FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0026237

Facility Name: Glenview Terrace Nursing Ctr

Address: 1511 Greenwood Road (Number) Glenview (City) 60025 (Zip Code)

County: Cook

Telephone Number: (847) 729-9090 **Fax #** (847) 729-9135

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/14 to 12/31/14 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) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Jenny Deloy, 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	314	Skilled (SNF)	314	114,610	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	114,610	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,387	18,874	30,566	62,827	8
9	SNF/PED					9
10	ICF	33,369			33,369	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,756	18,874	30,566	96,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.93%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/01/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 314 and days of care provided 22,158

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	774,373	81,920	377,611	1,233,904		1,233,904	8,211	1,242,115			1
2	Food Purchase		945,735		945,735	(158,264)	787,471	(4,984)	782,487			2
3	Housekeeping	622,201	123,837		746,038		746,038	11,386	757,424			3
4	Laundry	353,142	53,193		406,335		406,335		406,335			4
5	Heat and Other Utilities			337,594	337,594		337,594	5,885	343,479			5
6	Maintenance	249,915	119,216	361,531	730,662		730,662	12,340	743,002			6
7	Other (specify):*											7
8	TOTAL General Services	1,999,631	1,323,901	1,076,736	4,400,268	(158,264)	4,242,004	32,838	4,274,842			8
	B. Health Care and Programs											
9	Medical Director			127,000	127,000		127,000		127,000			9
10	Nursing and Medical Records	7,468,633	388,995	166,424	8,024,052		8,024,052	(5,083)	8,018,969			10
10a	Therapy	1,555,119		2,500	1,557,619		1,557,619		1,557,619			10a
11	Activities	415,377	36,932	8,044	460,353		460,353		460,353			11
12	Social Services	491,551		4,200	495,751		495,751		495,751			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,930,680	425,927	308,168	10,664,775		10,664,775	(5,083)	10,659,692			16
	C. General Administration											
17	Administrative	315,322		110,000	425,322		425,322	(97,500)	327,822			17
18	Directors Fees											18
19	Professional Services			847,286	847,286	(4,227)	843,059	(312,355)	530,704			19
20	Dues, Fees, Subscriptions & Promotions			290,418	290,418		290,418	(174,537)	115,881			20
21	Clerical & General Office Expenses	561,197	9,301	719,737	1,290,235		1,290,235	(169,553)	1,120,682			21
22	Employee Benefits & Payroll Taxes			2,507,316	2,507,316	158,264	2,665,580	(676)	2,664,904			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,388	11,388		11,388	202	11,590			24
25	Other Admin. Staff Transportation			5,038	5,038		5,038		5,038			25
26	Insurance-Prop.Liab.Malpractice			539,136	539,136		539,136	(46,452)	492,684			26
27	Other (specify):*							112,088	112,088			27
28	TOTAL General Administration	876,519	9,301	5,030,319	5,916,139	154,037	6,070,176	(688,783)	5,381,393			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,806,830	1,759,129	6,415,223	20,981,182	(4,227)	20,976,955	(661,028)	20,315,927			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Glenview Terrace Nursing Ctr #0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			224,581	224,581		224,581	574,415	798,996			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			316,173	316,173		316,173	84,653	400,826			32
33	Real Estate Taxes					4,227	4,227	1,072,746	1,076,973			33
34	Rent-Facility & Grounds			1,800,000	1,800,000		1,800,000	(1,800,000)				34
35	Rent-Equipment & Vehicles			70,800	70,800		70,800	(8,236)	62,564			35
36	Other (specify):*							78,078	78,078			36
37	**TOTAL Ownership**			2,411,554	2,411,554	4,227	2,415,781	1,656	2,417,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,518,406	1,590,855		3,109,261		3,109,261		3,109,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			609,106	609,106		609,106		609,106			42
43	Other (specify):*	162,203		241,702	403,905		403,905	(403,905)	0			43
44	**TOTAL Special Cost Centers**	1,680,609	1,590,855	850,808	4,122,272		4,122,272	(403,905)	3,718,367			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	14,487,439	3,349,984	9,677,585	27,515,008	(0)	27,515,008	(1,063,277)	26,451,731			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.**

