

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**I. IDPH Facility ID Number:** 0026237

**Facility Name:** Glenview Terrace Nursing Ctr

**Address:** 1511 Greenwood Road Glenview 60025  
 Number City Zip Code

**County:** Cook

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

**HFS ID Number:** 362846112001

**Date of Initial License for Current Owners:** 11/01/75

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 06/19/06

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>307</u>	Skilled (SNF)	<u>313</u>	<u>113,231</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>307</u>	TOTALS	<u>313</u>	<u>113,231</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,152</u>	<u>23,277</u>	<u>23,414</u>	<u>72,843</u>	8
9	SNF/PED					9
10	ICF	<u>31,431</u>	<u>2,406</u>	<u>348</u>	<u>34,185</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>57,583</u>	<u>25,683</u>	<u>23,762</u>	<u>107,028</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.52%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 12/01/75

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 307 and days of care provided 19,702

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	651,778	104,803	9,742	766,323		766,323	4,895	771,218			1
2	Food Purchase		583,305		583,305	(89,352)	493,953	(5,473)	488,480			2
3	Housekeeping	456,633	100,854		557,487		557,487	14,787	572,274			3
4	Laundry	260,547	51,420		311,967		311,967		311,967			4
5	Heat and Other Utilities			337,678	337,678		337,678	4,986	342,664			5
6	Maintenance	263,791	93,838	181,516	539,145		539,145	(931)	538,214			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>1,632,749</b>	<b>934,220</b>	<b>528,936</b>	<b>3,095,905</b>	<b>(89,352)</b>	<b>3,006,553</b>	<b>18,264</b>	<b>3,024,817</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			94,750	94,750		94,750		94,750			9
10	Nursing and Medical Records	6,726,576	335,665	53,329	7,115,570		7,115,570	(2,945)	7,112,625			10
10a	Therapy	836,548			836,548		836,548		836,548			10a
11	Activities	396,831	31,094	6,275	434,200		434,200	(10,907)	423,293			11
12	Social Services	378,958		2,875	381,833		381,833		381,833			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>8,338,913</b>	<b>366,759</b>	<b>157,229</b>	<b>8,862,901</b>		<b>8,862,901</b>	<b>(13,852)</b>	<b>8,849,049</b>			16
	<b>C. General Administration</b>											
17	Administrative	206,428		83,532	289,960		289,960	65,857	355,817			17
18	Directors Fees											18
19	Professional Services			578,571	578,571		578,571	(445,162)	133,409			19
20	Dues, Fees, Subscriptions & Promotions			207,979	207,979		207,979	(128,162)	79,817			20
21	Clerical & General Office Expenses	302,601	6,775	385,598	694,974		694,974	35,254	730,228			21
22	Employee Benefits & Payroll Taxes			1,638,075	1,638,075	89,352	1,727,427	(960)	1,726,467			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,862	9,862		9,862	2,031	11,893			24
25	Other Admin. Staff Transportation			889	889		889		889			25
26	Insurance-Prop.Liab.Malpractice			462,124	462,124		462,124	1,197	463,321			26
27	Other (specify):*							101,160	101,160			27
28	<b>TOTAL General Administration</b>	<b>509,029</b>	<b>6,775</b>	<b>3,366,630</b>	<b>3,882,434</b>	<b>89,352</b>	<b>3,971,786</b>	<b>(368,785)</b>	<b>3,603,001</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>10,480,691</b>	<b>1,307,754</b>	<b>4,052,795</b>	<b>15,841,240</b>		<b>15,841,240</b>	<b>(364,373)</b>	<b>15,476,867</b>			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr #0026237 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			182,715	182,715	182,715	1,272,272	1,454,987			30
31	Amortization of Pre-Op. & Org.						218	218			31
32	Interest			450,600	450,600	450,600	664,398	1,114,998			32
33	Real Estate Taxes						526,875	526,875			33
34	Rent-Facility & Grounds			2,340,000	2,340,000	2,340,000	(2,340,000)				34
35	Rent-Equipment & Vehicles			25,013	25,013	25,013	3,487	28,500			35
36	Other (specify):*			2,500	2,500	2,500	93,213	95,713			36
37	<b>TOTAL Ownership</b>			3,000,828	3,000,828	3,000,828	220,463	3,221,291			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	688,169	1,429,749		2,117,918	2,117,918		2,117,918			39
40	Barber and Beauty Shops	5,560		7,310	12,870	12,870		12,870			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			169,847	169,847	169,847		169,847			42
43	Other (specify):*	116,844		18,141	134,985	134,985	(134,985)				43
44	<b>TOTAL Special Cost Centers</b>	810,573	1,429,749	195,298	2,435,620	2,435,620	(134,985)	2,300,635			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	11,291,264	2,737,503	7,248,921	21,277,688	21,277,688	(278,895)	20,998,793			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,080)	02		4
5	Telephone, TV & Radio in Resident Rooms	(40)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	382,491	30		9
10	Interest and Other Investment Income	(363,208)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,393)	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	(371)	21		18
19	Entertainment				19
20	Contributions	(20,300)	20		20
21	Owner or Key-Man Insurance	(960)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,663)	21		24
25	Fund Raising, Advertising and Promotional	(49,855)	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	(636,755)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (755,134)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	476,239		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 476,239		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (278,895)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0026237  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Payroll - Drivers	\$ (39,457)	43	1
2 Marketing Salaries	(77,387)	43	2
3 Veterans Expenses	(2,948)	10	3
4 Bank Charges	(5,579)	21	4
5 Public Relations	(58,554)	20	5
6 Credit Card Fees	(33,143)	21	6
7 Admin Consultant	(4,800)	19	7
8 Accounting Fees - Bldg Co	(6,673)	19	8
9 Licenses and Fees - Bldg Co	(250)	20	9
10 Misc. Income	(192)	21	10
11 Non-Allowable Legal	(16,112)	19	11
12 COPE Adjustment	(7,764)	20	12
13 Non-Allowable Interest	(183,758)	32	13
14 Non-Allowable Other	(18,141)	43	14
15 Capitalized R&M	(5,770)	06	15
16 Misc. Income - Patient Purchases	(16,997)	11	16
17 Non-Allowable Expense	(170,484)	21	17
18			18
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99			99
100			100
101 Total	(636,755)		101

