		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0026237

Facility Name: Glenview Terrace Nsg. 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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,592	22,170	48,432	89,194	8
9	SNF/PED					9
10	ICF	2,305			2,305	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,897	22,170	48,432	91,499	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.84%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 16,669

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: 12/31/2018 Fiscal Year: 12/31/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,094,251	105,020		1,199,271		1,199,271	8,806	1,208,077			1
2	Food Purchase		1,084,342		1,084,342	(189,216)	895,126	(5,631)	889,495			2
3	Housekeeping	652,775	96,170		748,945		748,945	16,000	764,945			3
4	Laundry	120,263	398,187		518,450		518,450		518,450			4
5	Heat and Other Utilities			317,296	317,296		317,296	7,703	324,999			5
6	Maintenance	276,695	122,371	324,489	723,555		723,555	(15,608)	707,947			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,143,984	1,806,090	641,785	4,591,859	(189,216)	4,402,643	11,270	4,413,913			8
	B. Health Care and Programs											
9	Medical Director			174,000	174,000		174,000		174,000			9
10	Nursing and Medical Records	7,962,056	402,726	779,259	9,144,041		9,144,041	(13,997)	9,130,044			10
10a	Therapy											10a
11	Activities	654,333	71,166	8,726	734,225		734,225		734,225			11
12	Social Services	318,904		4,200	323,104		323,104		323,104			12
13	CNA Training											13
14	Program Transportation			11,621	11,621		11,621		11,621			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	8,935,293	473,892	977,806	10,386,991		10,386,991	(13,997)	10,372,994			16
	C. General Administration											
17	Administrative	329,247			329,247		329,247		329,247			17
18	Directors Fees											18
19	Professional Services			425,413	425,413		425,413	1,841	427,254			19
20	Dues, Fees, Subscriptions & Promotions			341,350	341,350		341,350	(264,527)	76,823			20
21	Clerical & General Office Expenses	527,281	3,710	461,014	992,005		992,005	93,481	1,085,486			21
22	Employee Benefits & Payroll Taxes			2,222,059	2,222,059	189,216	2,411,275	(647)	2,410,628			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,777	16,777		16,777	315	17,092			24
25	Other Admin. Staff Transportation			15,606	15,606		15,606	(12,014)	3,592			25
26	Insurance-Prop.Liab.Malpractice			710,879	710,879		710,879	3,401	714,280			26
27	Other (specify):*							111,099	111,099			27
28	**TOTAL General Administration**	856,528	3,710	4,193,098	5,053,336	189,216	5,242,552	(67,051)	5,175,501			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	11,935,805	2,283,692	5,812,689	20,032,186		20,032,186	(69,778)	19,962,408			29

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr #0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			111,450	111,450		111,450	476,755	588,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			454,678	454,678		454,678	(199,092)	255,586			32
33	Real Estate Taxes							953,709	953,709			33
34	Rent-Facility & Grounds			1,978,000	1,978,000		1,978,000	(1,978,000)				34
35	Rent-Equipment & Vehicles			63,905	63,905		63,905	(7,493)	56,412			35
36	Other (specify):*							73,628	73,628			36
37	**TOTAL Ownership**			2,608,033	2,608,033		2,608,033	(680,493)	1,927,540			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	3,380,464	1,210,466		4,590,930		4,590,930		4,590,930			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			615,886	615,886		615,886		615,886			42
43	Other (specify):*	92,710			92,710		92,710	(92,710)				43
44	**TOTAL Special Cost Centers**	3,473,174	1,210,466	615,886	5,299,526		5,299,526	(92,710)	5,206,816			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	15,408,979	3,494,158	9,036,608	27,939,745		27,939,745	(842,981)	27,096,764			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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,015)	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	(57,738)	30		9
10	Interest and Other Investment Income	(427,920)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,616)	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	(18,950)	21		18
19	Entertainment				19
20	Contributions	(20,600)	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	(282,620)	21		24
25	Fund Raising, Advertising and Promotional	(56,733)	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	(806,536)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,676,728)		$	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)	833,747		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 833,747		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (842,981)		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 Nsg. Ctr