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(3,137)	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	148,474	30		9
10	Interest and Other Investment Income	(358,027)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,847)	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	(2,431)	21		18
19	Entertainment				19
20	Contributions	(19,259)	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	(467,116)	21		24
25	Fund Raising, Advertising and Promotional	(22,590)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(945,297)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,671,230)		$	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)	607,953		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 607,953		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,063,277)		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

STATE OF ILLINOIS **Page 5A**

Glenview Terrace Nursing Ctr

ID# **0026237**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Auto Expense	$ (21,702)	43	1
2	Non Allowable Marketing Travel	(2,250)	43	2
3	Non Allowable Salary	(34,352)	43	3
4	Driver's Salary	(35,002)	43	4
5	Miscellaneous Income	(511)	21	5
6	State of Illinois Income	(120)	21	6
7	Marketing Salary	(90,599)	43	7
8	Veteran Expenses	(5,083)	10	8
9	Life Insurance	(676)	22	9
10	Bank Charges	(15,751)	21	10
11	Credit Card Fees	(24,199)	21	11
12	Public Relations	(115,643)	20	12
13	Building Co. - Annual Report Fee	(250)	20	13
14	Building Co. - Accounting Fees	(16,801)	19	14
15	Building Co. - Loan Amortization Costs	(5,532)	36	15
16	Building Co. - Legal	(19,993)	19	16
17	Building Co. - Bank Charges	(157)	21	17
18	Non Allowable Interest	(64,798)	32	18
19	Non Allowable Rent	(60,000)	34	19
20	Non Allowable Fees	(220,000)	43	20
21	Non Allowable Office Expense	(110,000)	21	21
22	PAC Dues	(18,223)	20	22
23	Non Allowable Legal Fees	(24,554)	19	23
24	Non Allowable Auto Lease	(11,445)	35	24
25	Additional R&M	2,344	06	25
26	Non-Allowable Settlement	(50,000)	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**	(945,297)		49

Glenview Terrace Nursing Ctr

ID# 0026237

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			8,211									8,211	1
2	Food Purchase	(4,984)											(4,984)	2
3	Housekeeping			11,386									11,386	3
4	Laundry													4
5	Heat and Other Utilities			5,885									5,885	5
6	Maintenance	2,344		9,996									12,340	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,640)		35,478									32,838	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,083)											(5,083)	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**	(5,083)											(5,083)	16
	C. General Administration													
17	Administrative				(97,500)								(97,500)	17
18	Directors Fees													18
19	Professional Services	(61,348)	40,045	(291,677)	625								(312,355)	19
20	Fees, Subscriptions & Promotions	(175,965)	250	1,178									(174,537)	20
21	Clerical & General Office Expenses	(620,285)	157	446,221	4,354								(169,553)	21
22	Employee Benefits & Payroll Taxes	(676)											(676)	22
23	Inservice Training & Education													23
24	Travel and Seminar			202									202	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(50,000)		3,548									(46,452)	26
27	Other (specify):*			110,599	1,489								112,088	27
28	**TOTAL General Administration**	(908,274)	40,452	270,071	(91,032)								(688,783)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(915,997)	40,452	305,549	(91,032)								(661,028)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nursing Ctr **#** 0026237 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	148,474	403,694	22,247									574,415	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(422,825)	491,137	16,341									84,653	32
33	Real Estate Taxes		1,056,511	16,235									1,072,746	33
34	Rent-Facility & Grounds	(60,000)	(1,740,000)										(1,800,000)	34
35	Rent-Equipment & Vehicles	(11,445)		3,209									(8,236)	35
36	Other (specify):*	(5,532)	83,610										78,078	36
37	TOTAL Ownership	(351,328)	294,952	58,032									1,656	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):*	(403,905)											(403,905)	43
44	TOTAL Special Cost Centers	(403,905)											(403,905)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,671,230)	335,404	363,581	(91,032)								(1,063,277)	45

