveway & Parking Area	2018	3,175		20	159	159	463	24
25	Door Locks And Frames	2018	4,051		20	203	203	524	25
26	Repaired 2 Compressors In Basement	2018	8,873		20	444	444	999	26
27	Repaired Burners For Boilers	2018	3,148		20	157	157	328	27
28	Repaired Valves & Gaskets For Turbo Charger Of Generator	2018	5,541		20	277	277	785	28
29	Installed New Fuel Tank	2018	10,194		20	510	510	1,190	29
30	Water Heater	2018	6,792		20	340	340	934	30
31	Parking Lot Asphalt Repairs	2018	19,260		20	963	963	2,408	31
32	Asphalt Striping Parking Lot	2018	3,800		20	190	190	475	32
33	Window And Door Replacement And Brickwork	2018	5,945		20	297	297	842	33
34	TOTAL (lines 1 thru 33)		\$ 20,223,817	\$ 660,618		\$ 606,643	\$ (53,975)	\$ 14,986,799	34

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 20,223,817	\$ 660,618		\$ 606,643	\$ (53,975)	\$ 14,986,799	1
2	Installation Of 2 Hot Water Boilers	2020	9,935		20	497	497	497	2
3	Flooring Replacement In Office, Bath & Elevator Area	2020	3,773		20	189	189	189	3
4	Replace Hot Water Storage Tank In Laundry Room	2020	6,480		20	324	324	324	4
5	Walk-In Freezer Compressor Repair	2020	4,666		20	233	233	233	5
6	Generator Turbo Repair	2020	4,023		20	201	201	201	6
7	Generator Repair - Replace Oil Pump And Turbo Charger	2020	6,682		20	334	334	334	7
8	Asphalt Patching For Pot Holes In Main Parking Lot	2020	2,850		20	143	143	143	8
9	Asphalt Patching - Rear Parking Area And Side Drive	2020	3,900		20	195	195	195	9
10	Replacement Of Kitchen Generators	2020	9,867		20	493	493	493	10
11	Phone System Replacement	2020	64,100		20	3,205	3,205	3,205	11
12	Laundry Hot Water Storage Tank Replacement	2020	6,480		20	324	324	324	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)		\$ 20,346,572	\$ 660,618		\$ 612,781	\$ (47,837)	\$ 14,992,937	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 20,346,572	\$ 660,618		\$ 612,781	\$ (47,837)	\$ 14,992,937	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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15									15
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,346,572	\$ 660,618		\$ 612,781	\$ (47,837)	\$ 14,992,937	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 20,346,572	\$ 660,618		\$ 612,781	\$ (47,837)	\$ 14,992,937	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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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)		\$ 20,346,572	\$ 660,618		\$ 612,781	\$ (47,837)	\$ 14,992,937	34

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Place New Office Carpeting	2019	5,001		20	250	250	500	9
10	Place New Office Carpeting - Front Office	2019	2,945		20	147	147	295	10
11	Rebuild caved-in sewer	2019	3,700		20	185	185	370	11
12	Asphalt patching to pot holes	2019	3,200		20	160	160	320	12
13	New fire door	2019	3,900		20	195	195	390	13
14	Boiler	2019	18,200		20	910	910	1,820	14
15	Water Heater	2019	8,250		20	413	413	825	15
16	Cooling system	2019	3,700		20	185	185	370	16
17	Water Heater	2019	8,500		20	425	425	850	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)		\$ 57,396	\$		\$ 2,870	\$ 2,870	\$ 5,740	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 57,396	\$		\$ 2,870	\$ 2,870	\$ 5,740	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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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 (lines 1 thru 33)		\$ 57,396	\$		\$ 2,870	\$ 2,870	\$ 5,740	34

