

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>314</u>	Skilled (SNF)	<u>314</u>	<u>114,610</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>314</u>	TOTALS	<u>314</u>	<u>114,610</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>37,313</u>	<u>24,358</u>	<u>25,763</u>	<u>87,434</u>	8	
9	SNF/PED					9	
10	ICF	<u>4,153</u>			<u>4,153</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>41,466</u>	<u>24,358</u>	<u>25,763</u>	<u>91,587</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.91%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 314 and days of care provided 17,095

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	1,015,686	97,326	5,882	1,118,894		1,118,894	8,036	1,126,930		1
2	Food Purchase		1,116,147		1,116,147	(195,056)	921,091	(4,867)	916,224		2
3	Housekeeping	608,364	104,870		713,234		713,234	11,265	724,499		3
4	Laundry	376,236	59,697		435,933		435,933		435,933		4
5	Heat and Other Utilities			394,668	394,668		394,668	8,276	402,944		5
6	Maintenance	253,432	161,333	401,804	816,569		816,569	21,329	837,898		6
7	Other (specify):*										7
8	TOTAL General Services	2,253,718	1,539,373	802,354	4,595,445	(195,056)	4,400,389	44,039	4,444,428		8
	B. Health Care and Programs										
9	Medical Director			148,600	148,600		148,600		148,600		9
10	Nursing and Medical Records	7,006,806	387,405	164,469	7,558,680		7,558,680	(12,271)	7,546,409		10
10a	Therapy	1,474,507	98		1,474,605		1,474,605		1,474,605		10a
11	Activities	456,912	29,246	9,508	495,666		495,666		495,666		11
12	Social Services	450,770		4,200	454,970		454,970		454,970		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	9,388,995	416,749	326,777	10,132,521		10,132,521	(12,271)	10,120,250		16
	C. General Administration										
17	Administrative	286,152			286,152		286,152	25,000	311,152		17
18	Directors Fees										18
19	Professional Services			284,852	284,852		284,852	(27,298)	257,554		19
20	Dues, Fees, Subscriptions & Promotions			348,502	348,502		348,502	(205,906)	142,596		20
21	Clerical & General Office Expenses	510,486	7,520	594,672	1,112,678		1,112,678	47,430	1,160,108		21
22	Employee Benefits & Payroll Taxes			2,317,665	2,317,665	195,056	2,512,721	(689)	2,512,032		22
23	Inservice Training & Education										23
24	Travel and Seminar			22,471	22,471		22,471	(473)	21,998		24
25	Other Admin. Staff Transportation			10,504	10,504		10,504		10,504		25
26	Insurance-Prop.Liab.Malpractice			562,033	562,033		562,033	(96,500)	465,533		26
27	Other (specify):*							121,152	121,152		27
28	TOTAL General Administration	796,638	7,520	4,140,699	4,944,857	195,056	5,139,913	(137,283)	5,002,630		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,439,351	1,963,642	5,269,830	19,672,823		19,672,823	(105,515)	19,567,308		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 Nsg. Ctr

#0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			223,782	223,782		223,782	566,883	790,665			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			284,738	284,738		284,738	82,955	367,693			32
33	Real Estate Taxes							959,323	959,323			33
34	Rent-Facility & Grounds			1,800,000	1,800,000		1,800,000	(1,800,000)				34
35	Rent-Equipment & Vehicles			70,166	70,166		70,166	(20,050)	50,116			35
36	Other (specify):*							77,017	77,017			36
37	TOTAL Ownership			2,378,686	2,378,686		2,378,686	(133,871)	2,244,815			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,543,023	1,774,967		3,317,990		3,317,990		3,317,990			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			576,145	576,145		576,145		576,145			42
43	Other (specify):*	229,376		13,676	243,052		243,052	(243,052)	(0)			43
44	TOTAL Special Cost Centers	1,772,399	1,774,967	589,821	4,137,187		4,137,187	(243,052)	3,894,135			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	14,211,750	3,738,609	8,238,337	26,188,696		26,188,696	(482,438)	25,706,258			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,911)	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	147,348	30		9
10	Interest and Other Investment Income	(372,552)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,956)	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	(5,644)	21		18
19	Entertainment				19
20	Contributions	(31,010)	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	(423,368)	21		24
25	Fund Raising, Advertising and Promotional	(41,641)	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	(756,327)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,488,060)		\$	30