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06**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)	
	<b>A. General Services</b>													
1	Dietary				4,895								4,895	1
2	Food Purchase	(5,473)											(5,473)	2
3	Housekeeping				14,787								14,787	3
4	Laundry													4
5	Heat and Other Utilities				4,986								4,986	5
6	Maintenance	(5,770)			4,839								(931)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(11,243)</b>			<b>29,507</b>								<b>18,264</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(2,945)											(2,945)	10
10a	Therapy													10a
11	Activities	(10,907)											(10,907)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(13,852)</b>											<b>(13,852)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			8,935		65,777	(12,188)	3,333					65,857	17
18	Directors Fees													18
19	Professional Services	(27,485)	6,573	546	(430,760)	2,393	3,488	83					(445,162)	19
20	Fees, Subscriptions & Promotions	(131,665)	250		3,247			6					(128,162)	20
21	Clerical & General Office Expenses	(270,472)		1,245	296,450	3,384	4,592	55					35,254	21
22	Employee Benefits & Payroll Taxes	(960)											(960)	22
23	Inservice Training & Education													23
24	Travel and Seminar				2,010		21						2,031	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				1,197								1,197	26
27	Other (specify):*			1,035	80,917	3,802	15,161	245					101,160	27
28	<b>TOTAL General Administration</b>	<b>(430,582)</b>	<b>6,823</b>	<b>11,761</b>	<b>(46,939)</b>	<b>75,356</b>	<b>11,074</b>	<b>3,722</b>					<b>(368,785)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(455,677)</b>	<b>6,823</b>	<b>11,761</b>	<b>(17,432)</b>	<b>75,356</b>	<b>11,074</b>	<b>3,722</b>					<b>(364,373)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	382,491	874,196		15,572			13					1,272,272	30
31	Amortization of Pre-Op. & Org.				218								218	31
32	Interest	(546,963)	1,179,657		31,704								664,398	32
33	Real Estate Taxes		515,199		11,676								526,875	33
34	Rent-Facility & Grounds		(2,340,000)										(2,340,000)	34
35	Rent-Equipment & Vehicles				3,487								3,487	35
36	Other (specify):*		93,213										93,213	36
37	<b>TOTAL Ownership</b>	<b>(164,472)</b>	<b>322,265</b>		<b>62,657</b>			<b>13</b>					<b>220,463</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(134,985)											(134,985)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(134,985)</b>											<b>(134,985)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(755,134)</b>	<b>329,088</b>	<b>11,761</b>	<b>45,225</b>	<b>75,356</b>	<b>11,074</b>	<b>3,735</b>					<b>(278,895)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Glenview Terrace Property LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 2,340,000	Glenview Terrace Property LLC	100.00%	\$	\$ (2,340,000)	1
2	V	32 Interest Income	2,415	Glenview Terrace Property LLC	100.00%		(2,415)	2
3	V	19 Accounting Fees		Glenview Terrace Property LLC	100.00%	6,573	6,573	3
4	V	20 Licenses and Fees		Glenview Terrace Property LLC	100.00%	250	250	4
5	V	32 Mortgage Interest		Glenview Terrace Property LLC	100.00%	1,136,013	1,136,013	5
6	V	33 Real Estate Taxes		Glenview Terrace Property LLC	100.00%	515,199	515,199	6
7	V	36 MIP Insurance		Glenview Terrace Property LLC	100.00%	78,310	78,310	7
8	V	30 Depreciation		Glenview Terrace Property LLC	100.00%	874,196	874,196	8
9	V	32 Interest Expense		Glenview Terrace Property LLC	100.00%	46,059	46,059	9