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated from Itex 6633 Bldg.</u>	1993	678,804	63,351	35	19,394	(43,957)	534,960	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from Itex 6633 Bldg.</u>	1993	85,413	1,155	20		(1,155)	85,413	9
10	<u>Allocated from Itex 6633 Bldg.</u>	1994	45,877	1,193	20		(1,193)	45,873	10
11	<u>Allocated from Itex 6633 Bldg.</u>	1995	7,819	53	20		(53)	7,819	11
12	<u>Allocated from Itex 6633 Bldg.</u>	1996	443		20			443	12
13	<u>Allocated from Itex 6633 Bldg.</u>	1997	13,189	742	20		(742)	13,189	13
14	<u>Allocated from Itex 6633 Bldg.</u>	1999	1,465	75	20		(75)	1,465	14
15	<u>Allocated from Itex 6633 Bldg.</u>	2005	6,413		20	321	321	4,930	15
16	<u>Allocated from Itex 6633 Bldg.</u>	2007	7,940	279	20	397	118	5,263	16
17	<u>Allocated from Itex 6633 Bldg.</u>	2008	30,261	1,156	20	1,000	(157)	12,576	17
18	<u>Allocated from Itex 6633 Bldg.</u>	2009	1,649	62	20		(62)	1,649	18
19	<u>Allocated from Itex 6633 Bldg.</u>	2010	3,522		20	176	176	1,827	19
20	<u>Allocated from Itex 6633 Bldg.</u>	2014	14,701		20	735	735	4,798	20
21	<u>Allocated from Itex 6633 Bldg.</u>	2016	1,683	57	20	84	27	351	21
22	<u>Allocated from Itex 6633 Bldg.</u>	2018	1,497	50	20	75	25	162	22
23	<u>Allocated from Itex 6633 Bldg.</u>	2019	16,435	548	20	822	273	890	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)		\$ 917,109	\$ 68,722		\$ 23,004	\$ (45,718)	\$ 721,608	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 917,109	\$ 68,722		\$ 23,004	\$ (45,718)	\$ 721,608	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 917,109	\$ 68,722		\$ 23,004	\$ (45,718)	\$ 721,608	34

**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	\$ 1,198,780	\$ 81	\$ 79,898	\$ 79,817	10	\$ 880,992	71
72	Current Year Purchases	2,813		141	141	10	141	72
73	Fully Depreciated Assets	3,797,994		98	98	10	3,797,970	73
74								74
75	TOTALS	\$ 4,999,587	\$ 81	\$ 80,137	\$ 80,056		\$ 4,679,103	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 25,513,661	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 660,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 692,918	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,220	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 19,672,040	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 127,680	92
93			93
94			94
95		\$ 127,680	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	Storage				60,000			5
6								6
7	TOTAL				\$60,000			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: \$11,618
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Residential Use	Ford Van	\$669.71	\$8,037	17
18					18
19					19
20					20
21	TOTAL		\$670	\$8,037	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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		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	\$ 822,174		\$	\$		\$ 822,174	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	110,984					110,984	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	1,238,746					1,238,746	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				624,723		624,723	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			159,547			127,463		287,010	13
14	TOTAL			\$ 2,331,451		\$	\$ 752,186		\$ 3,083,637	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.

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	\$ 900,778	\$ 1,636,182	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,126,135	5,126,135	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	181,395	181,395	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	1,130,736	1,642,221	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,340,544	\$ 8,587,433	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	1,528,906	9,940,896	15
16	Equipment, at Historical Cost	2,096,747	5,768,840	16
17	Accumulated Depreciation (book methods)	(3,313,224)	(20,031,685)	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	22,772,105	22,767,964	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,084,534	\$ 27,577,678	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 30,425,078	\$ 36,165,111	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,157,466	\$ 3,178,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,746,318	1,746,318	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	669,479	669,479	30
31	Accrued Taxes Payable (excluding real estate taxes)	695,828	695,828	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,178,556	32
33	Accrued Interest Payable		37,067	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,900,000	1,900,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,169,091	\$ 9,405,713	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,126,164	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	10,870,459	10,870,459	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,870,459	\$ 24,996,623	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,039,550	\$ 34,402,336	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,385,528	\$ 1,762,775	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 30,425,078	\$ 36,165,111	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,252,955	1
2	Restatements (describe):		2
3	State Replacement Tax	4,491	3
4	Depreciation	36,246	4
5	Bad Debt Expense & Rounding	(254,997)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,038,695	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	346,833	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 346,833	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)	\$ 11,385,528	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning: 01/01/20

Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 23,619,722	1
2	Discounts and Allowances for all Levels	(4,921,387)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,698,335	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,097,723	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,097,723	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	595	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	571,866	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	167,034	19
20	Radiology and X-Ray	33,290	20
21	Other Medical Services	74,717	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 847,502	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	520,931	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 520,931	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	4,542,960	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,542,960	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 28,707,451	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,724,906	31
32	Health Care	11,862,995	32
33	General Administration	5,404,033	33
	B. Capital Expense		
34	Ownership	2,481,659	34
	C. Ancillary Expense		
35	Special Cost Centers	3,300,884	35
36	Provider Participation Fee	586,141	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,360,618	40
41	Income before Income Taxes (line 30 minus line 40)**	346,833	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 346,833	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,425,790	44
45	Private Pay - Net Inpatient Revenue	4,519,562	45
46	Medicare - Net Inpatient Revenue	4,095,466	46
47	Other-(specify) Insurance	311,869	47
48	Other-(specify) Veteran, MMAI	5,345,648	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,698,335	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,760	2,000	\$ 115,505	\$ 57.75	1
2	Assistant Director of Nursing	1,798	2,187	99,309	45.41	2
3	Registered Nurses	102,697	126,306	3,918,012	31.02	3
4	Licensed Practical Nurses	31,906	40,134	1,204,125	30.00	4
5	CNAs & Orderlies	152,130	191,632	3,643,445	19.01	5
6	CNA Trainees					6
7	Licensed Therapist	51,134	62,179	2,331,451	37.50	7
8	Rehab/Therapy Aides	12,886	15,019	275,699	18.36	8
9	Activity Director	1,841	2,089	49,046	23.48	9
10	Activity Assistants	24,051	25,600	394,476	15.41	10
11	Social Service Workers	12,100	14,293	331,026	23.16	11
12	Dietician					12
13	Food Service Supervisor	8,342	9,784	303,115	30.98	13
14	Head Cook	7,290	7,839	159,595	20.36	14
15	Cook Helpers/Assistants	42,756	49,164	784,138	15.95	15
16	Dishwashers					16
17	Maintenance Workers	14,871	15,990	290,056	18.14	17
18	Housekeepers	40,753	49,005	780,210	15.92	18
19	Laundry	11,953	13,276	209,349	15.77	19
20	Administrator	1,984	2,040	135,401	66.37	20
21	Assistant Administrator					21
22	Other Administrative	1,699	1,729	142,601	82.48	22
23	Office Manager	5,660	6,873	153,814	22.38	23
24	Clerical	11,383	12,782	229,307	17.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,702	2,156	46,074	21.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	6,566	7,346	241,130	32.82	33
34	TOTAL (lines 1 - 33)	547,260	659,423	\$ 15,836,884 *	\$ 24.02	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	156,900	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	96,000	10-03	38
39	Pharmacist Consultant	Monthly	30,587	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	975	11-03	44
45	Social Service Consultant	Monthly	2,016	12-03	45
46	Other(specify)				46
47	Clergy	Per Visit	150	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 288,228		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,710	\$ 235,517	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,710	\$ 235,517		53

STATE OF ILLINOIS

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Facility Name & ID Number

Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Allen Hollander	Adminisrator	0	\$ 135,401
Ian Crook	Executive Director	0	67,601
Mark Hollander	Executive Director	0	75,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 278,002

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consultant	\$ 1,626
AK Care	Bookkeeping	857,000
2401 Incorporated	Healthcare Design Solutions	2,135
Consonus	Healthcare Support	11,185
Pathway Health Services	Management Support	8,583
AK Care	Administrative Consultant	1,667
Marcum LLP	Accounting	53,969
Paylocity	Payroll Processing	17,904
AK Care	Data Processing	19,622
Ability Network	Data Processing	10,571
See Attached	Legal	316,117
See Supplemental Schedule		210,787
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 1,511,165

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 187,832
Unemployment Compensation Insurance	54,379
FICA Taxes	1,027,232
Employee Health Insurance	602,411
Employee Meals	209,059
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	35,431
Misc. Employee Benefits	21,854
Savings Plan - Union	108,293
Christmas Expenses	5,098
TOTAL (agree to Schedule V, line 22, col.8)	\$ 2,251,589

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	27,833
Health Care Worker Background Check (Indicate # of checks performed 600)	6,000
Patient Background Checks 138	1,376
Dues & Subscriptions	60,172
Licenses & Fees	2,807
See Supplemental Schedule	609
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 98,797

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	14,529
See Supplemental Schedule	2,291
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 16,820

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- | | |
|--|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>HCCI - \$54,950</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>65,865</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>586,141</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>209,059</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>595</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u>
d. Have vehicle usage logs been maintained? <u>Yes</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|--|