FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054189

Facility Name: ABINGTON OF GLENVIEW NURSING

Address: 3901 GLENVIEW ROAD (Number) GLENVIEW (City) 60025 (Zip Code)

County: COOK

Telephone Number: (847) 729-0000 **Fax #** (847) 729-1552

HFS ID Number:

Date of Initial License for Current Owners: 02/22/16

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
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 01/01/2017 to 12/31/2017 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) ELISHA ATKIN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 _____

	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	192	Skilled (SNF)	192	70,080	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	192	TOTALS	192	70,080	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			15,020	15,020	8
9	SNF/PED					9
10	ICF	3,939	20,996		24,935	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,939	20,996	15,020	39,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.01%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 4/1/16

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 4/1/16 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified _____ and days of care provided 14,519

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	541,571	55,070	23,440	620,081		620,081		620,081			1
2	Food Purchase		257,962		257,962	(71,175)	186,787	(213)	186,574			2
3	Housekeeping	310,593	51,548		362,141		362,141		362,141			3
4	Laundry	83,962	31,422	702	116,086		116,086		116,086			4
5	Heat and Other Utilities			248,780	248,780		248,780		248,780			5
6	Maintenance	109,218	31,694	78,683	219,595		219,595		219,595			6
7	Other (specify):*			20,787	20,787		20,787		20,787			7
8	TOTAL General Services	1,045,344	427,696	372,392	1,845,432	(71,175)	1,774,257	(213)	1,774,044			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,035,011	263,701	23,461	4,322,173		4,322,173		4,322,173			10
10a	Therapy	1,890,678	6,681	54,422	1,951,781		1,951,781		1,951,781			10a
11	Activities	269,825	20,396	3,223	293,444		293,444		293,444			11
12	Social Services	114,367			114,367		114,367		114,367			12
13	CNA Training											13
14	Program Transportation			1,586	1,586		1,586		1,586			14
15	Other (specify):* Patient Personal Items		3,895		3,895		3,895		3,895			15
16	TOTAL Health Care and Programs	6,309,881	294,673	94,692	6,699,246		6,699,246		6,699,246			16
	C. General Administration											
17	Administrative	97,855		720,650	818,505		818,505	(612,754)	205,751			17
18	Directors Fees											18
19	Professional Services			137,912	137,912		137,912	(11,141)	126,771			19
20	Dues, Fees, Subscriptions & Promotions			132,183	132,183		132,183	(117,796)	14,387			20
21	Clerical & General Office Expenses	508,995	43,396	244,037	796,428		796,428	(313,605)	482,823			21
22	Employee Benefits & Payroll Taxes			1,487,700	1,487,700	71,175	1,558,875		1,558,875			22
23	Inservice Training & Education			1,521	1,521		1,521		1,521			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			21,115	21,115		21,115	(21,115)				25
26	Insurance-Prop.Liab.Malpractice			161,276	161,276		161,276	19,910	181,186			26
27	Other (specify):*			104,269	104,269		104,269	(87,710)	16,559			27
28	TOTAL General Administration	606,850	43,396	3,010,663	3,660,909	71,175	3,732,084	(1,144,211)	2,587,873			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,962,075	765,765	3,477,747	12,205,587		12,205,587	(1,144,424)	11,061,163			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#: ABINGTON OF GLENVIEW NURSING **#0054189** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	23,440	
	REPAIRS & MAINTENANCE		0	
				23,440
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		702	
				702
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		51,051	
	ELECTRICITY		96,491	
	WATER		77,247	
	CABLE TV - LOBBY		23,991	
				248,780
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		22,098	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		3,482	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,198	
	ELEVATOR MAINTENANCE & REPAIR		28,987	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,287	
	FIRE SERVICE		14,631	
				78,683
7	**OTHER**			
	SCAVENGER		20,787	
	SECURITY SERVICE		0	
				20,787
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		14,536	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	8,925	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				23,461
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	52,749	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
	SIGN LANGUAGE		1,673	
				54,422
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,223	
				3,223
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING **#0054189** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,586	
				1,586
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	720,650	720,650
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	90,092	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	47,820	
				137,912
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	909	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	93,846	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	16,600	
	DUES & SUBSCRIPTIONS	XIX F	6,440	
	LICENSES & PERMITS	XIX F	7,947	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	6,441	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				132,183
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		28,962	
	EQUIPMENT REPAIR & MAINTENANCE		3,588	
	OUTSIDE CLERICAL SERVICES		180,563	
	PENALTIES / OVERDRAFT CHARGES	VI 18	326	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		30,598	
	MESSENGER SERVICE		0	
				244,037