ID# 0026237

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (3,604)	21	1
2	Payroll - Drivers	(19,147)	43	2
3	Marketing Dept. - In House	(73,563)	43	3
4	Veteran Expenses	(13,997)	10	4
5	Life Insurance	(647)	22	5
6	Bank Charges	(20,848)	21	6
7	Credit Card Fees	(67,412)	21	7
8	Non-allowable Travel	(12,014)	25	8
9	Public Relations	(161,223)	20	9
10	Building Co. - Office Expense	(15)	21	10
11	Building Co. - Audit	(16,073)	19	11
12	Building Co.- Amort of Loan Cost	(5,532)	36	12
13	Non-allowable Rent	(60,000)	34	13
14	PAC Dues	(26,690)	20	14
15	Non-allowable Seminars	(4,156)	24	15
16	Non-allowable Legal	(18,363)	19	16
17	Capitalized R&M	(37,160)	06	17
18	Non-allowable Interest	(255,917)	32	18
19	Non-allowable Auto Lease	(10,133)	35	19
20	Late Fees	(42)	21	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**	(806,536)		49

Glenview Terrace Nsg. Ctr

ID# 0026237

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			8,806									8,806	1
2	Food Purchase	(5,631)											(5,631)	2
3	Housekeeping			16,000									16,000	3
4	Laundry													4
5	Heat and Other Utilities			7,703									7,703	5
6	Maintenance	(37,160)	7,069	14,483									(15,608)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(42,791)	7,069	46,992									11,270	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(13,997)											(13,997)	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**	(13,997)											(13,997)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(34,436)	29,528	6,749									1,841	19
20	Fees, Subscriptions & Promotions	(265,246)		719									(264,527)	20
21	Clerical & General Office Expenses	(393,491)	15	486,957									93,481	21
22	Employee Benefits & Payroll Taxes	(647)											(647)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(4,156)		4,471									315	24
25	Other Admin. Staff Transportation	(12,014)											(12,014)	25
26	Insurance-Prop.Liab.Malpractice			3,401									3,401	26
27	Other (specify):*			111,099									111,099	27
28	**TOTAL General Administration**	(709,990)	29,543	613,396									(67,051)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(766,778)	36,612	660,388									(69,778)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(57,738)	507,996	26,497									476,755	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(683,837)	463,663	21,082									(199,092)	32
33	Real Estate Taxes		928,929	24,780									953,709	33
34	Rent-Facility & Grounds	(60,000)	(1,918,000)										(1,978,000)	34
35	Rent-Equipment & Vehicles	(10,133)		2,640									(7,493)	35
36	Other (specify):*	(5,532)	79,160										73,628	36
37	**TOTAL Ownership**	(817,240)	61,748	74,999									(680,493)	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):*	(92,710)											(92,710)	43
44	**TOTAL Special Cost Centers**	(92,710)											(92,710)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,676,728)	98,360	735,387									(842,981)	45

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,918,000	Glenview Terrace Property, LLC		$	$ (1,918,000)	1
2	V	32	Interest	192	Glenview Terrace Property, LLC		463,855	463,663	2
3	V	21	Office Expense		Glenview Terrace Property, LLC		15	15	3
4	V	19	Legal Expense		Glenview Terrace Property, LLC		13,455	13,455	4
5	V	19	Audit Expense		Glenview Terrace Property, LLC		16,073	16,073	5
6	V	36	Amortization of Loan Costs		Glenview Terrace Property, LLC		5,532	5,532	6
7	V	33	Real Estate Tax Expense		Glenview Terrace Property, LLC		928,929	928,929	7
8	V	36	MIP Insurance		Glenview Terrace Property, LLC		73,628	73,628	8
9	V	30	Depreciation		Glenview Terrace Property, LLC		507,996	507,996	9
10	V	06	Additional R&M		Glenview Terrace Property, LLC		7,069	7,069	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,918,192			$ 2,016,552	$ * 98,360	14