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,740,000	Glenview Terrace Property, LLC	100.00%	$	$ (1,740,000)	1
2	V	32	Interest Income	753	Glenview Terrace Property, LLC	100.00%		(753)	2
3	V	20	Annual Report Fee		Glenview Terrace Property, LLC	100.00%	250	250	3
4	V	19	Legal		Glenview Terrace Property, LLC	100.00%	19,993	19,993	4
5	V	19	Accounting Fees		Glenview Terrace Property, LLC	100.00%	16,801	16,801	5
6	V	19	Architectual & Appraisal Fees		Glenview Terrace Property, LLC	100.00%	3,251	3,251	6
7	V	21	Bank Charges		Glenview Terrace Property, LLC	100.00%	157	157	7
8	V	32	Mortgage Interest Expense		Glenview Terrace Property, LLC	100.00%	491,890	491,890	8
9	V	33	Real Estate Taxes		Glenview Terrace Property, LLC	100.00%	1,056,511	1,056,511	9
10	V	36	MIP Insurance		Glenview Terrace Property, LLC	100.00%	78,078	78,078	10
11	V	30	Depreciation		Glenview Terrace Property, LLC	100.00%	403,694	403,694	11
12	V	36	Loan Amortization		Glenview Terrace Property, LLC	100.00%	5,532	5,532	12
13	V								13
14	Total			$ 1,740,753			$ 2,076,157	$ * 335,404	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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	ITEX / AK CARE COMPANY	100.00%	$ 8,211	$ 8,211	15
16	V	3	HOUSEKEEPING		ITEX / AK CARE COMPANY	100.00%	11,386	11,386	16
17	V	5	UTILITIES		ITEX / AK CARE COMPANY	100.00%	5,885	5,885	17
18	V	6	REPAIRS AND MAINT.		ITEX / AK CARE COMPANY	100.00%	9,996	9,996	18
19	V	19	PROFESSIONAL FEES		ITEX / AK CARE COMPANY	100.00%	15,323	15,323	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX / AK CARE COMPANY	100.00%	1,178	1,178	20
21	V	21	CLERICAL AND GENERAL		ITEX / AK CARE COMPANY	100.00%	55,745	55,745	21
22	V	24	EDUCATION AND SEMINARS		ITEX / AK CARE COMPANY	100.00%	202	202	22
23	V	26	INSURANCE		ITEX / AK CARE COMPANY	100.00%	3,548	3,548	23
24	V	30	DEPRECIATION		ITEX / AK CARE COMPANY	100.00%	22,247	22,247	24
25	V	32	INTEREST		ITEX / AK CARE COMPANY	100.00%	16,341	16,341	25
26	V	33	REAL ESTATE TAXES		ITEX / AK CARE COMPANY	100.00%	16,235	16,235	26
27	V	35	EQUIPMENT RENTAL		ITEX / AK CARE COMPANY	100.00%	3,209	3,209	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX / AK CARE COMPANY	100.00%	390,476	390,476	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX / AK CARE COMPANY	100.00%	110,599	110,599	33
34	V								34
35	V								35
36	V	19	HOME OFFICE	307,000	ITEX / AK CARE COMPANY	100.00%		(307,000)	36
37	V								37
38	V								38
39	Total			$ 307,000			$ 670,581	$ * 363,581	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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR FINANCIAL SERVICES CORP.	100.00%	$ 12,500	$ 12,500	15
16	V	19	PROFESSIONAL FEES		JLR FINANCIAL SERVICES CORP.	100.00%	625	625	16
17	V	21	OFFICE		JLR FINANCIAL SERVICES CORP.	100.00%	4,354	4,354	17
18	V	27	EMPLOYEE BENEFITS		JLR FINANCIAL SERVICES CORP.	100.00%	1,489	1,489	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	110,000	JLR FINANCIAL SERVICES CORP.	100.00%		(110,000)	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			$ 110,000			$ 18,968	$ * (91,032)	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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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: 01/01/14 Ending: 12/31/14

