FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0026237

Facility Name: Glenview Terrace 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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/16 Ending: 12/31/16

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	114,924	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	314	TOTALS	314	114,924	7

B. Census-For the entire report period.

	1 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	27,498	23,191	39,000	89,689	8
9	SNF/PED					9
10	ICF	3,677			3,677	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,175	23,191	39,000	93,366	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.24%

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 16,472

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,057,373	124,245	1,250	1,182,868		1,182,868	10,852	1,193,720			1
2	Food Purchase		1,163,694		1,163,694	(200,275)	963,419	(4,489)	958,930			2
3	Housekeeping	549,019	113,357		662,376		662,376	15,292	677,668			3
4	Laundry	335,600	144,778		480,378		480,378		480,378			4
5	Heat and Other Utilities			289,351	289,351		289,351	4,444	293,795			5
6	Maintenance	256,485	143,816	423,903	824,204		824,204	18,989	843,193			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,198,477	1,689,890	714,504	4,602,871	(200,275)	4,402,596	45,088	4,447,684			8
	B. Health Care and Programs											
9	Medical Director			159,100	159,100		159,100		159,100			9
10	Nursing and Medical Records	7,358,225	457,604	138,418	7,954,247		7,954,247	(32,637)	7,921,610			10
10a	Therapy	1,807,293			1,807,293		1,807,293		1,807,293			10a
11	Activities	582,625	47,244	6,651	636,520		636,520		636,520			11
12	Social Services	293,022		4,350	297,372		297,372		297,372			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	10,041,165	504,848	308,519	10,854,532		10,854,532	(32,637)	10,821,895			16
	C. General Administration											
17	Administrative	283,629			283,629		283,629		283,629			17
18	Directors Fees											18
19	Professional Services			625,941	625,941	(59,861)	566,080	(191,387)	374,693			19
20	Dues, Fees, Subscriptions & Promotions			392,696	392,696		392,696	(250,102)	142,594			20
21	Clerical & General Office Expenses	528,319	6,980	515,891	1,051,190		1,051,190	136,505	1,187,695			21
22	Employee Benefits & Payroll Taxes			2,244,644	2,244,644	200,275	2,444,919	(9,306)	2,435,613			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,808	14,808		14,808	76	14,884			24
25	Other Admin. Staff Transportation			766	766		766		766			25
26	Insurance-Prop.Liab.Malpractice			621,878	621,878		621,878	4,768	626,646			26
27	Other (specify):*							113,797	113,797			27
28	**TOTAL General Administration**	811,948	6,980	4,416,624	5,235,552	140,414	5,375,966	(195,649)	5,180,317			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	13,051,590	2,201,718	5,439,647	20,692,955	(59,861)	20,633,094	(183,198)	20,449,896			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: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			200,348	200,348		200,348	580,107	780,455			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			373,415	373,415		373,415	(55,702)	317,713			32
33	Real Estate Taxes					59,861	59,861	968,617	1,028,478			33
34	Rent-Facility & Grounds			1,878,000	1,878,000		1,878,000	(1,878,000)				34
35	Rent-Equipment & Vehicles			78,464	78,464		78,464	(16,252)	62,212			35
36	Other (specify):*							75,923	75,923			36
37	**TOTAL Ownership**			2,530,227	2,530,227	59,861	2,590,088	(325,307)	2,264,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,137,672	1,381,473		2,519,145		2,519,145		2,519,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			585,493	585,493		585,493		585,493			42
43	Other (specify):*	184,951		10,541	195,492		195,492	(195,492)	0			43
44	**TOTAL Special Cost Centers**	1,322,623	1,381,473	596,034	3,300,130		3,300,130	(195,492)	3,104,638			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	14,374,213	3,583,191	8,565,908	26,523,312	(0)	26,523,312	(703,997)	25,819,315			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: 01/01/16 Ending: 12/31/16

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	(1,613)	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	67,516	30		9
10	Interest and Other Investment Income	(361,562)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,876)	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	(1,507)	21		18
19	Entertainment				19
20	Contributions	(24,035)	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	(345,185)	21		24
25	Fund Raising, Advertising and Promotional	(53,576)	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	(820,156)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,542,994)		$	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)	838,997		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 838,997		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (703,997)		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