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 6633 BLDG./ AK CARE BOOK. SVCS.		$ 8,806	$ 8,806	15
16	V	3	HOUSEKEEPING		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		16,000	16,000	16
17	V	5	UTILITIES		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		7,703	7,703	17
18	V	6	REPAIRS AND MAINT.		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		14,483	14,483	18
19	V	19	PROFESSIONAL FEES		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		6,749	6,749	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		719	719	20
21	V	21	CLERICAL AND GENERAL		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		66,458	66,458	21
22	V	24	EDUCATION AND SEMINARS		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		4,471	4,471	22
23	V	26	INSURANCE		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		3,401	3,401	23
24	V	30	DEPRECIATION		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		26,497	26,497	24
25	V	32	INTEREST		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		21,082	21,082	25
26	V	33	REAL ESTATE TAXES		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		24,780	24,780	26
27	V	33	RE TAX PROTEST FEES		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.				27
28	V	35	EQUIPMENT RENTAL		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		2,640	2,640	28
29	V								29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		420,499	420,499	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.		111,099	111,099	33
34	V								34
35	V								35
36	V	19	BOOKEEPING FEES		ITEX 6633 BLDG./ AK CARE BOOK. SVCS.				36
37	V								37
38	V								38
39	Total			$			$ 735,387	$ * 735,387	39

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	22	EMPLOYEE BENEFITS	$ 210,248	ITEX CARE GROUP, INC.		$ 210,248	$	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			$ 210,248			$ 210,248	$ *	39

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2
3	AHUVA WEINREB	1.18%	WHITEHALL NORTH	DEERFIELD	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	ALBERT MILSTEIN	2.17%			ITEX CARE GROUP, INC.	LINCOLNWOOD	EMPLOYEE BENEFITS	4
5	BARBARA GELLER	0.13%						5
6	DAVIS GLENVIEW TERRACE LLC	9.82%						6
7	DENISE CHAN	3.95%						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	Elliott Robinson Delta Disc. Trust	0.13%						14
15	ESTATE OF SHELDON ROBINSON	0.40%						15
16	ESTHER V. STEIN	0.26%						16
17	FEIGE C. KNOBEL DISCRETIONARY TRUST	7.14%						17
18	FREDA ROBINSON	1.28%						18
19	FREDA ROBINSON REVOCABLE TRUST	0.99%						19
20	Gail Levitt Delta Disc. Trust	0.13%						20
21	HENRY CHEN	1.98%						21
22	IRVING CUTLER	0.40%						22
23	J & J PARTNERSHIP	8.26%						23
24	JACK RAJCHENBACH FAMILY TRUST	3.35%						24
25	JANET HARRIS	2.37%						25
26	JOEL E. JACOBSON	0.26%						26
27	LAURENCE & CORALIE ZUNG	4.15%						27
28	LEAH FINK REPARATIONS TRUST	1.98%						28
29	LEONARD & MOLLY BOLNICK	0.79%						29
30	MARK HOLLANDER DISCRETIONARY TRUST	7.14%						30

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	MOSHE Y. DAVIS	1.18%						1
2	NESANEL B. DAVIS	1.18%						2
3	RAJCHENBACH GLENVIEW TERRACE LLC	9.80%						3
4	ROBINSON - LEVITT FAMILY TRUST	0.30%						4
5	SHARON HOLLANDER DISCRETIONARY TRST	7.14%						5
6	SHELDON ROBINSON DELTA TRUST	1.98%						6
7	SHELDON ROBINSON REVOCABLE TRUST	3.56%						7
8	SHOSHANA BRAUN	1.18%						8
9	SNYDER - MILSTEIN LLC	0.99%						9
10	SOREL SIMON TRUST	0.40%						10
11	STEVE AND BARBARA GELLER	0.30%						11
12	YEHOSHUA Y. DAVIS	1.18%						12
13	YEHUDA SILVER	0.59%						13
14	YISROEL M. DAVIS	1.18%						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mark Hollander	Relative	Administrative	0%	See Attached	24	45.00%	Salary	$ 146,165	17-01	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	$ 146,165		13