10	V	36 Loan Amortization Costs		Glenview Terrace Property LLC	100.00%	14,903	14,903	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,342,415			\$ 2,671,503	\$ * 329,088	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/06Ending: 12/31/06**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 8,935	8,935	15	
16	V	19 PROFESSIONAL FEES				546	546	16	
17	V	21 OFFICE				1,245	1,245	17	
18	V	27 PAYROLL TAXES				1,035	1,035	18	
19	V							19	
20	V	17 C. RAJCHENBACH-COMP.						20	
21	V	27 PAYROLL TAXES						21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V	17 MANAGEMENT FEES						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		\$			\$ 11,761	\$ *	11,761	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/06Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 4,895	4,895	15
16	V	3	HOUSEKEEPING				14,787	14,787	16
17	V	5	UTILITIES				4,986	4,986	17
18	V	6	REPAIRS AND MAINT.				4,839	4,839	18
19	V	19	PROFESSIONAL FEES				7,738	7,738	19
20	V	20	FEES, SUBSCRIPTIONS				3,247	3,247	20
21	V	21	CLERICAL AND GENERAL				29,955	29,955	21
22	V	24	EDUCATION/SEMINARS				2,010	2,010	22
23	V	26	INSURANCE				1,197	1,197	23
24	V	27	EMPLOYEE BENEFITS				1,770	1,770	24
25	V	30	DEPRECIATION				15,572	15,572	25
26	V	31	AMORTIZATION				218	218	26
27	V	32	INTEREST				31,704	31,704	27
28	V	33	REAL ESTATE TAXES				11,676	11,676	28
29	V	35	EQUIPMENT RENTAL				3,487	3,487	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES				266,495	266,495	32
33	V	27	GEN ADMIN. - EMP. BEN.				79,147	79,147	33
34	V								34
35	V	19	Bookkeeping/Data Processing	438,498				(438,498)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 438,498				\$ 483,723	\$ * 45,225	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 65,777	65,777	15
16	V	19 PROFESSIONAL FEES				2,393	2,393	16
17	V	21 OFFICE				3,384	3,384	17
18	V	27 PAYROLL TAXES				3,802	3,802	18
19	V							19
20	V							20
21	V							21
22	V	17 MANAGEMENT FEES						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		\$			\$ 75,356	\$ * 75,356	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/06Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 71,344	\$ 71,344	15
16	V	19 PROFESSIONAL FEES				3,488	3,488	16
17	V	21 CLERICAL AND GENERAL				4,592	4,592	17
18	V	24 SEMINARS				21	21	18
19	V	27 GEN ADMIN.- EMP. BEN.				15,161	15,161	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	83,532				(83,532)	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		\$ 83,532			\$ 94,606	\$ * 11,074	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 3,333	\$ 3,333	15
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	83	83	16
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	6	6	17
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	55	55	18
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	245	245	19
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	13	13	20
21	V							21
22	V	17 MANAGEMENT FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			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		\$			\$ 3,735	\$ *	3,735 39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/06 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Rajchenbach	Owner	Administrative	9.80%	See Attached	6.00	9.23%	JLR	\$ 8,935	17-7	1
2	Bernard Hollander	Owner	Administrative	18.06%	See Attached	20.00	30.77%	Shaymark	65,777	17-7	2
3	Mark Hollander	Relative	Administrative	0.00%	See Attached	17.00	28.33%	Salary	40,000	17-1	3
4	Yosef Davis	Owner	Administrative	9.80%	See Attached	1.00	1.67%	Intercare	3,333	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 118,045		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 JLR MANAGEMENT CORP.  
 Street Address 6633 NORTH LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 679-9141  
 Fax Number ( 847) 679-1820