Glenview Terrace Nursing Ctr

ID# 0026237

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (937)	21	1
2	Drivers Salary	(26,448)	43	2
3	Marketing Salary	(88,672)	43	3
4	Veterans Expenses	(32,637)	10	4
5	Life Insurance	(547)	22	5
6	Bank Charges	(21,040)	21	6
7	Credit Card Fees	(41,846)	21	7
8	Public Relations	(156,934)	20	8
9	Insurance - Officers Life	(8,759)	22	9
10	PAC Dues	(12,530)	20	10
11	Non- Allowable Auto Lease	(19,703)	35	11
12	State of Illinois Income	(280)	21	12
13	Non- Allowable Auto Expense	(10,541)	43	13
14	Non-Allowable Marketing Travel	(5,492)	43	14
15	Building Co. - Annual Report Fee	(250)	20	15
16	Building Co. - Accounting Fees	(20,460)	19	16
17	Non-Allowable Salary	(64,339)	43	17
18	Capitalized R&M	(5,400)	06	18
19	Non-Allowable Legal Fees	(47,685)	19	19
20	Building Co.- Amort of Loan Cost	(5,532)	36	20
21	Marketing Director Recruitment	(11,000)	20	21
22	Non-Allowable Rent	(60,000)	34	22
23	Non Allowable Interest	(192,145)	32	23
24	Additional R&M	13,021	06	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(820,156)		49

Glenview Terrace Nursing Ctr

ID# 0026237

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 Nursing Ctr # 0026237 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			10,852									10,852	1
2	Food Purchase	(4,489)											(4,489)	2
3	Housekeeping			15,292									15,292	3
4	Laundry													4
5	Heat and Other Utilities			4,444									4,444	5
6	Maintenance	7,621		11,368									18,989	6
7	Other (specify):*													7
8	**TOTAL General Services**	3,132		41,956									45,088	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(32,637)											(32,637)	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**	(32,637)											(32,637)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(68,145)	80,321	(203,563)									(191,387)	19
20	Fees, Subscriptions & Promotions	(258,325)	250	7,973									(250,102)	20
21	Clerical & General Office Expenses	(410,795)		547,300									136,505	21
22	Employee Benefits & Payroll Taxes	(9,306)											(9,306)	22
23	Inservice Training & Education													23
24	Travel and Seminar			76									76	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			4,768									4,768	26
27	Other (specify):*			113,797									113,797	27
28	**TOTAL General Administration**	(746,571)	80,571	470,351									(195,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(776,076)	80,571	512,307									(183,198)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	67,516	489,701	22,890									580,107	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(553,707)	477,940	20,065									(55,702)	32
33	Real Estate Taxes		948,832	19,785									968,617	33
34	Rent-Facility & Grounds	(60,000)	(1,818,000)										(1,878,000)	34
35	Rent-Equipment & Vehicles	(19,703)		3,451									(16,252)	35
36	Other (specify):*	(5,532)	81,455										75,923	36
37	TOTAL Ownership	(571,426)	179,928	66,191									(325,307)	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):*	(195,492)											(195,492)	43
44	TOTAL Special Cost Centers	(195,492)											(195,492)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,542,994)	260,499	578,498									(703,997)	45

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 1,818,000	Glenview Terrace Property, LLC	100.00%	$	$ (1,818,000)	1
2	V	32	Interest	373	Glenview Terrace Property, LLC	100.00%	478,313	477,940	2
3	V	20	Annual Report Fee		Glenview Terrace Property, LLC	100.00%	250	250	3
4	V	19	Real Estate Tax Appeal		Glenview Terrace Property, LLC	100.00%	56,611	56,611	4
5	V	19	Accounting Fees		Glenview Terrace Property, LLC	100.00%	20,460	20,460	5
6	V	19	Architectural & Appraisal Fees		Glenview Terrace Property, LLC	100.00%	3,250	3,250	6
7	V	33	Real Estate Tax Expense		Glenview Terrace Property, LLC	100.00%	948,832	948,832	7
8	V	36	MIP Insurance		Glenview Terrace Property, LLC	100.00%	75,923	75,923	8
9	V	30	Depreciation		Glenview Terrace Property, LLC	100.00%	489,701	489,701	9
10	V	36	Amortization of Loan Costs		Glenview Terrace Property, LLC	100.00%	5,532	5,532	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,818,373			$ 2,078,872	$ * 260,499	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: 01/01/16 Ending: 12/31/16