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	576,805	
	UNEMPLOYMENT COMPENSATION	XIX D	58,545	
	WORKERS COMPENSATION INSURANC	XIX D	185,626	
	HOSPITALIZATION INSURANCE	XIX D	645,171	
	EMPLOYEE BENEFITS - OTHER	XIX D	21,553	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				1,487,700
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,521	
				1,521
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		21,115	
				21,115
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		161,276	
				161,276
27	**OTHER**			
	BAD DEBTS	VI 24	104,269	
				104,269

GRAND TOTAL COLUMN 3 OTHER **3,477,747**

ABINGTON OF GLENVIEW NURSING
SCHEDULES
12/31/2017

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	257,962
LESS SALES TAX	(213)
NET FOOD	257,749
TOTAL PATIENT CENSUS	39,955
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	119,865
ADD # EMPLOYEE MEALS/DAY	125
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	45,625
PATIENT MEALS	119,865
ADD EMPLOYEE MEALS	45,625
TOTAL MEALS/YEAR	165,490
NET FOOD	257,749
DIVIDE TOTAL MEALS/YEAR	165,490
COST PER MEAL	1.56
TIMES EMPLOYEE MEALS	45,625
EMPLOYEE MEAL RECLASSIFICATION	**71,175**

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING #0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			32,650	32,650		32,650	184,381	217,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			160,130	160,130		160,130	266,164	426,294			32
33	Real Estate Taxes							149,162	149,162			33
34	Rent-Facility & Grounds			1,453,467	1,453,467		1,453,467	(737,746)	715,721			34
35	Rent-Equipment & Vehicles			132,081	132,081		132,081	(20,249)	111,832			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,778,328	1,778,328		1,778,328	(158,288)	1,620,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		505,981	32,961	538,942		538,942		538,942			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			279,176	279,176		279,176		279,176			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		505,981	312,137	818,118		818,118		818,118			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,962,075	1,271,746	5,568,212	14,802,033		14,802,033	(1,302,712)	13,499,321			45

***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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
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	(20,365)	30		9
10	Interest and Other Investment Income	(403)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(213)	2		13
14	Non-Care Related Interest	(1,325)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(326)	21		18
19	Entertainment	(909)	20		19
20	Contributions	(16,600)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(104,269)	27		24
25	Fund Raising, Advertising and Promotional	(93,846)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(307,702)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (545,958)		$	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)	(756,754)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (756,754)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,302,712)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ABINGTON OF GLENVIEW NURSING

ID# 0054189

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGE	$ (28,962)	21	1
2	MARKETING SALARIES	(219,794)	21	2
3	LEGAL FEES	(10,811)	19	3
4	PREFESSIONAL FEES	(330)	19	4
5	EQUIPMENT RENTAL	(19,172)	35	5
6	TRANSPORTATION STAFF	(21,115)	25	6
7	AUTO LEASING	(1,077)	35	7
8	BACKGROUND CHECKS	(6,441)	20	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				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**	(307,702)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(213)	0	0	0	0	0	0	0	0	0	0	(213)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(213)	0	0	0	0	0	0	0	0	0	0	(213)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(612,754)	0	0	0	0	0	0	0	0	(612,754)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,141)	0	0	0	0	0	0	0	0	0	0	(11,141)	19
20	Fees, Subscriptions & Promotions	(117,796)	0	0	0	0	0	0	0	0	0	0	(117,796)	20
21	Clerical & General Office Expenses	(249,082)	0	(64,523)	0	0	0	0	0	0	0	0	(313,605)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(21,115)	0	0	0	0	0	0	0	0	0	0	(21,115)	25
26	Insurance-Prop.Liab.Malpractice	0	19,910	0	0	0	0	0	0	0	0	0	19,910	26
27	Other (specify):*	(104,269)	0	16,559	0	0	0	0	0	0	0	0	(87,710)	27
28	**TOTAL General Administration**	(503,403)	19,910	(660,718)	0	0	0	0	0	0	0	0	(1,144,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(503,616)	19,910	(660,718)	0	0	0	0	0	0	0	0	(1,144,424)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(20,365)	204,746	0	0	0	0	0	0	0	0	0	184,381	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,728)	267,892	0	0	0	0	0	0	0	0	0	266,164	32
33	Real Estate Taxes	0	149,162	0	0	0	0	0	0	0	0	0	149,162	33
34	Rent-Facility & Grounds	0	(737,746)	0	0	0	0	0	0	0	0	0	(737,746)	34
35	Rent-Equipment & Vehicles	(20,249)	0	0	0	0	0	0	0	0	0	0	(20,249)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(42,342)	(115,946)	0	0	0	0	0	0	0	0	0	(158,288)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(545,958)	(96,036)	(660,718)	0	0	0	0	0	0	0	0	(1,302,712)	45