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 81,900	\$ 81,900	6	\$ 8,935	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		6	546	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	11,414	11,414	6	1,245	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,486		6	1,035	4
5										5
6										6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED	40	1	60,037	60,037			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED	40	1	4,770				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					\$ 172,607	\$ 153,351		\$ 11,761	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	464,645	5	\$ 20,433	\$ 111,325	\$ 4,895	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	464,645	5	61,719	111,325	14,787	2
3	5	UTILITIES	AVAILABLE BED DAYS	464,645	5	20,809	111,325	4,986	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	464,645	5	20,199	111,325	4,839	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	464,645	5	32,295	111,325	7,738	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	464,645	5	13,550	111,325	3,247	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	464,645	5	125,027	111,325	29,955	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	464,645	5	8,388	111,325	2,010	8
9	26	INSURANCE	AVAILABLE BED DAYS	464,645	5	4,996	111,325	1,197	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	464,645	5	7,390	111,325	1,770	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	464,645	5	64,993	111,325	15,572	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	464,645	5	908	111,325	218	12
13	32	INTEREST	AVAILABLE BED DAYS	464,645	5	132,326	111,325	31,704	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	464,645	5	48,735	111,325	11,676	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	464,645	5	14,552	111,325	3,487	15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	957,084	957,084	266,495	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	284,246		79,147	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,817,650	\$ 957,084	\$ 483,723	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization SHAYMARK MANAGEMENT CORP.  
 Street Address 6633 NORTH LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 679-9141  
 Fax Number ( 847) 679-1820