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 6633 BLDG./ AK CARE BOOK. SVCS.
Street Address: 6633 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	270,830	3	$ 20,810	$	114,610	$ 8,806	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	270,830	3	37,810		114,610	16,000	2
3	5	UTILITIES	AVAILABLE BED DAYS	270,830	3	18,203		114,610	7,703	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	270,830	3	34,225		114,610	14,483	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	270,830	3	15,949		114,610	6,749	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	270,830	3	1,698		114,610	719	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	270,830	3	157,045		114,610	66,458	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	270,830	3	10,566		114,610	4,471	8
9	26	INSURANCE	AVAILABLE BED DAYS	270,830	3	8,038		114,610	3,401	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	270,830	3	62,614		114,610	26,497	10
11	32	INTEREST	AVAILABLE BED DAYS	270,830	3	49,819		114,610	21,082	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	270,830	3	58,556		114,610	24,780	12
13	33	RE TAX PROTEST FEES	AVAILABLE BED DAYS	270,830	3			114,610		13
14	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	270,830	3	6,239		114,610	2,640	14
15										15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	982,795	982,795		420,499	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	259,661			111,099	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,724,028	$ 982,795		$ 735,387	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 CARE GROUP, INC.
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	22	EMPLOYEE BENEFITS	INSURANCE PREMIUM			$	$		$ 210,248	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					$	$		$ 210,248	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 14,616,478			$ 463,855	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				2,907,505			184,071	6
7	INAC		X	Insurance Financing							14,689	7
8												8
9	TOTAL Facility Related						$	$ 17,523,983			$ 662,615	9
	B. Non-Facility Related*											
10	Interest Income		X								(427,920)	10
11	Interest Income - Bldg. Co.		X								(192)	11
12	Allocated from ITEX/AK Care		X								21,082	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (407,030)	14
15	TOTALS (line 9+line14)						$	$ 17,523,983			$ 255,585	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 73,628 Line # 36

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 978,879	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.)		$ 955,418	2
3. Under or (over) accrual (line 2 minus line 1).		$ (23,461)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 977,170	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.		$ 953,709	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	886,032	8
	2014	913,886	9
	2015	930,933	10
	2016	932,278	11
	2017	930,638	12

2018 Accrual: $930,638 x 1.05 = $977,170 (Rounded)

Beginning Accrual Adjusted

Allocated from ITEX/AK Care: $24,780

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenview Terrace Nsg. Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 930,638.37	$ 930,638.37
2.	10-35-312-022-0000	Allocated from ITEX	$ 58,284.84	$ 23,579.75
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 988,923.21	$ 954,218.12

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenview Terrace Nsg. Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$	35	$	$	$ 2,750,940	4
5				1989	1,453,936		35	36,348	36,348	1,060,785	5
6				2002	4,266,341	507,996	35	106,659	(401,337)	853,271	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			107,015	22
23	Various			1990	98,033		20			85,774	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			43,883	28
29	Various			1996	93,171		20			93,164	29
30	Various			1997	102,244		20	1,528	1,528	75,481	30
31	Various			1998	103,389		20	2,144	2,144	101,883	31
32	Various			1999	150,958		20	3,525	3,525	149,853	32
33	Various			2000	37,198		20	1,860	1,860	33,991	33
34	Various			2001	217,477		20	10,876	10,876	191,300	34
35	Various			2002	5,478,039		20	190,949	190,949	4,786,276	35
36	Various			2003	1,988,331		20	51,600	51,600	1,543,152	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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 152,653	37
38	Various	2005	112,564		20	1,287	1,287	108,387	38
39	Various	2006	43,728		20			43,728	39
40	Various	2007	78,767		20	1,525	1,525	74,009	40
41	Various	2008	249,755		20	2,077	2,077	247,717	41
42	Various	2009	186,004		20	4,711	4,711	54,206	42
43	Various	2010	61,561		20	3,459	3,459	51,306	43
44	Various	2011	183,418		20	12,527	12,527	152,673	44
45	Various	2012	129,851		20	3,737	3,737	106,534	45
46	Various	2013	16,374		20	1,149	1,149	9,716	46
47	Various	2014	167,372		20	17,336	17,336	82,254	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)		900,674	21,993		22,454	462	676,466	68
69	Financial Statement Depreciation			111,450			(111,450)		69
70	TOTAL (lines 4 thru 69)		$ 19,402,861	$ 641,439		$ 476,711	$ (164,727)	$ 13,844,809	70