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 PROPERTY, LLC		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 COI	LINCOLNWOOD	FINANCIAL SVCS	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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Rajchenbach	Relative	Administrative	0.00%	See Attached	6	10.00%	Alloc. Salary	$ 12,500	17-7	1
2	Mark Hollander	Relative	Administrative	0.00%	See Attached	27	45.00%	Salary	145,900	17-1	2
3	Allen Hollander	Relative	Clerical	0.00%	See Attached	3.33	8.33%	Salary	7,291	21-1	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	$ 165,691		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: 01/01/14 Ending: 12/31/14

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 [X]

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

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

	1 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	359,890	4	$ 25,783	$	114,610	$ 8,211	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	359,890	4	35,754		114,610	11,386	2
3	5	UTILITIES	AVAILABLE BED DAYS	359,890	4	18,480		114,610	5,885	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	359,890	4	31,390		114,610	9,996	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	359,890	4	48,116		114,610	15,323	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	359,890	4	3,699		114,610	1,178	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	359,890	4	175,045		114,610	55,745	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	359,890	4	635		114,610	202	8
9	26	INSURANCE	AVAILABLE BED DAYS	359,890	4	11,140		114,610	3,548	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	359,890	4	69,859		114,610	22,247	10
11	32	INTEREST	AVAILABLE BED DAYS	359,890	4	51,314		114,610	16,341	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	359,890	4	50,980		114,610	16,235	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	359,890	4	10,076		114,610	3,209	13
14										14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	1,133,459	1,133,459		390,476	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	321,043			110,599	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,986,773	$ 1,133,459		$ 670,581	25

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: JLR FINANCIAL SERVICES CORP.
Street Address: 6633 NORTH LINCOLN
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	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	48	9	$ 100,000	$ 100,000	6	$ 12,500	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	9	5,000		6	625	2
3	21	OFFICE	AVG. HOURS WORKED	48	9	34,828	34,828	6	4,354	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	48	9	11,911		6	1,489	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					$ 151,739	$ 134,828		$ 18,968	25

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 15,519,429			$ 491,890	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				4,742,706			176,948	6
7	INAC		X	Insurance Financing							9,632	7
8	See Supplemental Schedule							180,693			64,795	8
9	TOTAL Facility Related						$	$ 20,442,827			$ 743,265	9
	B. Non-Facility Related*											
10	Interest Income		X								(358,027)	10
11	Interest Income - Bldg Co.		X								(753)	11
12	Allocated from ITEX		X								16,341	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (342,439)	14
15	TOTALS (line 9+line14)						$	$ 20,442,827			$ 400,826	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 78,078 Line # 36

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

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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				$	$ 180,693			$ 22,466	8
9	Shareholder Loans	X									42,328	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							180,693			64,795	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.)

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 759,880	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.)		$ 902,267	2
3. Under or (over) accrual (line 2 minus line 1).		$ 142,387	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 930,346	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.)**		$ 4,227	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 1,076,960	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	630,272	8
	2010	676,238	9
	2011	690,901	10
	2012	723,683	11
	2013	886,032	12

2014 Accrual = $886,032 x 1.05 = $930,334 (Rounded)

Allocated from ITEX: $16,235

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenview Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-28-401-042-0000	Long Term Care Property	$ 886,032.14	$ 886,032.14
2.	10-35-312-022-0000	Allocation from ITEX/AK Care	$ 53,423.84	$ 16,264.69
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 939,455.98	$ 902,296.83

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:** 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 Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1978	$ 167,502	1
2					2
3	TOTALS			$ 167,502	3

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	314			1975	$ 2,750,940	$ 403,694	40	$ 68,774	$ (334,920)	$ 2,638,320	4
5				1989	1,453,936		40	36,348	36,348	915,392	5
6				2002	4,266,341		40	106,659	106,659	426,636	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			2,929	25
26	Various			1993	103,239		20			101,906	26
27	Various			1994	23,033		20	945	945	22,624	27
28	Various			1995	44,266		20	2,213	2,213	42,979	28
29	Various			1996	93,171		20	4,659	4,659	86,534	29
30	Various			1997	102,244		20	3,431	3,431	64,468	30
31	Various			1998	103,389		20	4,025	4,025	87,662	31
32	Various			1999	150,958		20	3,531	3,531	135,740	32
33	Various			2000	37,198		20	1,860	1,860	26,552	33
34	Various			2001	217,477		20	10,874	10,874	147,802	34
35	Various			2002	5,478,038		20	265,692	265,692	3,848,613	35
36	Various			2003	1,988,331		20	72,841	72,841	1,275,245	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: 01/01/14 Ending: 12/31/14