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	5	\$ 157,864	\$ 157,864	20	\$ 65,777	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	5	5,742		20	2,393	2
3	21	OFFICE	AVG. HOURS WORKED	48	5	8,121	8,121	20	3,384	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	48	5	9,125		20	3,802	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					\$ 180,852	\$ 165,985		\$ 75,356	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 CAREPATH HEALTH NETWORK  
 Street Address 6633 N LINCOLN AVENUE  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 888) 707-6700  
 Fax Number ( 847) 679-2150

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	CARE PATH FEES	302,112	9	\$ 258,032	\$ 258,032	83,532	\$ 71,344	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	302,112	9	12,615	83,532	83,532	3,488	2
3	21	CLERICAL AND GENERAL	CARE PATH FEES	302,112	9	16,607	83,532	83,532	4,592	3
4	24	SEMINARS	CARE PATH FEES	302,112	9	75	83,532	83,532	21	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	302,112	9	54,833	83,532	83,532	15,161	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					\$ 342,162	\$ 258,032		\$ 94,606	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization INTERCARE, LTD. C/O MANAGCARE  
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR  
 City / State / Zip Code CHICAGO, IL. 60659  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	30	6	\$ 100,000	\$ 100,000	1	\$ 3,333	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	30	6	2,500		1	83	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	30	6	182		1	6	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	30	6	1,652		1	55	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	30	6	7,344		1	245	5
6	30	DEPRECIATION	AVG. HOURS WORKED	30	6	394		1	13	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					\$ 112,072	\$ 100,000		\$ 3,735	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	HUD		X	Mortgage			\$	\$ 15,672,712			\$ 1,136,013	1					
2	McGrath		X	Auto Loan				8,297			656	2					
3												3					
4												4					
5	See Supplemental Schedule											5					
<b>Working Capital</b>																	
6	Bank One		X	Line of Credit				2,839,000			256,123	6					
7	INAC		X	Insurance Financing							10,065	7					
8	See Supplemental Schedule										261,518	8					
9	TOTAL Facility Related						\$	\$ 18,520,009			\$ 1,664,375	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(363,208)	10					
11	Interest Income - Bldg Co		X								(2,415)	11					
12												12					
13	See Supplemental Schedule										(183,755)	13					
14	TOTAL Non-Facility Related						\$	\$			(549,378)	14					
15	TOTALS (line 9+line14)						\$	\$ 18,520,009			\$ 1,114,997	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,310 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	<b>TOTAL Long-Term</b>											7
	<b>Working Capital</b>											
8	Shareholder Loan	X		Working Capital			\$	\$			\$ 81,325	8
9	Related Parties	X		Working Capital							102,430	9
10	Building Company		X								46,059	10
11	Allocate ITEX		X								31,704	11
12												12
13												13
14	<b>TOTAL Working Capital</b>										261,518	14
	<b>B. Non-Facility Related*</b>											
15	Shareholder/Rel Party Int	X					\$	\$			\$ (183,755)	15
16												16
17												17
18												18
19												19
20	<b>TOTAL Non-Facility Related</b>										(183,755)	20

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 report.		\$ 487,622	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.)		\$ 500,857	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ 13,235	3																				
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 513,640	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 526,875	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	2001	324,496	8																				
	2002	371,760	9																				
	2003	444,798	10																				
	2004	464,402	11																				
	2005	489,181	12																				
<table border="1"> <tr> <td colspan="2"></td> <td colspan="2"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>						<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
		<b>FOR BHF USE ONLY</b>																					
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				
<p>2006 Accrual - \$489,181 X 1.05 = \$513,640</p> <p>Allocate From ITEX / A.K. Care - \$11,676</p>																							

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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Glenview Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-28-401-042-0000</u>	<u>Long Term Care Property</u>	\$ <u>489,180.98</u>	\$ <u>489,180.98</u>
2. <u>10-35-312-022-0000</u>	<u>Central Office</u>	\$ <u>50,977.89</u>	\$ <u>11,676.46</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>540,158.87</u>	\$ <u>500,857.44</u>