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	2	
		Amount	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)	1,005,622		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,005,622		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (482,438)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY

48		49		50		51		52	
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Glenview Terrace Nsg. Ctr

ID# 0026237

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Driver's Salary	\$ (35,715)	43	1
2	Marketing Salary	(129,413)	43	2
3	Veteran Expenses	(12,271)	10	3
4	Life Insurance	(689)	22	4
5	Bank Charges	(16,451)	21	5
6	Credit Card Fees	(33,251)	21	6
7	Public Relations	(122,165)	20	7
8	Miscellaneous Income	(25)	21	8
9	State of Illinois Income	(140)	21	9
10	Non-Allowable Auto Lease	(22,763)	35	10
11	Building Co. - Annual Report Fee	(250)	20	11
12	Building Co. - Accounting Fees	(25,145)	19	12
13	Building Co. - Bank Charges	(27)	21	13
14	Building Co. - Office Expenses	(187)	21	14
15	Building Co. - Permits	(27,895)	20	15
16	Non-Allowable Rent	(60,000)	34	16
17	PAC Dues	(13,273)	20	17
18	Non-Allowable Seminar	(737)	24	18
19	Non-Allowable Settlement	(100,000)	26	19
20	Non-Allowable Legal Fees	(37,223)	19	20
21	Non Allowable Auto Expense	(13,676)	43	21
22	Non Allowable Marketing Travel	(3,600)	43	22
23	Additional R&M	9,651	06	23
24	Non-Allowable Interest	(50,435)	32	24
25	Non-Allowable Salary	(60,648)	43	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(756,327)		49