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 19,402,861	$ 641,439		$ 476,711	$ (164,727)	$ 13,844,809	1
2	Wallpaper Project - Hallway	2015	35,504		20	3,550	3,550	12,426	2
3	Door Alerts	2015	4,274		20	611	611	2,035	3
4	Door Alerts	2015	4,274		20	611	611	1,984	4
5	Door Alerts	2015	4,274		20	611	611	1,933	5
6	Wallpaper Project - Hallway	2015	3,278		20	328	328	1,120	6
7	Shower Wall Tile	2015	3,200		20	160	160	640	7
8	Generator Repair	2015	7,331		20	367	367	1,191	8
9	Built In Drawers And Tops	2015	3,000		20	600	600	2,350	9
10	Cables And Jacks	2015	5,460		20	273	273	978	10
11	Wallpaper Project - Hallways & Dining Room	2015	8,474		20	424	424	1,377	11
12	Design Dining/Patient Rm/Wallcovering/Lighting 1St/2Nd Flr Bath	2016	3,540		20	177	177	531	12
13	Wallpaper Dining / Excercise Rooms & Elevators	2016	5,260		20	263	263	789	13
14	Lighting Fixtures	2016	43,036		20	2,152	2,152	6,276	14
15	Privacy Panels & Roman Shades	2016	56,757		20	2,838	2,838	6,385	15
16	2Nd Floor - Vinyl Tile & Install Wallbase	2016	12,000		20	600	600	1,700	16
17	2Nd Floor - Vinyl Tile	2016	12,917		20	646	646	1,561	17
18	2Nd Floor - Vinyl Tile	2016	3,293		20	165	165	384	18
19	2Nd Floor - Vinyl Tile In Rooms 254, 269, 282	2016	13,793		20	690	690	1,552	19
20	Remove Carpet & Install Luxury Vinyl Tile - 2Nd Floor	2016	118,260		20	5,913	5,913	12,811	20
21	Elevator Repair - Modernization	2016	101,283		20	5,064	5,064	12,238	21
22	Taco In Line Circulating Pump	2016	4,300		20	215	215	609	22
23	Raypak Boiler	2016	12,985		20	649	649	1,840	23
24	Taco In Line Circulating Pump	2016	5,200		20	260	260	585	24
25	Electrical Work Can Lights All Rooms	2016	6,000		20	300	300	825	25
26	Electrical Work Can Lights All Rooms	2016	5,700		20	285	285	689	26
27	Electrical Work - Elevators	2016	6,147		20	307	307	640	27
28	Signs	2016	4,861		20	243	243	689	28
29	Gas Water Heater	2016	7,941		20	397	397	827	29
30	Handrails	2016	2,500		20	125	125	365	30
31	Wallpaper - 2Nd Floor Corridor, Private/Exercise/Rehab Rooms	2016	29,860		20	1,493	1,493	3,235	31
32	Cable Drops Resident Tv'S	2016	18,000		20	900	900	2,625	32
33	Cable Drops Resident Tv'S	2016	11,813		20	591	591	1,378	33
34	TOTAL (lines 1 thru 33)		$ 19,967,376	$ 641,439		$ 508,519	$ (132,919)	$ 13,929,377	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 19,967,376	$ 641,439		$ 508,519	$ (132,919)	$ 13,929,377	1
2	Wallpaper In Hallways/Doors/Nooks/Nurses Station	2016	2,837		20	567	567	1,702	2
3	Level Parking Area, Asphalt Patch To Holes In Parking Area/Drive	2016	2,550		20	128	128	298	3
4	Repair Sewers In Parking Area With Mortar/Cement; Apply Aspha	2016	2,850		20	143	143	321	4
5	Elevator	2017	21,723		20	1,086	1,086	2,172	5
6	Blacktop Paving	2017	3,475		20	174	174	290	6
7	Switch Replacement	2017	3,146		20	157	157	184	7
8	Compressor Replacement	2017	3,735		20	187	187	358	8
9	Roof Top Compressor Replacement	2017	4,545		20	227	227	322	9
10	Kitchen Blower Replacement	2017	4,106		20	205	205	291	10
11	Compressor Replacement - Heat Pump	2017	3,245		20	162	162	230	11
12	Condensor Fan Motor	2017	4,113		20	206	206	223	12
13	Wiring Elevator	2017	5,698		20	285	285	570	13
14	Fire Alarm Repairs	2017	9,853		20	493	493	985	14
15	Tower Pump Repairs	2017	3,107		20	155	155	272	15
16	Add More Switch Position Contacts To Elevaotr Contacts	2017	2,863		20	143	143	286	16