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%	$ 10,852	$ 10,852	15
16	V	3	HOUSEKEEPING		ITEX / AK CARE COMPANY	100.00%	15,292	15,292	16
17	V	5	UTILITIES		ITEX / AK CARE COMPANY	100.00%	4,444	4,444	17
18	V	6	REPAIRS AND MAINT.		ITEX / AK CARE COMPANY	100.00%	11,368	11,368	18
19	V	19	PROFESSIONAL FEES		ITEX / AK CARE COMPANY	100.00%	18,937	18,937	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX / AK CARE COMPANY	100.00%	7,973	7,973	20
21	V	21	CLERICAL AND GENERAL		ITEX / AK CARE COMPANY	100.00%	83,478	83,478	21
22	V	24	EDUCATION AND SEMINARS		ITEX / AK CARE COMPANY	100.00%	76	76	22
23	V	26	INSURANCE		ITEX / AK CARE COMPANY	100.00%	4,768	4,768	23
24	V	30	DEPRECIATION		ITEX / AK CARE COMPANY	100.00%	22,890	22,890	24
25	V	32	INTEREST		ITEX / AK CARE COMPANY	100.00%	20,065	20,065	25
26	V	33	REAL ESTATE TAXES		ITEX / AK CARE COMPANY	100.00%	19,785	19,785	26
27	V	35	EQUIPMENT RENTAL		ITEX / AK CARE COMPANY	100.00%	3,451	3,451	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX / AK CARE COMPANY	100.00%	463,822	463,822	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX / AK CARE COMPANY	100.00%	113,797	113,797	33
34	V								34
35	V								35
36	V	19	CENTRALIZED BOOKKEEPING	222,500	ITEX / AK CARE COMPANY	100.00%		(222,500)	36
37	V								37
38	V								38
39	Total			$ 222,500			$ 800,998	$ * 578,498	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM SHOSHANA	0.59%	CLARIDGE IMPERIAL, LTD.	CHICAGO	GLENVIEW TERRACE PROPERTY, LLC		BUILDING CO.	1
2	ADINA AARON	0.26%	HARMONY NURSING & REHAB.	CHICAGO	ITEX / A.K. CARE	LINCOLNWOOD	BOOKEEPING CO./MANAGE	2
3	AHUVA WEINREB	1.18%	WHITEHALL NORTH	DEERFIELD	JLR FINANCIAL SERVICES COF	LINCOLNWOOD	FINANCIAL SVCS	3
4	ALBERT MILSTEIN	2.17%			SEASONS HOSPICE	PARK RIDGE	HOSPICE	4
5	DARRIN CHAN	1.98%						5
6	DAVIS GLENVIEW TERRACE LLC	9.82%						6
7	DENISE CHAN	1.98%						7
8	DEVORAH SHOSHANA	0.59%						8
9	DISCRETIONARY TRUST FOR JENNIFER	2.87%						9
10	DISCRETIONARY TRUST FOR JULIE T.Y.	2.87%						10
11	ELIEZER LEON SILVER	0.59%						11
12	ELIYAHU DAVIS	1.18%						12
13	ELLIOTT ROBINSON	1.88%						13
14	ESTHER V. STEIN	0.26%						14
15	FEIGE C. KNOBEL DISCRETIONARY TRUST	6.02%						15
16	FREDA ROBINSON	1.28%						16
17	HENRY CHEN	1.98%						17
18	IRVING CUTLER	0.40%						18
19	J & J PARTNERSHIP	8.26%						19
20	JANET HARRIS	2.37%						20
21	JAY ROBINSON	0.39%						21
22	JOEL E. JACOBSON	0.26%						22
23	LAURENCE & CORALIE ZUNG	4.15%						23
24	LEAH FINK REPARATIONS TRUST	1.98%						24
25	LEONARD & MOLLY BOLNICK	0.79%						25
26	MARK HOLLANDER DISCRETIONARY TRUST	6.02%						26
27	MOSHE Y. DAVIS	1.18%						27
28	NAOMI FARKAS	3.95%						28
29	NESANEL B. DAVIS	1.18%						29
30	R & L ASSOCIATES	0.40%						30