Glenview Terrace Nsg. Ctr

Report Period Beginning: ID# 0026237
 Ending: 01/01/15
 12/31/15

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		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			8,036									8,036	1
2	Food Purchase	(4,867)											(4,867)	2
3	Housekeeping			11,265									11,265	3
4	Laundry													4
5	Heat and Other Utilities			8,276									8,276	5
6	Maintenance	9,651		11,678									21,329	6
7	Other (specify):*													7
8	TOTAL General Services	4,784		39,255									44,039	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,271)											(12,271)	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	(12,271)											(12,271)	16
	C. General Administration													
17	Administrative				25,000								25,000	17
18	Directors Fees													18
19	Professional Services	(62,368)	25,145	9,612	313								(27,298)	19
20	Fees, Subscriptions & Promotions	(236,234)	28,145	2,183									(205,906)	20
21	Clerical & General Office Expenses	(479,093)	(2,936)	524,355	5,104								47,430	21
22	Employee Benefits & Payroll Taxes	(689)											(689)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(737)		264									(473)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(100,000)		3,500									(96,500)	26
27	Other (specify):*			119,272	1,880								121,152	27
28	TOTAL General Administration	(879,120)	50,354	659,186	32,297								(137,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(886,607)	50,354	698,441	32,297								(105,515)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	147,348	401,978	17,557									566,883	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(422,987)	490,228	15,714									82,955	32
33	Real Estate Taxes		943,144	16,179									959,323	33
34	Rent-Facility & Grounds	(60,000)	(1,740,000)										(1,800,000)	34
35	Rent-Equipment & Vehicles	(22,763)		2,713									(20,050)	35
36	Other (specify):*		77,017										77,017	36
37	TOTAL Ownership	(358,401)	172,367	52,163									(133,871)	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):*	(243,052)											(243,052)	43
44	TOTAL Special Cost Centers	(243,052)											(243,052)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,488,060)	222,721	750,604	32,297								(482,438)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,740,000	Glenview Terrace Property, LLC	100.00%	\$	\$ (1,740,000)	1
2	V	32 Interest Income	512	Glenview Terrace Property, LLC	100.00%		(512)	2
3	V	20 Annual Report Fee		Glenview Terrace Property, LLC	100.00%	250	250	3
4	V	21 Office Expenses		Glenview Terrace Property, LLC	100.00%	187	187	4
5	V	20 Permits		Glenview Terrace Property, LLC	100.00%	27,895	27,895	5
6	V	19 Accounting Fees		Glenview Terrace Property, LLC	100.00%	25,145	25,145	6
7	V	21 Bank Charges		Glenview Terrace Property, LLC	100.00%	27	27	7
8	V	32 Mortgage Interest Expense		Glenview Terrace Property, LLC	100.00%	485,208	485,208	8
9	V	33 Real Estate Tax Expense		Glenview Terrace Property, LLC	100.00%	943,144	943,144	9
10	V	36 MIP Insurance		Glenview Terrace Property, LLC	100.00%	77,017	77,017	10
11	V	30 Depreciation		Glenview Terrace Property, LLC	100.00%	401,978	401,978	11
12	V	32 Interest Expense		Glenview Terrace Property, LLC	100.00%	5,532	5,532	12
13	V	21 Miscellaneous Income	3,150	Glenview Terrace Property, LLC	100.00%		(3,150)	13
14	Total		\$ 1,743,662			\$ 1,966,383	\$ * 222,721	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>DIETARY</u>	\$	<u>ITEX / AK CARE COMPANY</u>	100.00%	\$ 8,036	\$	8,036	15
16	V	3 <u>HOUSEKEEPING</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	11,265		11,265	16
17	V	5 <u>UTILITIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	8,276		8,276	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	11,678		11,678	18
19	V	19 <u>PROFESSIONAL FEES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	9,612		9,612	19
20	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	2,183		2,183	20
21	V	21 <u>CLERICAL AND GENERAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	58,648		58,648	21
22	V	24 <u>EDUCATION AND SEMINARS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	264		264	22
23	V	26 <u>INSURANCE</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	3,500		3,500	23
24	V	30 <u>DEPRECIATION</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	17,557		17,557	24
25	V	32 <u>INTEREST</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	15,714		15,714	25
26	V	33 <u>REAL ESTATE TAXES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	16,179		16,179	26
27	V	35 <u>EQUIPMENT RENTAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	2,713		2,713	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21 <u>CLERICAL SALARIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	465,707		465,707	32
33	V	27 <u>GEN ADMIN. - EMP. BEN.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	119,272		119,272	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 750,604	\$ *	750,604	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR FINANCIAL SERVICES CORP.	100.00%	\$ 25,000	\$	25,000	15
16	V	19 PROFESSIONAL FEES		JLR FINANCIAL SERVICES CORP.	100.00%	313		313	16
17	V	21 OFFICE		JLR FINANCIAL SERVICES CORP.	100.00%	5,104		5,104	17
18	V	27 EMPLOYEE BENEFITS		JLR FINANCIAL SERVICES CORP.	100.00%	1,880		1,880	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		\$			\$ 32,297	\$ *	32,297	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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./MANAGE	2
3	AHUYA WEINREB	1.177%	WHITEHALL NORTH	DEERFIELD	JLR FINANCIAL SERVICES CO	LINCOLNWOOD	FINANCIAL SVCS	3
4	ALBERT MILSTEIN	2.170%			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 Nsg. Ctr

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Report Period Beginning:

01/01/15

Ending:

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Rajchenbach	Relative	Administrative	0.00%	See Attached	6.00	10.00%	Alloc. Salary	\$ 25,000	17-7	1
2	Mark Hollander	Relative	Administrative	0.00%	See Attached	27.00	45.00%	Salary	114,900	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 139,900		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Glenview Terrace Nsg. Ctr