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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
ELISHA ATKIN	40.505	OAKRIDGE HEALTHCARE CENTER,LLC	HILLSIDE, ILL	ABINGTON OF		
DACT MANAGEMENT LLC	12.00			GLENVIEW, PROP	GLENVIEW	REAL ESTATE
SANFORD BOKOR TRUST	4.99	MCALLISTER NURSING & REHAB LLC	COUNTRY CLUB	MCALLISTER		
LAWRENCE SCHWARTZ	2.00		HILS	PROPERTY,LLC	COUNTRY CLUB HILLS	REAL ESTATE
JOEL ATKIN	40.505			INNOVATIVE MGT	MORTON GROVE	MANAGEMENT
				OAKRIDGE		
				PROPERTY, LLC	HILLSIDE	REAL ESTATE

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	RENT	$ 1,453,467	ABINGTON OF GLENVIEW PROPERTIES, LLC		$	$ (1,453,467)	1
2	V	26	INSURANCE - PROPERTY				19,910	19,910	2
3	V	30	DEPRECIATION- IMPROVE				160,924	160,924	3
4	V	30	DEPRECIATION- SL EQUIP				43,822	43,822	4
5	V	32	AMORT LOAN COSTS				27,051	27,051	5
6	V	32	INTEREST				240,841	240,841	6
7	V	33	REAL ESTATE TAXES				149,162	149,162	7
8	V	34	RENT				715,721	715,721	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,453,467			$ 1,357,431	$ * (96,036)	14

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	21	Outside Clerical	$ 180,563	INNOVATIVE MANAGEMENT		$	$ (180,563)	15
16	V	17	Management Fees	720,650				(720,650)	16
17	V	17	Administrator- Eli Atkin				37,982	37,982	17
18	V	17	Administration- Joel Atkin				37,982	37,982	18
19	V	17	Admiinistrator- Helen Lacek				31,932	31,932	19
20	V	21	Clerical Salaries- Tzvi Atkin				17,570	17,570	20
21	V	21	Clerical Salaries- Corey Fuchs				13,492	13,492	21
22	V	21	Clerical Salaries- Yosef Tsadok				504	504	22
23	V	21	Clerical Salaries				84,474	84,474	23
24	V	27	Payroll Taxes				16,559	16,559	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			$ 901,213			$ 240,495	$ * (660,718)	39

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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								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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	TZVI (STEVE) ATKIN	OTHER ADMIN	Administration		see attached	see attached		SALARY	$ 17,570	17-7	1
2								SALARY	26,069	21-1	2
3						10					3
4	JOEL ATKIN	OTHER ADMIN	Administration ans	40.50	see attached	see attached		SALARY	37,982	17-7	4
5			Financial Servise			0					5
6	ELISHA ATKIN	ADMINISTRATOR	Adiministator	40.50	see attached	see attached		SALARY	37,982	17-7	6
7						10					7
8	YOSEF TZADOK	CLERICAL	Asst in Fin Analysis		see attached	see attached]		SALARY	504	17-7	8
9						40		SALARY	96,895	17-1	9
10											10
11	COREY FUCHS	CLERICAL	Bookkeeping		see attached	see attached		SALARY	13,492	17-7	11
12						0					12
13								TOTAL	$ 230,494		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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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: INNOVATIVE MANAGEMENT ASSOCIATES,
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE ILL 60053
Phone Number: (708) 573-1100
Fax Number: (708) 573-1720

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrator- Eli Atkin	Available Beds	369,015	7	$ 200,000	$ 200,000	70,080	$ 37,982	1
2	17	Administration- Joel Atkin	Available Beds	369,015	7	200,000	200,000	70,080	37,982	2
3	17	Admiinistrator- Helen Lacek	Available Beds	369,015	7	168,140	168,140	70,080	31,932	3
4	21	Clerical Salaries- Tzvi Atkin	Available Beds	369,015	7	92,516	92,516	70,080	17,570	4
5	21	Clerical Salaries- Corey Fuchs	Available Beds	369,015	7	71,046	71,046	70,080	13,492	5
6	21	Clerical Salaries- Yosef Tsadok	Available Beds	369,015	7	2,654	2,654	70,080	504	6
7	21	Clerical Salaries	Available Beds	369,015	7	444,808	444,808	70,080	84,474	7
8	27	Payroll Taxes	Available Beds	369,015	7	87,195		70,080	16,559	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					$ 1,266,359	$ 1,179,164		$ 240,495	25