17	Door Locks And Frames	2018	4,051		20	473	473	473	17
18	Repaired 2 Compressors In Basement	2018	8,873		20	444	444	444	18
19	Repaired Burners For Boilers	2018	3,148		20	52	52	52	19
20	Repaired Valves And Gaskets For Turbo Charger Of Generator	2018	5,541		20	923	923	923	20
21	Installed New Fuel Tank	2018	10,194		20	680	680	680	21
22	Installed Water Heater	2018	6,792		20	1,019	1,019	1,019	22
23	Parking Lot Asphalt Repairs	2018	19,260		20	642	642	642	23
24	Asphalt Striping Parking Lot	2018	3,800		20	127	127	127	24
25	Window And Door Replacement And Brickwork	2018	5,945		20	248	248	248	25
26	Cast Iron Replacement For Back Stairs	2018	2,795		20	140	140	140	26
27	Generator Repair	2018	4,314		20	216	216	216	27
28	Cooler Repair And Water Tank In Basement	2018	3,371		20	169	169	169	28
29	Roof Repair	2018	2,625		20	131	131	131	29
30	Compressor Repair In 2Nd Floor	2018	3,871		20	194	194	194	30
31	Installed On 3Rd Floor Room Honeywell Control Panel/Electrical	2018	2,540		20	127	127	127	31
32	Repaired Heat Pump Pipes In Basement Boiler Room	2018	5,487		20	274	274	274	32
33	Compressor Repair In Basement	2018	3,264		20	163	163	163	33
34	TOTAL (lines 1 thru 33)		$ 20,141,093	$ 641,439		$ 518,859	$ (122,580)	$ 13,943,902	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 20,141,093	$ 641,439		$ 518,859	$ (122,580)	$ 13,943,902	1
2	Installed Wall Mount Stopper Station At 2Nd Floor,3Rd Flr Electri	2018	2,818		20	141	141	141	2
3	Seal Coating - Installed Stones/Asphalt	2018	2,900		20	145	145	145	3
4	Patched Driveway & Parking Area	2018	3,175		20	159	159	159	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,149,985	$ 641,439		$ 519,303	$ (122,136)	$ 13,944,347	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 20,149,985	$ 641,439		$ 519,303	$ (122,136)	$ 13,944,347	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,149,985	$ 641,439		$ 519,303	$ (122,136)	$ 13,944,347	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 6633 Bldg.	1993	678,804	17,405	20	19,394	1,989	496,171	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ITEX 6633 Bldg.	1993	85,413	502	20		(502)	85,413	9
10	Allocated from ITEX 6633 Bldg.	1994	45,877	1,193	20		(1,193)	45,873	10
11	Allocated from ITEX 6633 Bldg.	1995	7,819	21	20		(21)	7,819	11
12	Allocated from ITEX 6633 Bldg.	1996	443		20			443	12
13	Allocated from ITEX 6633 Bldg.	1997	13,189	338	20		(338)	13,189	13
14	Allocated from ITEX 6633 Bldg.	1999	1,465	38	20	73	36	1,465	14
15	Allocated from ITEX 6633 Bldg.	2005	6,413		20	321	321	4,289	15
16	Allocated from ITEX 6633 Bldg.	2007	7,940	185	20	397	212	4,469	16
17	Allocated from ITEX 6633 Bldg.	2008	30,261	776	20	1,000	224	10,577	17
18	Allocated from ITEX 6633 Bldg.	2009	1,649	42	20	165	123	1,566	18
19	Allocated from ITEX 6633 Bldg.	2010	3,522		20	176	176	1,475	19
20	Allocated from ITEX 6633 Bldg.	2014	14,701	847	20	735	(112)	3,328	20
21	Allocated from ITEX 6633 Bldg.	2016	1,683	43	20	168	125	365	21
22	Allocated from ITEX 6633 Bldg.	2018	1,497	602	20	25	(576)	25	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)		$ 900,674	$ 21,993		$ 22,454	$ 462	$ 676,466	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 900,674	$ 21,993		$ 22,454	$ 462	$ 676,466	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 900,674	$ 21,993		$ 22,454	$ 462	$ 676,466	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,368,949	$ 135	$ 64,627	$ 64,492	10	$ 959,545	71