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Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ITEX / 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	359,890	4	\$ 25,233	\$ 114,610	\$ 8,036	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	359,890	4	35,372	114,610	11,265	2
3	5	UTILITIES	AVAILABLE BED DAYS	359,890	4	25,988	114,610	8,276	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	359,890	4	36,670	114,610	11,678	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	359,890	4	30,182	114,610	9,612	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	359,890	4	6,855	114,610	2,183	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	359,890	4	184,161	114,610	58,648	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	359,890	4	828	114,610	264	8
9	26	INSURANCE	AVAILABLE BED DAYS	359,890	4	10,991	114,610	3,500	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	359,890	4	55,133	114,610	17,557	10
11	32	INTEREST	AVAILABLE BED DAYS	359,890	4	49,344	114,610	15,714	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	359,890	4	50,804	114,610	16,179	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	359,890	4	8,519	114,610	2,713	13
14									14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	1,244,148	1,244,148	465,707	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	318,638		119,272	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,082,866	\$ 1,244,148	\$ 750,604	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED 48	9	\$ 200,000	\$ 200,000	6	\$ 25,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 48	9	2,500		6	313	2
3	21	OFFICE	AVG. HOURS WORKED 48	9	40,828	40,828	6	5,104	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 48	9	15,037		6	1,880	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				\$ 258,365	\$ 240,828		\$ 32,297	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD		X	Mortgage				\$	\$ 15,304,251		\$ 490,740	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	MB Financial		X	Line of Credit					4,086,699		178,649	6								
7	INAC		X	Insurance Financing							9,520	7								
8	See Supplemental Schedule										46,135	8								
9	TOTAL Facility Related							\$	\$ 19,390,950		\$ 725,044	9								
B. Non-Facility Related*																				
10	Interest Income		X								(372,552)	10								
11	Interest Income - Bldg Co.		X								(512)	11								
12	Allocated from ITEX		X								15,714	12								
13												13								
14	TOTAL Non-Facility Related							\$	\$		\$ (357,350)	14								
15	TOTALS (line 9+line14)							\$	\$ 19,390,950		\$ 367,694	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 77,017 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 Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
6										6									
7	TOTAL Long-Term									7									
Working Capital																			
8	Omnicare		X							\$ 2,519 8									
9	Shareholder Loans	X								\$ 43,616 9									
10										10									
11										11									
12										12									
13										13									
14	TOTAL Working Capital									\$ 46,135 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	930,346		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.)		\$	930,065		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(281)		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	959,593		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	959,312		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	676,238	8	FOR BHF USE ONLY	
	2011	690,901	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	723,683	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	886,032	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	913,886	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2015 Accrual = \$913,886 x 1.05 = \$959,580 (Rounded)					
Allocated from ITEX: \$16,179					

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,000 B. General Construction Type: Exterior Brick Frame Steel & Concrete Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1978</u>	<u>\$ 167,502</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 167,502	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	314		1975	\$ 2,750,940	\$ 401,978	40	\$ 68,774	\$ (333,205)	\$ 2,707,094	4
5			1989	1,453,936		40	36,348	36,348	951,740	5
6			2002	4,266,341		40	106,659	106,659	533,295	6
7										7
8										8
Improvement Type**										
9	Various		1975	28,890		20			28,890	9
10	Various		1977	11,520		20			11,520	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			2,004	14
15	Various		1982	6,604		20			6,604	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			10,997	18
19	Various		1986	2,080		20			2,080	19
20	Various		1987	2,375		20			2,375	20
21	Various		1988	4,955		20			4,955	21
22	Various		1989	111,464		20			111,464	22
23	Various		1990	98,033		20			98,033	23
24	Various		1991	2,229		20			2,229	24
25	Various		1992	3,024		20			3,024	25
26	Various		1993	103,239		20			103,239	26
27	Various		1994	23,033		20			23,033	27
28	Various		1995	44,266		20	905	905	43,884	28
29	Various		1996	93,171		20	4,659	4,659	91,193	29
30	Various		1997	102,244		20	3,431	3,431	67,899	30
31	Various		1998	103,389		20	4,025	4,025	91,687	31
32	Various		1999	150,958		20	3,531	3,531	139,270	32
33	Various		2000	37,198		20	1,860	1,860	28,412	33
34	Various		2001	217,477		20	10,874	10,874	158,676	34
35	Various		2002	5,478,038		20	265,612	265,612	4,114,225	35
36	Various		2003	1,988,331		20	72,476	72,476	1,347,721	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2004	\$ 154,078	\$	20	\$ 960	\$ 960	\$ 149,772	37
38	Various	2005	112,565		20	7,003	7,003	98,500	38
39	Various	2006	43,728		20	3,147	3,147	42,941	39
40	Various	2007	78,768		20	7,114	7,114	60,455	40
41	Various	2008	249,755		20	9,937	9,937	225,765	41
42	Various	2009	186,004		20	4,710	4,710	40,076	42
43	Various	2010	61,561		20	5,270	5,270	40,932	43
44	Various	2011	183,417		20	23,862	23,862	107,275	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F & 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H & 12I)</u>		675,397	17,442		17,498	56	457,768	68
69	<u>Financial Statement Depreciation</u>			223,782			(223,782)		69
70	TOTAL (lines 4 thru 69)		\$ 18,863,986	\$ 643,202		\$ 658,653	\$ 15,451	\$ 11,931,003	70