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	$ 4,595	$ 4,595	$ 148,811	37
38	Various	2005	112,565		20	7,801	7,801	91,497	38
39	Various	2006	43,728		20	3,147	3,147	39,794	39
40	Various	2007	78,768		20	7,114	7,114	53,341	40
41	Various	2008	249,755		20	9,937	9,937	215,829	41
42	Various	2009	186,004		20	5,075	5,075	35,365	42
43	Various	2010	61,561		20	7,716	7,716	35,662	43
44									44
45									45
46									46
47									47
48									48
49									49
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		675,397	21,988		19,475	(2,513)	440,300	68
69	Financial Statement Depreciation			224,581			(224,581)		69
70	TOTAL (lines 4 thru 69)		$ 18,680,569	$ 650,263		$ 646,712	$ (3,551)	$ 11,157,722	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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 18,680,569	$ 650,263		$ 646,712	$ (3,551)	$ 11,157,722	1
2	Carpet For Office	2011	3,049		20	436	436	1,561	2
3	Carpet 2Nd Floor Hallway	2011	15,000		20	2,143	2,143	7,321	3
4	Carpet 2Nd Floor Hallway	2011	19,850		20	2,836	2,836	9,452	4
5	Carpet 24 Rooms 1St Floor	2011	13,000		20	1,857	1,857	5,726	5
6	Ac Repair	2011	4,574		20	915	915	3,202	6
7	Boiler Work	2011	6,654		20	1,331	1,331	4,214	7
8	Air Conditioning System	2011	3,339		20	668	668	2,671	8
9	Wallcoverings	2011	2,708		20	542	542	2,166	9
10	Cornice Boards And Draperies	2011	3,023		20	605	605	2,318	10
11	Wallcoverings	2011	5,669		20	1,134	1,134	4,346	11
12	Wallcoverings	2011	3,163		20	633	633	2,320	12
13	Wallcoverings	2011	3,703		20	741	741	2,283	13
14	Computer Cubbies And Walls	2011	9,500		20	1,900	1,900	7,125	14
15	Bearing And Housing Repair	2011	3,108		20	622	622	2,383	15
16	Concrete Repair	2011	3,760		20	251	251	919	16
17	Ceramic Wall Tile	2011	3,400		20	340	340	1,303	17
18	French Door	2011	3,500		20	350	350	1,225	18
19	Airconditioning System For Elevator Room	2011	10,243		20	1,024	1,024	3,756	19
20	Roof Air Unit	2011	21,350		20	2,135	2,135	7,473	20
21	Roof Air Unit	2011	3,439		20	344	344	1,204	21
22	Roof Air Unit	2011	19,782		20	1,978	1,978	6,594	22
23	Repaired Heating / Cooling Unit	2011	2,913		20	146	146	570	23
24	Repaired Boiler	2011	6,654		20	333	333	1,054	24
25	Replaced Heating / Cooling Unit	2011	3,339		20	167	167	668	25
26	Replace Sprinkler Heads	2011	3,457		20	173	173	533	26
27	Repaired Elevator Pit	2011	5,241		20	262	262	1,026	27
28	Asphalt Coating	2012	3,200		20	213	213	516	28
29	Carpeting Resident Rooms	2012	16,750		20	3,350	3,350	8,654	29
30	Carpeting First Floor Hallway	2012	18,480		20	3,696	3,696	9,548	30
31	Carpeting First Floor Hallway	2012	18,480		20	3,696	3,696	8,624	31
32	Asphalt Paving	2012	11,850		20	790	790	1,909	32
33	Wallcovering - 480 Yards Dining Room	2012	6,158		20	1,232	1,232	3,695	33
34	TOTAL (lines 1 thru 33)		$ 18,938,904	$ 650,263		$ 683,550	$ 33,287	$ 11,274,081	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: 01/01/14 Ending: 12/31/14