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	9.80%						1
2	ROBINSON-LEVITT FAMILY TRUST	0.30%						2
3	ROSLYN HAMER	1.58%						3
4	SANDI SPRECKMAN TRUST	0.39%						4
5	SHARON HOLLANDER DISCRETIONARY TRUST	6.02%						5
6	SHELDON AND FREDA ROBINSON	0.99%						6
7	SHELDON ROBINSON	0.40%						7
8	SHELDON ROBINSON DELTA TRUST	1.98%						8
9	SHELDON ROBINSON REVOCABLE TRUST	3.56%						9
10	SHOSHANA BRAUN	1.18%						10
11	SNYDER-MILSTEIN LLC	0.99%						11
12	SOREL SIMON TRUST	0.40%						12
13	STEVE AND BARBARA GELLER	0.30%						13
14	SUSAN MOESER	0.39%						14
15	YEHUDA SILVER	0.59%						15
16	YEHOSHUA Y. DAVIS	1.18%						16
17	YISROEL M. DAVIS	1.18%						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: 01/01/16 Ending: 12/31/16

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	Mark Hollander	Relative	Administrative	0.00%	See Attached	27	45.00%	Salary	$ 114,900	17-1	1
2											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	$ 114,900		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 Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	271,572	3	$ 25,643	$	114,924	$ 10,852	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	271,572	3	36,137		114,924	15,292	2
3	5	UTILITIES	AVAILABLE BED DAYS	271,572	3	10,501		114,924	4,444	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	271,572	3	26,863		114,924	11,368	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	271,572	3	44,750		114,924	18,937	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	271,572	3	18,841		114,924	7,973	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	271,572	3	197,264		114,924	83,478	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	271,572	3	180		114,924	76	8
9	26	INSURANCE	AVAILABLE BED DAYS	271,572	3	11,266		114,924	4,768	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	271,572	3	54,090		114,924	22,890	10
11	32	INTEREST	AVAILABLE BED DAYS	271,572	3	47,416		114,924	20,065	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	271,572	3	46,754		114,924	19,785	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	271,572	3	8,156		114,924	3,451	13
14										14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	1,051,890	1,051,890		463,822	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	258,078			113,797	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,837,829	$ 1,051,890		$ 800,998	25

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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			$	$ 15,082,197			$ 478,313	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	MB Financial		X	Line of Credit				4,107,505			171,515	6
7	INAC		X	Insurance Financing							9,755	7
8					-							8
9	TOTAL Facility Related						$	$ 19,189,702			$ 659,583	9
	B. Non-Facility Related*											
10	Interest Income		X								(361,562)	10
11	Interest Income - Bldg. Co		X								(373)	11
12	Allocated from ITEX		X								20,065	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (341,870)	14
15	TOTALS (line 9+line14)						$	$ 19,189,702			$ 317,713	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 75,923 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: 01/01/16 Ending: 12/31/16

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 959,581	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.)		$ 950,718	2
3. Under or (over) accrual (line 2 minus line 1).		$ (8,863)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 977,480	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.)		$ 59,861	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.		$ 1,028,478	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	690,901	8
	2012	723,683	9
	2013	886,032	10
	2014	913,886	11
	2015	930,933	12

2016 Accrual: $930,933 x 1.05 = $977,480 (Rounded)

Allocated from ITEX: $19,785

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

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

	(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	$ 930,932.58	$ 930,932.58
2.	10-35-312-022-0000	Allocated from ITEX	$ 54,446.07	$ 23,040.52
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 985,378.65	$ 953,973.10