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 18,863,986	\$ 643,202		\$ 658,653	\$ 15,451	\$ 11,931,003	1
2	Asphalt Coating	2012	3,200		20	213	213	729	2
3	Carpeting Resident Rooms	2012	16,750		20	3,350	3,350	12,004	3
4	Carpeting First Floor Hallway	2012	18,480		20	3,696	3,696	13,244	4
5	Carpeting First Floor Hallway	2012	18,480		20	3,696	3,696	12,320	5
6	Asphalt Paving	2012	11,850		20	790	790	2,699	6
7	Wallcovering - 480 Yards Dining Room	2012	6,158		20	1,232	1,232	4,926	7
8	Wallcovering 330 Yards	2012	3,705		20	741	741	2,717	8
9	Wallcovering 660 Yards	2012	7,410		20	1,482	1,482	5,434	9
10	Wallcovering 300 Yards	2012	3,382		20	676	676	2,424	10
11	Room Heaters	2012	3,214		20	643	643	1,982	11
12	Baseboard Oak	2012	4,160		20	832	832	3,328	12
13	Ao Smith Water Heater	2012	8,974		20	897	897	3,515	13
14	Remove & Replace Taco Pump	2012	6,400		20	640	640	2,347	14
15	Ao Smith Boiler	2012	6,253		20	625	625	2,241	15
16	Install Sprinklers; Extend Sprinklers With Two Piece Excutechon	2012	4,685		20	234	234	898	16
17	Replaced 2Nd Flat Plate Heat Exchanger	2012	6,750		20	338	338	1,153	17
18	Draperies For Patient Rooms	2013	3,600		20	720	720	2,160	18
19	Trane Heat Pump	2013	4,100		20	410	410	957	19
20	Heat Pump Tower, Circle, And Motor	2013	6,100		20	610	610	1,423	20
21	Generator Valve Repair	2013	2,574		20	129	129	290	21
22	Wallpaper For Public Restrooms	2014	2,892		20	578	578	675	22
23	Replacing 265 Square Feet Of Concrete Sidewalks	2014	3,400		20	227	227	283	23
24	Roof Tear Off And Replacement South Wing	2014	74,260		20	7,426	7,426	14,852	24
25	Roof Repair Around Chiller Unit	2014	38,338		20	3,834	3,834	7,668	25
26	New Heat Pump	2014	4,442		20	888	888	962	26
27	Walk In Freezer	2014	6,800		20	1,360	1,360	2,153	27
28	Private Bathrooms Resident Rooms-Install Drywall & Wall Tile, P	2014	29,500		20	1,475	1,475	1,844	28
29	Video Monitoring System 2Nd Floor	2014	3,920		20	784	784	980	29
30	3Rd Floor Monitoring System	2014	3,820		20	764	764	828	30
31	Wallpaper Project - Hallways	2015	35,504		20	1,775	1,775	1,775	31
32	Door Alerts/Alarm	2015	4,274		20	204	204	204	32
33	Door Alerts/Alarm	2015	4,274		20	153	153	153	33
34	TOTAL (lines 1 thru 33)		\$ 19,221,634	\$ 643,202		\$ 700,075	\$ 56,873	\$ 12,040,169	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 19,221,634	\$ 643,202		\$ 700,075	\$ 56,873	\$ 12,040,169	1
2	Door Alerts/Alarm	2015	4,274		20	102	102	102	2
3	Wallpaper Project - Hallways	2015	3,278		20	137	137	137	3
4	Place Tile For Shower Wall	2015	3,200		20	213	213	213	4
5	Generator Repair	2015	7,331		20	92	92	92	5
6	Install Built In Drawers And Tops	2015	3,000		20	550	550	550	6
7	Cables And Jacks Installed	2015	5,460		20	212	212	212	7
8	Wallpaper Project - Hallways & Dining Room	2015	8,474		20	212	212	212	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)		\$ 19,256,651	\$ 643,202		\$ 701,592	\$ 58,390	\$ 12,041,687	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,256,651	\$ 643,202		\$ 701,592	\$ 58,390	\$ 12,041,687	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)	\$ 19,256,651	\$ 643,202		\$ 701,592	\$ 58,390	\$ 12,041,687	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 19,256,651	\$ 643,202		\$ 701,592	\$ 58,390	\$ 12,041,687	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)	\$ 19,256,651	\$ 643,202		\$ 701,592	\$ 58,390	\$ 12,041,687	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company		\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocation from ITEX	1993	510,824	13,098	20	14,595	1,497	329,602	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from ITEX	1993	64,276	378	20		(378)	64,276	9
10	Allocation from ITEX	1994	34,524	898	20		(898)	34,521	10
11	Allocation from ITEX	1995	5,884	16	20	234	218	5,882	11
12	Allocation from ITEX	1996	333		20	16	16	333	12
13	Allocation from ITEX	1997	9,926	255	20	496	241	9,181	13
14	Allocation from ITEX	1999	1,102	28	20	55	27	937	14
15	Allocation from ITEX	2005	4,826		20	241	241	2,503	15
16	Allocation from ITEX	2007	5,975	139	20	299	160	2,467	16
17	Allocation from ITEX	2008	22,773	584	20	752	168	5,703	17
18	Allocation from ITEX	2009	1,241	32	20	124	92	806	18
19	Allocation from ITEX	2010	2,650	55	20	133	78	712	19
20	Allocation from ITEX	2014	11,063	1,959	20	553	(1,406)	845	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	\$ 17,442		\$ 17,498	\$ 56	\$ 457,768	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 675,397	\$ 17,442		\$ 17,498	\$ 56	\$ 457,768	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)	\$ 675,397	\$ 17,442		\$ 17,498	\$ 56	\$ 457,768	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 1,333,075	\$ 115	\$ 86,112	\$ 85,997	10	\$ 1,093,429	71
72	Current Year Purchases	25,599		2,944	2,944	10	2,944	72
73	Fully Depreciated Assets	3,111,747		17	17	10	3,111,596	73
74								74
75	TOTALS	\$ 4,470,421	\$ 115	\$ 89,073	\$ 88,958		\$ 4,207,969	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)	\$ 23,894,574	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 643,317	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 790,665	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 147,348	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 16,249,656	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	Floor Plan, Land Title Survey	\$ 694,237	92
93			93
94			94
95		\$ 694,237	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 39,693 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	<u>Residential Use</u>	<u>Ford Van</u>	\$ <u>868.62</u>	\$ <u>10,423</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>868.62</u>	\$ <u>10,423</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 853,643		\$			\$ 853,643	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	214,702			10,555		225,257	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	351,093			202,203		553,296	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 prescripts				1,166,972		1,166,972	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>			123,585			395,237		518,822	13
14	TOTAL			\$ 1,543,023		\$	\$ 1,774,967		\$ 3,317,990	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.