72	Current Year Purchases	34,212	4,369	4,235	(134)	10	4,235	72
73	Fully Depreciated Assets	3,582,674		40	40	10	3,582,504	73
74								74
75	TOTALS	$ 4,985,834	$ 4,504	$ 68,902	$ 64,398		$ 4,546,284	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)	$ 25,303,321	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 645,943	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 588,206	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (57,738)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 18,490,631	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 Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 42,871 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	$ 861.80	$ 13,542	17
18					18
19					19
20					20
21	TOTAL		$ 861.80	$ 13,542	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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 1,013,816		$	$		$ 1,013,816	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	132,720			18,960		151,680	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	2,059,626					2,059,626	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				907,363		907,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			174,302			284,143		458,445	13
14	TOTAL			$ 3,380,464		$	$ 1,210,466		$ 4,590,930	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 Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$	$ 115,867	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,793,383	3,793,383	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	487,112	487,112	6
7	Other Prepaid Expenses	20,697	20,697	7
8	Accounts Receivable (owners or related parties)	295,671	295,671	8
9	Other(specify): See Attached Schedule	494,604	1,095,909	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,092,967	$ 5,810,139	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		198,820	13
14	Buildings, at Historical Cost		8,932,843	14
15	Leasehold Improvements, at Historical Cost	1,442,565	9,825,160	15
16	Equipment, at Historical Cost	2,066,813	5,689,056	16
17	Accumulated Depreciation (book methods)	(3,152,368)	(18,843,530)	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	10,827,877	11,285,822	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,184,887	$ 17,088,171	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,277,854	$ 22,898,310	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,034,753	$ 2,055,753	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,907,505	2,907,505	29
30	Accrued Salaries Payable	527,580	527,580	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,608	14,608	31
32	Accrued Real Estate Taxes(Sch.IX-B)		977,170	32
33	Accrued Interest Payable	21,666	21,666	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	56,317	232,544	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,562,429	$ 6,736,826	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,616,478	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)**	$	$ 14,616,478	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,562,429	$ 21,353,304	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,715,425	$ 1,545,006	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,277,854	$ 22,898,310	48