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

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 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) 236-6300 FAX #: (847) 236-6301

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

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

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	$ 489,701	35	$ 43,846	$ (445,855)	$ 2,750,940	4
5				1989	1,453,936		35	36,348	36,348	988,088	5
6				2002	4,266,341		35	106,659	106,659	639,954	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			22,624	27
28	Various			1995	44,266		20			43,884	28
29	Various			1996	93,171		20	1,970	1,970	93,163	29
30	Various			1997	102,244		20	3,431	3,431	71,330	30
31	Various			1998	103,389		20	4,025	4,025	95,712	31
32	Various			1999	150,958		20	3,531	3,531	142,801	32
33	Various			2000	37,198		20	1,860	1,860	30,272	33
34	Various			2001	217,477		20	10,874	10,874	169,550	34
35	Various			2002	5,478,038		20	265,612	265,612	4,379,837	35
36	Various			2003	1,988,331		20	71,916	71,916	1,419,637	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: 01/01/16 Ending: 12/31/16

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	$ 960	$ 960	$ 150,732	37
38	Various	2005	112,565		20	5,528	5,528	104,028	38
39	Various	2006	43,728		20	787	787	43,728	39
40	Various	2007	78,768		20	7,114	7,114	67,569	40
41	Various	2008	249,755		20	9,937	9,937	235,703	41
42	Various	2009	186,004		20	4,710	4,710	44,786	42
43	Various	2010	61,561		20	3,458	3,458	44,390	43
44	Various	2011	183,417		20	18,098	18,098	125,373	44
45	Various	2012	129,851		20	20,086	20,086	92,046	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		899,179	21,918		23,004	1,086	631,312	68
69	Financial Statement Depreciation			200,348			(200,348)		69
70	TOTAL (lines 4 thru 69)		$ 19,217,619	$ 711,967		$ 643,754	$ (68,213)	$ 12,766,014	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: 01/01/16 Ending: 12/31/16

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		$ 19,217,619	$ 711,967		$ 643,754	$ (68,213)	$ 12,766,014	1
2	Draperies For Patient Rooms	2013	3,600		20	720	720	2,880	2
3	Trane Heat Pump	2013	4,100		20	410	410	1,367	3
4	Heat Pump Tower, Circle, And Motor	2013	6,100		20	610	610	2,033	4
5	Generator Valve Repair	2013	2,574		20	129	129	418	5
6	Wallpaper For Public Restrooms	2014	2,892		20	578	578	1,253	6
7	Replacing 265 Square Feet Of Concrete Sidewalks	2014	3,400		20	227	227	510	7
8	Roof Tear Off And Replacement South Wing	2014	74,260		20	7,426	7,426	22,278	8
9	Roof Repair Around Chiller Unit	2014	38,338		20	3,834	3,834	11,501	9
10	New Heat Pump	2014	4,442		20	888	888	1,851	10
11	Walk In Freezer	2014	6,800		20	1,360	1,360	3,513	11
12	Private Bathrooms Resident Rooms-Install Drywall & Wall Tile, P	2014	29,500		20	1,475	1,475	3,319	12
13	Video Monitoring System 2Nd Floor	2014	3,920		20	784	784	1,764	13
14	3Rd Floor Monitoring System	2014	3,820		20	764	764	1,592	14
15	Wallpaper Project - Hallways	2015	35,504		20	3,550	3,550	5,326	15
16	Door Alerts	2015	4,274		20	611	611	814	16
17	Door Alerts	2015	4,274		20	611	611	763	17
18	Door Alerts	2015	4,274		20	611	611	712	18
19	Wallpaper Project - Hallway	2015	3,278		20	328	328	464	19
20	Shower Wall Tile	2015	3,200		20	160	160	320	20
21	Generator Repair	2015	7,331		20	367	367	458	21
22	Built In Drawers And Tops	2015	3,000		20	600	600	1,150	22
23	Cables And Jacks	2015	5,460		20	273	273	432	23
24	Wallpaper Project - Hallways & Dining Room	2015	8,474		20	424	424	530	24
25	Design Dining/Patient Rooms/Wallcoverings/Lighting 1St/2Nd Flo	2016	3,540		20	177	177	177	25
26	Lighting Fixtures In Bathroom/Halls/Patient Rooms	2016	43,036		20	1,972	1,972	1,972	26
27	Install Privacy Panels & Roman Shades In Patient/Exercise Room	2016	56,757		20	709	709	709	27
28	2Nd Floor - Vinyl Tile & Install Wallbase	2016	12,000		20	500	500	500	28
29	2Nd Floor - Vinyl Tile	2016	12,917		20	269	269	269	29
30	2Nd Floor - Vinyl Tile	2016	3,293		20	55	55	55	30
31	2Nd Floor - Vinyl Tile In Rooms 254,269,282	2016	13,793		20	172	172	172	31
32	Remove Carpet & Install Luxury Vinyl Tile - 2Nd Floor	2016	118,260		20	986	986	986	32
33	Elevator Repair - Modernization	2016	101,283		20	2,110	2,110	2,110	33
34	TOTAL (lines 1 thru 33)		$ 19,845,312	$ 711,967		$ 677,443	$ (34,524)	$ 12,838,214	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: 01/01/16 Ending: 12/31/16