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning: 01/01/15

Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 49,278	\$ 661,329	1
2	Cash-Patient Deposits	45,543	45,543	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,143,944	5,143,944	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	634,386	634,386	6
7	Other Prepaid Expenses	71,102	71,102	7
8	Accounts Receivable (owners or related parties)	225,883	225,883	8
9	Other(specify):	427,166	997,516	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,597,302	\$ 7,779,703	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	1,427,410	9,028,687	15
16	Equipment, at Historical Cost	1,978,675	5,412,677	16
17	Accumulated Depreciation (book methods)	(2,672,092)	(16,827,619)	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):	9,282,578	9,994,838	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,016,571	\$ 16,740,246	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,613,873	\$ 24,519,949	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,048,984	\$ 2,064,984	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,043	44,043	28
29	Short-Term Notes Payable	4,086,699	4,086,699	29
30	Accrued Salaries Payable	848,916	848,916	30
31	Accrued Taxes Payable (excluding real estate taxes)	70,350	70,350	31
32	Accrued Real Estate Taxes(Sch.IX-B)		959,593	32
33	Accrued Interest Payable	18,459	58,633	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	287,387	513,270	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,404,838	\$ 8,646,488	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,304,251	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)	\$	\$ 15,304,251	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,404,838	\$ 23,950,739	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,209,035	\$ 569,210	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,613,873	\$ 24,519,949	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,764,859	1
2	Restatements (describe):		2
3	State Replacement Tax	(6,371)	3
4	Due from Intercare	(250,000)	4
5	Rounding	2	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,508,490	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	700,545	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 700,545	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)	\$ 9,209,035	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning: 01/01/15