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		$ 18,938,904	$ 650,263		$ 683,550	$ 33,287	$ 11,274,081	1
2	Wallcovering 330 Yards	2012	3,705		20	741	741	1,976	2
3	Wallcovering 660 Yards	2012	7,410		20	1,482	1,482	3,952	3
4	Wallcovering 300 Yards	2012	3,382		20	676	676	1,748	4
5	Room Heaters	2012	3,214		20	643	643	1,339	5
6	Baseboard Oak	2012	4,160		20	832	832	2,496	6
7	Ao Smith Water Heater	2012	8,974		20	897	897	2,617	7
8	Remove & Replace Taco Pump	2012	6,400		20	640	640	1,707	8
9	Ao Smith Boiler	2012	6,253		20	625	625	1,615	9
10	Install Sprinklers; Extend Sprinklers With Two Piece Excutcheon	2012	4,685		20	234	234	664	10
11	Replaced 2Nd Flat Plate Heat Exchanger	2012	6,750		20	338	338	816	11
12	Draperies For Patient Rooms	2013	3,600		20	720	720	1,440	12
13	Trane Heat Pump	2013	4,100		20	410	410	547	13
14	Heat Pump Tower, Circle, And Motor	2013	6,100		20	610	610	813	14
15	Generator Valve Repair	2013	2,574		20	129	129	161	15
16	Wallpaper For Public Restrooms	2014	2,892		20	96	96	96	16
17	Replacing 265 Square Feet Of Concrete Sidewalks	2014	3,400		20	57	57	57	17
18	Roof Tear Off And Replacement South Wing	2014	74,260		20	7,426	7,426	7,426	18
19	Roof Repair Around Chiller Unit	2014	38,338		20	3,834	3,834	3,834	19
20	New Heat Pump	2014	4,442		20	74	74	74	20
21	Walk In Freezer	2014	6,800		20	793	793	793	21
22	Private Bathrooms Resident Rooms-Install Drywall & Wall Tile, Plumbin	2014	29,500		20	738	738	738	22
23	Video Monitoring System 2Nd Floor	2014	3,920		20	196	196	196	23
24	3Rd Floor Monitoring System	2014	3,820		20	64	64	64	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,177,583	$ 650,263		$ 705,805	$ 55,542	$ 11,309,249	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: 01/01/14 Ending: 12/31/14

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		$ 19,177,583	$ 650,263		$ 705,805	$ 55,542	$ 11,309,249	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,177,583	$ 650,263		$ 705,805	$ 55,542	$ 11,309,249	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: 01/01/14 Ending: 12/31/14

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		$ 19,177,583	$ 650,263		$ 705,805	$ 55,542	$ 11,309,249	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,177,583	$ 650,263		$ 705,805	$ 55,542	$ 11,309,249	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: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 01/01/14 Ending: 12/31/14

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		$	$		$	$	$	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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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)		$	$		$	$	$	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: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocation from ITEX	1993	510,824	13,098	20	14,595	1,497	315,007	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocation from ITEX	1993	64,276	378	20	940	562	64,276	9
10	Allocation from ITEX	1994	34,524	898	20	1,237	339	34,521	10
11	Allocation from ITEX	1995	5,884	16	20	294	278	5,648	11
12	Allocation from ITEX	1996	333		20	17	17	317	12
13	Allocation from ITEX	1997	9,926	255	20	496	241	8,685	13
14	Allocation from ITEX	1999	1,102	28	20	55	27	882	14
15	Allocation from ITEX	2005	4,826		20	241	241	2,290	15
16	Allocation from ITEX	2007	5,975	139	20	299	160	2,168	16
17	Allocation from ITEX	2008	22,773	584	20	752	168	4,952	17
18	Allocation from ITEX	2009	1,241	32	20	124	92	682	18
19	Allocation from ITEX	2010	2,650	111	20	133	22	580	19
20	Allocation from ITEX	2014	11,063	6,449	20	292	(6,157)	292	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)		$ 675,397	$ 21,988		$ 19,475	$ (2,513)	$ 440,300	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: 01/01/14 Ending: 12/31/14