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	FIFTH THIRD BANK		X	MORTGAGE	38K PLUS INT	8/31/17	$ 20,000,000	$ 19,886,000	8/31/19	VARIABL	$ 240,841	1
2												2
3	LOAN COSTS	X		LOAN COSTS	W/O OVER LOAN		162,304	135,253			27,051	3
4	FIRST INSURANCE										2,340	4
5	VENDORS										3,573	5
	Working Capital											
6	DACT MANAGEMENT	X		WORKING CAPITAL	INT ONLY	4/1/16	1,000,000	900,000	REVOLV	0.0700	91,893	6
7	BANK LEUMI		X	WORKING CAPITAL	INT ONLY	6/8/16	300,000		REVOLV		50,344	7
8	FIFTH THIRD BANK		X	WORKING CAPITAL	INT ONLY	8/31/17	300,000	825,000			10,655	8
9	TOTAL Facility Related						$ 21,762,304	$ 21,746,253			$ 426,697	9
	B. Non-Facility Related*											
10				BED TAX							1,325	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,325	14
15	TOTALS (line 9+line14)						$ 21,762,304	$ 21,746,253			$ 428,022	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** 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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	357,986	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	149,162	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015		11
2016	357,986	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~100% OF THE PRIOR YEAR REAL ESTATE TAX BILL - THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL. REAL ESTATE TAX EXP IS BASED ON 100% OF 2016 TAX BILL (357,986) MINUS 208,824 FOR PRIOR OWNER PORTION

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ABINGTON OF GLENVIEW NURSING COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054189

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-32-401-167-0000	NURSING HOME	$ 357,986.00	$ 357,986.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 357,986.00	$ 357,986.00

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 X 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,817 B. General Construction Type: Exterior BRICK MASONRY Frame STEEL Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (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 [ ] (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).

N/A

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	NURSING HOME		2017	$ 1,472,000	1
2					2
3	TOTALS			$ 1,472,000	3

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	192		2017	1989	$ 16,235,484	$ 156,110	39	$ 156,110	$	$ 156,110	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR REHAB			2017	9,960	32	39	32		32	9
10	TILING, MOLDING, & CHARI RAIL			2017	345,756	1,847	39	1,847		1,847	10
11	CABINETS AND COUNTERTOPS-BISTRO AREA			2017	30,000	160		160		160	11
12	CABINETS AND COUNTERTOPS-NURSE STATION			2017	20,000	107		107		107	12
13	CABINETS AND COUNTERTOPS-THERAPY AREA			2017	25,000	134		134		134	13
14	CABINETS AND COUNTERTOPS-BACK THERAPY AREA			2017	10,000	53		53		53	14
15	CABINETS AND COUNTERTOPS-RECEPTION DESK			2017	5,000	27		27		27	15
16	CABINETS AND COUNTERTOPS-FRONT LOBBY AREA			2017	10,000	53		53		53	16
17	FIRST FLOOR REMODEL-INTEGREL CONSTRUCT GEN CONTRAC			2017	449,392	2,401		2,401		2,401	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											34
35											35
36											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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 17,140,592	$ 160,924		$ 160,924	$	$ 160,924	70

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 106,126	$ 13,536	$ 10,613	$ (2,923)	10 YRS	$ 15,919	71
72	Current Year Purchases	33,447	19,114	1,672	(17,442)	10 YRS	1,672	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		43,822	43,822				74
75	TOTALS	$ 139,573	$ 76,472	$ 56,107	$ (20,365)		$ 17,591	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)	$ 18,752,165	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 237,396	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 217,031	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,365)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 178,515	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		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GLENRIDGE ASSOCIATES II D/B/A/THE ABINGTON OF GLENVIEW

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 [X] 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:	1989	192	4/1/16	$ 1,453,467			3
4	Additions							4
5								5
6								6
7	TOTAL		192		$ 1,453,467 **			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: [X] 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.	4/1/2017	$
13.	4/1/2018	$
14.	4/1/2019	$