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		$ 19,845,312	$ 711,967		$ 677,443	$ (34,524)	$ 12,838,214	1
2	Taco In Line Circulating Pump	2016	4,300		20	179	179	179	2
3	Raypak Boiler	2016	12,985		20	541	541	541	3
4	Taco In Line Circulating Pump	2016	5,200		20	65	65	65	4
5	Electrical Work Can Lights All Rooms	2016	6,000		20	225	225	225	5
6	Electrical Work Can Lights All Rooms	2016	5,700		20	119	119	119	6
7	Electrical Work - Elevators	2016	6,147		20	26	26	26	7
8	Signs	2016	4,861		20	203	203	203	8
9	Gas Water Heater	2016	7,941		20	33	33	33	9
10	Handrails	2016	2,500		20	115	115	115	10
11	Wallpaper-2Nd Floor Corridor, Private/Exercise/Rehab Rooms	2016	29,860		20	249	249	249	11
12	Cable Drops Resident Tv'S	2016	18,000		20	825	825	825	12
13	Cable Drops Resident Tv'S	2016	11,813		20	197	197	197	13
14	Wallpaper In Hallways/Doors/Nooks/Nurses Station	2016	2,837		20	567	567	567	14
15	Leveling Of Parking Area, Asphalt Patching To Holes In Parking	2016	2,550		20	128	128	128	15
16	Repair 3X Damage Sewers In Main Parking Area With Mortar/H	2016	2,850		20	143	143	143	16
17	Wallpaper In Dining/Exercise Rooms & Elevators	2016	5,260		20	263	263	263	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)		$ 19,974,115	$ 711,967		$ 681,319	$ (30,648)	$ 12,842,089	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: 01/01/16 Ending: 12/31/16

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		$ 19,974,115	$ 711,967		$ 681,319	$ (30,648)	$ 12,842,089	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)		$ 19,974,115	$ 711,967		$ 681,319	$ (30,648)	$ 12,842,089	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: 01/01/16 Ending: 12/31/16

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		$ 19,974,115	$ 711,967		$ 681,319	$ (30,648)	$ 12,842,089	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)		$ 19,974,115	$ 711,967		$ 681,319	$ (30,648)	$ 12,842,089	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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: 01/01/16 Ending: 12/31/16