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		$ 675,397	$ 21,988		$ 19,475	$ (2,513)	$ 440,300	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 675,397	$ 21,988		$ 19,475	$ (2,513)	$ 440,300	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: 01/01/14 Ending: 12/31/14

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	$ 1,362,666	$ 260	$ 89,141	$ 88,881	10	$ 1,060,620	71
72	Current Year Purchases	24,238		4,050	4,050	10	4,050	72
73	Fully Depreciated Assets	3,054,246				10	3,054,069	73
74								74
75	TOTALS	$ 4,441,149	$ 260	$ 93,192	$ 92,932		$ 4,118,739	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)	$ 23,786,234	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 650,523	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 798,997	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 148,474	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,427,988	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	Appraisals, Expansion Plans	$ 83,361	92
93			93
94			94
95		$ 83,361	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.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 42,764 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 Van	$ 1,650	$ 19,800	17
18					18
19					19
20					20
21	TOTAL		$ 1,650.00	$ 19,800	21

* 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.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 829,778		$	$		$ 829,778	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	213,723			23,285		237,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	356,710			255,134		611,844	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				1,028,453		1,028,453	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			118,195			283,983		402,178	13
14	TOTAL			$ 1,518,406		$	$ 1,590,855		$ 3,109,261	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.

STATE OF ILLINOIS

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 46,636	$ 277,838	1
2	Cash-Patient Deposits	41,289	41,289	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,079,822	7,079,822	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	617,409	617,409	6
7	Other Prepaid Expenses	25,500	25,500	7
8	Accounts Receivable (owners or related parties)	123,744	123,744	8
9	Other(specify):	1,989,898	2,413,664	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,924,298	$ 10,579,266	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	1,357,011	8,958,288	15
16	Equipment, at Historical Cost	1,931,084	5,365,086	16
17	Accumulated Depreciation (book methods)	(2,448,310)	(16,201,859)	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):	6,595,158	7,789,949	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,434,943	$ 15,043,127	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,359,241	$ 25,622,393	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,079,437	$ 2,095,437	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,789	39,789	28
29	Short-Term Notes Payable	4,923,399	4,923,399	29
30	Accrued Salaries Payable	854,175	854,175	30
31	Accrued Taxes Payable (excluding real estate taxes)	72,575	72,575	31
32	Accrued Real Estate Taxes(Sch.IX-B)		930,346	32
33	Accrued Interest Payable	22,724	63,463	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	602,283	726,027	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,594,382	$ 9,705,211	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,519,429	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,519,429	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,594,382	$ 25,224,640	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,764,859	$ 397,753	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,359,241	$ 25,622,393	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,506,679	1	
2	Restatements (describe):		2	
3	**Rounding**	(2)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,506,677	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,298,581	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	(40,399)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,258,182	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)**	$ 8,764,859	24	*