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: $ 131,004 Description:
(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			$	$	17
18				1,077	18
19					19
20					20
21	TOTAL		$	$ 1,077	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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,700			2,700	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				504,584		504,584	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB/RADIOLOGY;EKG Other (specify): Med. Supplies	39-2				30,261	1,397		30,261 1,397	13
14	TOTAL			$		$ 32,961	$ 505,981		$ 538,942	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 ABINGTON OF GLENVIEW NURSING # 0054189 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 287,066	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (120,000))	3,629,648		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,220		6
7	Other Prepaid Expenses	19,463		7
8	Accounts Receivable (owners or related parties)	125,620		8
9	Other(specify): DUE FROM AFFILIATES	3,458,245		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,603,262	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	139,573		16
17	Accumulated Depreciation (book methods)	(91,400)		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 (spe Deposit on Fixed Asse	25,695		22
23	Other(specify): Abington of Glenview Properties	888,599		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 962,467	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,565,729	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,538,192	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	825,000		29
30	Accrued Salaries Payable	530,612		30
31	Accrued Taxes Payable (excluding real estate taxes)	389,628		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO PRIOR OWNER	5,874		36
37	DUE TO ABINGTON OF GLENVIEW PI	1,743,442		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,032,748	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	87,130		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	NOTE PAYABLE - DACT	900,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 987,130	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,019,878	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,545,851	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,565,729	$	48

***(See instructions.)**

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,503,498	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,503,496	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,080,876	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	(26,929)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	(11,592)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,042,355	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)**	$ 2,545,851	24 *

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

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 15,102,518	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,102,518	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	497,157	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 497,157	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	(548)	13
14	Non-Patient Meals	3,844	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,296	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	403	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 403	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VACATION PAY SETTLEMENTS	279,535	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 279,535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,882,909	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,845,432	31
32	Health Care	6,699,246	32
33	General Administration	3,660,909	33
	B. Capital Expense		
34	Ownership	1,778,328	34
	C. Ancillary Expense		
35	Special Cost Centers	538,942	35
36	Provider Participation Fee	279,176	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,802,033	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,080,876	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,080,876	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 598,134	44
45	Private Pay - Net Inpatient Revenue	5,579,589	45
46	Medicare - Net Inpatient Revenue	8,546,559	46
47	Other-(specify) INSURANCE	378,236	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,102,518	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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 ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	1,965	2,166	$ 104,758	$ 48.36	1
2	Assistant Director of Nursing	1,973	2,150	87,593	40.74	2
3	Registered Nurses	36,874	39,725	1,275,495	32.11	3
4	Licensed Practical Nurses	15,545	16,523	496,007	30.02	4
5	CNAs & Orderlies	101,084	108,750	1,562,542	14.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	47,641	49,981	1,890,678	37.83	8
9	Activity Director	3,690	4,171	91,526	21.94	9
10	Activity Assistants	12,396	13,218	178,299	13.49	10
11	Social Service Workers	4,660	4,852	114,367	23.57	11
12	Dietician					12
13	Food Service Supervisor	1,940	2,086	56,898	27.28	13
14	Head Cook	7,645	8,755	132,869	15.18	14
15	Cook Helpers/Assistants	28,021	30,668	351,804	11.47	15
16	Dishwashers					16
17	Maintenance Workers	4,349	4,734	109,218	23.07	17
18	Housekeepers	21,850	23,846	310,593	13.02	18
19	Laundry	5,617	6,363	83,962	13.20	19
20	Administrator	2,053	2,110	97,855	46.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,037	2,166	81,214	37.49	23
24	Clerical	19,138	20,683	427,781	20.68	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	12,025	13,294	221,836	16.69	31
32	Other Health Care(specify)	10,212	10,801	286,780	26.55	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	340,715	367,042	$ 7,962,075 *	$ 21.69	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	M	$ 23,440	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,925	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		52,749	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,223	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 100,337		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ABINGTON OF GLENVIEW NURSING # 0054189 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JASON LEE	ADMINISTRATOR		$ 960
YOSEF TSADOK	ADMINISTRATOR		96,895
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,855

B. Administrative - Other

Description	Amount
	$
MANAGEMENT FEES - INNOVATIVE	720,650
TOTAL (agree to Schedule V, line 17, col. 3)	$ 720,650
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		137,912
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 137,912

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 185,626
Unemployment Compensation Insurance		58,545
FICA Taxes		576,805
Employee Health Insurance		645,171
Employee Meals		71,175
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		21,553
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 1,558,875

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	16,600
MARKETING/ADV/PROMO	94,755
LICENSES/DUES/SUBSCRIPTIONS	14,387
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(16,600)
Less: Public Relations Expense	(909)
Non-allowable advertising	(93,846)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,387

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

ABINGTON OF GLENVIEW NURSING
Legal Fee Schedule

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **279,176**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **71,175** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(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 fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NO**
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:

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