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
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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from ITEX	1993	678,804	17,405	35	19,394	1,989	457,383	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from ITEX	1993	85,413	502	20		(502)	85,413	9
10	Allocation from ITEX	1994	45,877	1,193	20		(1,193)	45,873	10
11	Allocation from ITEX	1995	7,819	22	20		(22)	7,819	11
12	Allocation from ITEX	1996	443		20			443	12
13	Allocation from ITEX	1997	13,189	338	20	659	321	12,859	13
14	Allocation from ITEX	1999	1,465	38	20	73	35	1,318	14
15	Allocation from ITEX	2005	6,413		20	321	321	3,648	15
16	Allocation from ITEX	2007	7,940	185	20	397	212	3,675	16
17	Allocation from ITEX	2008	30,261	776	20	1,000	224	8,579	17
18	Allocation from ITEX	2009	1,649	42	20	165	123	1,237	18
19	Allocation from ITEX	2010	3,522		20	176	176	1,123	19
20	Allocation from ITEX	2014	14,701	1,412	20	735	(677)	1,858	20
21	Allocation from ITEX	2016	1,683	5	20	84	79	84	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)		$ 899,179	$ 21,918		$ 23,004	$ 1,086	$ 631,312	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: 01/01/16 Ending: 12/31/16

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		$ 899,179	$ 21,918		$ 23,004	$ 1,086	$ 631,312	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)		$ 899,179	$ 21,918		$ 23,004	$ 1,086	$ 631,312	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: 01/01/16 Ending: 12/31/16

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	$ 1,288,492	$ 131	$ 72,673	$ 72,542	10	$ 1,098,417	71
72	Current Year Purchases	346,285	839	26,438	25,599	10	26,438	72
73	Fully Depreciated Assets	3,258,339		23	23	10	3,257,478	73
74								74
75	TOTALS	$ 4,893,116	$ 970	$ 99,134	$ 98,164		$ 4,382,332	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 25,034,733	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 712,937	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 780,453	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 67,516	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 17,224,421	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	CIP Addition	$ 171,476	92
93			93
94			94
95		$ 171,476	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: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 51,739 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	$ 869	$ 10,473	17
18					18
19					19
20					20
21	TOTAL		$ 869	$ 10,473	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	$ 772,831		$	$		$ 772,831	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	234,520			12,525		247,045	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 02	hrs				129,999		129,999	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				941,028		941,028	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			130,321			297,921		428,242	13
14	TOTAL			$ 1,137,672		$	$ 1,381,473		$ 2,519,145	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:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 46,036	$ 123,464	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,677,173	4,677,173	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	634,202	634,202	6
7	Other Prepaid Expenses	60,753	60,753	7
8	Accounts Receivable (owners or related parties)	532,323	532,323	8
9	Other(specify): See Attached Schedule	2,037,187	2,630,269	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,989,174	$ 8,659,684	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		8,932,844	14
15	Leasehold Improvements, at Historical Cost	1,430,246	9,755,962	15
16	Equipment, at Historical Cost	1,978,675	5,531,591	16
17	Accumulated Depreciation (book methods)	(2,872,874)	(17,518,102)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	7,830,516	8,537,616	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,366,563	$ 15,438,731	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,355,737	$ 24,098,415	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,072,161	$ 2,093,161	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,107,505	4,336,657	29
30	Accrued Salaries Payable	407,033	407,033	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,781	8,781	31
32	Accrued Real Estate Taxes(Sch.IX-B)		977,480	32
33	Accrued Interest Payable	20,107	59,698	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,083	525,817	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,618,670	$ 8,408,627	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,853,045	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)**	$	$ 14,853,045	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,618,670	$ 23,261,672	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,737,067	$ 836,743	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,355,737	$ 24,098,415	48

***(See instructions.)**

Facility Name & ID Number Glenview Terrace Nursing Ctr **#** 0026237 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,209,036	1
2	Restatements (describe):		2
3	State Replacement Tax	(11,365)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,197,671	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	539,396	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)**	$ 539,396	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)**	$ 9,737,067	24 *