Ending:

12/31/15

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

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 24,275,209	1
2	Discounts and Allowances for all Levels	(7,869,202)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,406,007	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,978,650	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,978,650	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	1,911	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,573,536	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	310,887	19
20	Radiology and X-Ray		20
21	Other Medical Services	243,719	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,130,053	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	372,552	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 372,552	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,979	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,979	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,889,241	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	4,595,445	31
32	Health Care	10,132,521	32
33	General Administration	4,944,857	33
B. Capital Expense			
34	Ownership	2,378,686	34
C. Ancillary Expense			
35	Special Cost Centers	3,561,042	35
36	Provider Participation Fee	576,145	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 26,188,696	40
41	Income before Income Taxes (line 30 minus line 40)**	700,545	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 700,545	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 7,496,011	44
45	Private Pay - Net Inpatient Revenue	5,643,791	45
46	Medicare - Net Inpatient Revenue	2,860,264	46
47	Other-(specify) <u>Insurance</u>	241,279	47
48	Other-(specify) <u>Veterans</u>	164,662	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,406,007	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.

Facility Name & ID Number Glenview Terrace Nsg. Ctr

0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,688	1,872	\$ 100,544	\$ 53.71	1
2	Assistant Director of Nursing	9,144	10,982	327,071	29.78	2
3	Registered Nurses	62,057	74,054	2,173,625	29.35	3
4	Licensed Practical Nurses	55,878	64,884	1,546,283	23.83	4
5	CNAs & Orderlies	198,827	231,236	2,751,156	11.90	5
6	CNA Trainees					6
7	Licensed Therapist	45,040	52,463	1,543,023	29.41	7
8	Rehab/Therapy Aides	32,466	41,590	1,474,507	35.45	8
9	Activity Director	1,776	2,080	39,979	19.22	9
10	Activity Assistants	40,288	44,123	416,933	9.45	10
11	Social Service Workers	20,074	22,349	450,770	20.17	11
12	Dietician					12
13	Food Service Supervisor	11,483	12,474	305,605	24.50	13
14	Head Cook	5,713	6,515	100,204	15.38	14
15	Cook Helpers/Assistants	51,974	57,618	609,877	10.58	15
16	Dishwashers					16
17	Maintenance Workers	10,878	12,929	253,432	19.60	17
18	Housekeepers	42,472	49,208	608,364	12.36	18
19	Laundry	28,181	32,249	376,236	11.67	19
20	Administrator	1,868	2,080	106,466	51.19	20
21	Assistant Administrator					21
22	Other Administrative	3,040	3,120	179,686	57.59	22
23	Office Manager	1,787	2,123	53,397	25.15	23
24	Clerical	20,380	22,862	457,089	19.99	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	5,646	6,842	108,127	15.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	7,061	7,717	229,376	29.72	33
34	TOTAL (lines 1 - 33)	657,721	761,370	\$ 14,211,750 *	\$ 18.67	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	85	\$ 4,062	01-03	35
36	Medical Director	Monthly	148,600	09-03	36
37	Medical Records Consultant	Monthly	4,696	10-03	37
38	Nurse Consultant	Monthly	114,000	10-03	38
39	Pharmacist Consultant	Monthly	45,773	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	9,508	11-03	44
45	Social Service Consultant	Monthly	4,200	12-03	45
46	Other(specify) <u>Dietary Services</u>	Monthly	1,820	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	85	\$ 332,659		49

C. CONTRACT NURSES

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/15

Ending:

12/31/15**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: \$40,223
- (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. \$ 4,100 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. \$ 576,145
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. \$ 195,056 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,911
- (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.