*** This must agree with page 17, line 47.**

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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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 26,433,441	1
2	Discounts and Allowances for all Levels	(9,907,803)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,525,638	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,817,417	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,817,417	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	3,137	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,528,580	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	323,815	19
20	Radiology and X-Ray		20
21	Other Medical Services	237,083	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,092,615	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	358,027	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 358,027	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	19,892	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,892	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 28,813,589	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,400,268	31
32	Health Care	10,664,775	32
33	General Administration	5,916,139	33
	B. Capital Expense		
34	Ownership	2,411,554	34
	C. Ancillary Expense		
35	Special Cost Centers	3,513,166	35
36	Provider Participation Fee	609,106	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 27,515,008	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,298,581	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,298,581	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,692,574	44
45	Private Pay - Net Inpatient Revenue	4,389,089	45
46	Medicare - Net Inpatient Revenue	3,396,372	46
47	Other-(specify) Insurance	585,905	47
48	Other-(specify) MMAI	461,698	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,525,638	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	1,960	$ 109,344	$ 55.79	1
2	Assistant Director of Nursing	4,336	5,816	275,917	47.44	2
3	Registered Nurses	83,965	96,882	2,660,350	27.46	3
4	Licensed Practical Nurses	50,002	57,042	1,345,807	23.59	4
5	CNAs & Orderlies	209,526	239,004	2,971,826	12.43	5
6	CNA Trainees					6
7	Licensed Therapist	47,655	54,878	1,518,406	27.67	7
8	Rehab/Therapy Aides	36,580	44,637	1,555,119	34.84	8
9	Activity Director	1,776	2,080	39,979	19.22	9
10	Activity Assistants	32,143	36,894	375,398	10.18	10
11	Social Service Workers	24,588	27,430	491,551	17.92	11
12	Dietician					12
13	Food Service Supervisor	3,300	3,490	95,316	27.31	13
14	Head Cook	9,642	10,929	105,608	9.66	14
15	Cook Helpers/Assistants	38,063	43,294	573,449	13.25	15
16	Dishwashers					16
17	Maintenance Workers	12,861	14,854	249,915	16.82	17
18	Housekeepers	44,454	51,353	622,201	12.12	18
19	Laundry	28,452	32,682	353,142	10.81	19
20	Administrator	3,548	3,621	106,391	29.38	20
21	Assistant Administrator					21
22	Other Administrative	3,745	3,860	208,931	54.13	22
23	Office Manager	1,820	2,224	56,330	25.33	23
24	Clerical	26,402	29,336	504,867	17.21	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	5,668	6,676	105,389	15.79	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	5,413	5,709	162,203	28.41	33
34	TOTAL (lines 1 - 33)	675,899	774,651	$ 14,487,439 *	$ 18.70	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	772	$ 36,921	01-03	35
36	Medical Director	Monthly	127,000	09-03	36
37	Medical Records Consultant	Monthly	4,232	10-03	37
38	Nurse Consultant	Monthly	114,000	10-03	38
39	Pharmacist Consultant	Monthly	48,192	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	8,044	11-03	44
45	Social Service Consultant	Monthly	4,200	12-03	45
46	Other(specify)				46
47	Rehab Nursing Consultant	Monthly	2,500	10a-03	47
48	Dietary Services Consultant	Monthly	340,690	01-03	48
49	TOTAL (lines 35 - 48)	772	$ 685,779		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bradley Bartels	Administrator	0	$ 106,391
Mark Hollander	Exec. Director	0	145,900
Ian Crook	VP Operations	0	63,030
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 315,321

B. Administrative - Other

Description	Amount
JLR Financial Services Corp. - Financial services	$ 110,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 110,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 58,331
See Attached	Legal	69,939
M L Enterprise	Purchasing Consultant	2,250
Itex - AK Care	Centralized Bookkeeping	307,000
Personnel Planners	Unemployment Consulting	2,606
Joint Commission	Accreditation	12,642
Health Medex	Data Processing	125,903
Provinet	Data Processing	133,239
AK Care	Data Processing	87,241
ADL Data Systems	Data Processing	5,321
Am Ex	Data Processing	34,256
See Supplemental Schedule		8,558
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 847,285

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 475,987
Unemployment Compensation Insurance	96,453
FICA Taxes	1,078,280
Employee Health Insurance	701,218
Employee Meals	158,264
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	32,906
Pension Plan	101,815
Other Employee Benefits	7,282
Christmas Expense	12,701
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,664,905

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	47,517
Health Care Worker Background Check	19,751
(Indicate # of checks performed 198)	
Patient Background Checks	
Licenses & Permits	2,719
Dues & Subscriptions	44,717
Allocated from ITEX	1,178
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 115,881

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,388
Allocated from ITEX	202
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,590

**See instructions.

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

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

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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. **ICLTC: $32,970**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,230** Line **10-02**

(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. $ **609,106**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **158,264** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,137**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.