*(See instructions.)

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,205,999	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,206,000	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	509,425	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)**	$ 509,425	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)**	$ 10,715,425	24 *

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 27,466,697	1
2	Discounts and Allowances for all Levels	(7,618,929)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 19,847,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,412,034	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,412,034	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,015	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,206,412	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	456,156	19
20	Radiology and X-Ray		20
21	Other Medical Services	92,261	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,757,844	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	427,920	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 427,920	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,604	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,604	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 28,449,170	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,591,859	31
32	Health Care	10,386,991	32
33	General Administration	5,053,336	33
	B. Capital Expense		
34	Ownership	2,608,033	34
	C. Ancillary Expense		
35	Special Cost Centers	4,683,640	35
36	Provider Participation Fee	615,886	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 27,939,745	40
41	**Income before Income Taxes (line 30 minus line 40)****	509,425	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 509,425	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,831,003	44
45	Private Pay - Net Inpatient Revenue	5,888,032	45
46	Medicare - Net Inpatient Revenue	4,544,078	46
47	Other-(specify) Insurance	768,839	47
48	Other-(specify) Veteran, MMAI	4,815,816	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 19,847,768	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,476	2,086	$ 106,453	$ 51.03	1
2	Assistant Director of Nursing	1,829	2,086	98,497	47.22	2
3	Registered Nurses	81,058	89,405	2,829,994	31.65	3
4	Licensed Practical Nurses	60,198	64,430	1,867,463	28.98	4
5	CNAs & Orderlies	177,588	196,518	2,994,549	15.24	5
6	CNA Trainees					6
7	Licensed Therapist	90,642	100,047	3,380,464	33.79	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,840	2,154	46,187	21.44	9
10	Activity Assistants	47,372	50,740	608,146	11.99	10
11	Social Service Workers	14,237	16,316	318,904	19.55	11
12	Dietician					12
13	Food Service Supervisor	9,585	10,731	269,540	25.12	13
14	Head Cook	8,223	9,390	124,570	13.27	14
15	Cook Helpers/Assistants	49,703	54,098	700,141	12.94	15
16	Dishwashers					16
17	Maintenance Workers	12,596	15,026	276,695	18.41	17
18	Housekeepers	44,837	51,128	652,775	12.77	18
19	Laundry	8,406	9,310	120,263	12.92	19
20	Administrator	1,815	2,086	112,008	53.70	20
21	Assistant Administrator	2,900	3,211	71,074	22.13	21
22	Other Administrative	1,555	1,702	146,165	85.88	22
23	Office Manager	3,408	4,030	98,146	24.35	23
24	Clerical	20,615	22,738	429,135	18.87	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	2,685	3,128	65,100	20.81	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,930	4,121	92,710	22.50	33
34	TOTAL (lines 1 - 33)	646,498	714,481	$ 15,408,979 *	$ 21.57	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		$		35
36	Medical Director	Monthly	174,000	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	84,000	10-03	38
39	Pharmacist Consultant	Monthly	29,899	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	8,726	11-03	44
45	Social Service Consultant	Monthly	4,200	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 305,625		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13,211	$ 660,560	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	13,211	$ 660,560		53

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bradley Bartels	Administrator	0	$ 112,008
Mark Hollander	Exec. Director	0	146,165
Sandra Cedrinds	Controller	0	42,782
Various	Assit Admin	0	28,292
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 329,247

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
PointClick Care	Data Processing	$ 49,865
Cave/Provinet	Data Processing	25,487
Ability Network	Data Processing	9,933
Paylocity	Data Processing	13,430
Netsmart / Health Medx	Data Processing	59,747
Great American Financial	Time Clock Software	14,215
Patient Ping	Data Processing	4,500
Casamba	Data Processing	770
See Attached	Legal Fees	186,960
Personnel Planners	Unemployment Consultant	1,893
HK Payroll	Payroll Processing	1,186
See Supplemental Schedule		57,427
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 425,413

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 271,843
Unemployment Compensation Insurance	76,505
FICA Taxes	1,153,343
Employee Health Insurance	540,393
Employee Meals	189,216
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	37,356
Misc. Employee Benefits	12,261
Savings Plan - Union	100,586
Christmas Expenses	29,125
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,410,628

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	$ 1,990
Advertising: Employee Recruitment	14,368
Health Care Worker Background Check	11,950
(Indicate # of checks performed 1195)	
Patient Background Checks	
Dues and Subscriptions	46,773
Licenses and Permits	1,023
Allocated from ITEX/AK Care	719
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 76,823

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,621
Allocated from ITEX/AK Care	4,471
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,092

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **HCCI - $53,380**

(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. $ **58,753** 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? YES **X** 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. $ **615,886**
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. $ **189,216** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,015**

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

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

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

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