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 24,525,928	1
2	Discounts and Allowances for all Levels	(6,250,804)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 18,275,124	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,577,585	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,577,585	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	1,613	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,391,052	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	307,637	19
20	Radiology and X-Ray		20
21	Other Medical Services	146,918	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,847,220	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	361,562	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 361,562	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,217	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,217	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 27,062,708	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,602,871	31
32	Health Care	10,854,532	32
33	General Administration	5,235,552	33
	B. Capital Expense		
34	Ownership	2,530,227	34
	C. Ancillary Expense		
35	Special Cost Centers	2,714,637	35
36	Provider Participation Fee	585,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 26,523,312	40
41	**Income before Income Taxes (line 30 minus line 40)****	539,396	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 539,396	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,698,421	44
45	Private Pay - Net Inpatient Revenue	5,361,579	45
46	Medicare - Net Inpatient Revenue	3,651,929	46
47	Other-(specify) Insurance	672,258	47
48	Other-(specify) Veteran, MMAI	2,890,937	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 18,275,124	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 Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,529	1,719	$ 95,004	$ 55.27	1
2	Assistant Director of Nursing	4,581	5,237	202,916	38.75	2
3	Registered Nurses	71,085	79,458	2,307,140	29.04	3
4	Licensed Practical Nurses	68,278	75,177	1,917,526	25.51	4
5	CNAs & Orderlies	197,525	220,963	2,745,590	12.43	5
6	CNA Trainees					6
7	Licensed Therapist	32,192	37,642	1,137,672	30.22	7
8	Rehab/Therapy Aides	46,492	52,645	1,807,293	34.33	8
9	Activity Director	1,758	2,079	40,547	19.50	9
10	Activity Assistants	50,962	54,796	542,078	9.89	10
11	Social Service Workers	13,815	15,896	293,022	18.43	11
12	Dietician					12
13	Food Service Supervisor	11,423	12,612	326,301	25.87	13
14	Head Cook	8,563	9,786	133,578	13.65	14
15	Cook Helpers/Assistants	52,583	58,173	597,494	10.27	15
16	Dishwashers					16
17	Maintenance Workers	12,503	14,076	256,485	18.22	17
18	Housekeepers	41,876	48,773	549,019	11.26	18
19	Laundry	25,301	29,512	335,600	11.37	19
20	Administrator	1,933	2,087	107,596	51.56	20
21	Assistant Administrator					21
22	Other Administrative	2,621	2,723	176,033	64.65	22
23	Office Manager	2,059	2,339	59,177	25.30	23
24	Clerical	25,661	28,133	469,142	16.68	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	3,817	4,984	90,049	18.07	31
32	Other Health Care(specify)					32
33	Other(specify)	6,116	6,631	182,205	27.48	33
34	TOTAL (lines 1 - 33)	682,673	765,441	$ 14,371,467 *	$ 18.78	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	26	$ 1,250	01-03	35
36	Medical Director	Monthly	159,100	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	106,750	10-03	38
39	Pharmacist Consultant	Monthly	26,868	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	6,651	11-03	44
45	Social Service Consultant	Monthly	4,350	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	26	$ 309,769		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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bradley Bartels	Administrator	0	$ 107,596
Mark Hollander	Exec. Director	0	114,900
Ian Crook	VP Operations	0	61,133
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 283,629

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 1,668
Netsmart/Health MedX	Data Processing	112,969
AK Care	Centralized Bookkeeping	222,500
Joint Commission	Accreditation	11,963
M L Enterprise	Purchasing Consultant	2,506
See Attached	Legal Fees	122,583
Marcum LLP	Accounting	52,406
2401 Incorporated	Architectural Services	1,720
E-Health Data Solutions	Data Processing	3,480
Paycom Payroll	Data Processing	17,157
Cave/Provinet	Data Processing	20,914
See Supplemental Schedule		56,074
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 625,941

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 366,310
Unemployment Compensation Insurance	82,077
FICA Taxes	1,068,198
Employee Health Insurance	553,563
Employee Meals	200,275
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	30,113
Employee Benefits	18,420
Pension Plan	97,459
Christmas Expense	19,198
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,435,613

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	38,571
Health Care Worker Background Check	14,000
(Indicate # of checks performed 140)	
Patient Background Checks	
Licenses & Permits	2,587
Dues & Subscriptions	79,463
Allocated from ITEX	7,973
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 142,594

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14,808
Allocated from ITEX	76
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,884

**See instructions.

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: $37,970**

(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. $ **36,319** Line **10**

(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. $ **585,493**
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. $ **200,275** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,613**

(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 1**
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