**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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Glenview Terrace Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: 218 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	305		1978	1975	\$ 2,750,940	\$ 253,135		\$ 68,774	\$ (184,361)	\$ 2,088,128	4
5				1989	1,453,936			36,348	36,348	624,614	5
6				2002	4,266,341			462,432	462,432	2,028,125	6
7				2004	37,074			3,709	3,709	10,817	7
8											8
	<b>Improvement Type**</b>										
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	95	95	2,071	19
20	Various			1987	2,375		20	119	119	1,546	20
21	Various			1988	4,955		20	248	248	3,694	21
22	Various			1989	111,464		20	5,574	5,574	91,344	22
23	Various			1990	98,033		20	4,903	4,903	68,797	23
24	Various			1991	2,229		20	111	111	1,516	24
25	Various			1992	3,024		20	151	151	2,060	25
26	Various			1993	103,239		20	5,163	5,163	70,800	26
27	Various			1994	23,033		20	1,152	1,152	13,618	27
28	Various			1995	44,266		20	2,214	2,214	25,274	28
29	Various			1996	93,171		20	4,659	4,659	49,268	29
30	Various			1997	102,244		20	3,706	3,706	35,525	30
31	Various			1998	103,389		20	6,252	6,252	52,412	31
32	Various			1999	150,958		20	11,569	11,569	89,133	32
33	Various			2000	37,198		20	1,860	1,860	11,673	33
34	Various			2001	217,477		20	10,876	10,876	60,814	34
35	Various			2002	5,478,039		20	327,273	327,273	1,563,102	35
36											36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

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**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		475,401	11,923		15,943	4,020	205,504	68
69			431,517			(431,517)		69
70		\$ 15,642,859	\$ 696,575		\$ 973,131	\$ 276,556	\$ 7,170,865	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number    Glenview Terrace Nursing Ctr

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 15,642,859	\$ 696,575		\$ 973,131	\$ 276,556	\$ 7,170,865	1
2	Heaters	2003	2,016		20	168	168	658	2
3	Ewing Doherty	2003	1,359		20	136	136	510	3
4	Fountain	2003	2,354		20	157	157	549	4
5	Fountain	2003	3,268		20	218	218	762	5
6	Elevator	2003	2,621		20	131	131	502	6
7	Condenser	2003	5,250		20	350	350	1,225	7
8	24000 Btu Lanitrol	2003	1,585		20	132	132	451	8
9	Beauty Shop Fixtures	2003	1,600		20	160	160	560	9
10	Ceiling Tiles	2003	3,906		20	195	195	635	10
11	Sodding	2003	4,500		20	300	300	1,025	11
12	Ceiling Tiles	2003	1,008		20	50	50	181	12
13	Ceiling Tile	2003	1,248		20	62	62	218	13
14	Wallcovering	2003	2,859		20			2,859	14
15	Beauty Shop Plumbing	2003	2,500		20	167	167	583	15
16	Beauty Shop Electrical Work	2003	1,350		20	135	135	461	16
17	Beauty Shop Electrical Work	2003	3,000		20	300	300	1,025	17
18	Beauty Shop Electrical Work	2003	700		20	70	70	239	18
19	Fire Doors	2003	810		20	116	116	395	19
20	Fire Doors	2003	1,200		20	171	171	600	20
21	Exhaust Fans For Beauty Shop	2003	2,774		20	277	277	902	21
22	Fountain	2003	3,268		20	327	327	1,171	22
23	Windows & Doors	2003	30,000		20	3,000	3,000	10,250	23
24	Fixtures	2003	1,903		20	381	381	1,268	24
25	Plumbing	2003	515		20	52	52	206	25
26	Pa System	2003	1,656		20	237	237	828	26
27	Painting	2003	1,200		20			1,200	27
28	Security Alarm	2003	6,069		20	867	867	3,107	28
29	Boiler Repair	2003	7,500		20	625	625	2,031	29
30	Light Fixtures	2003	1,756		20	351	351	1,112	30
31	Window Shades	2003	2,811		20	281	281	960	31
32	Sprinkler Installation	2003	6,353		20	424	424	1,447	32
33	Building Costs To R. Kane	2003	26,000		20	2,600	2,600	8,450	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,777,798	\$ 696,575		\$ 985,571	\$ 288,996	\$ 7,217,235	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 15,777,798	\$ 696,575		\$ 985,571	\$ 288,996	\$ 7,217,235	1
2	Beauty Shop Fixtures	2003	1,616		20	323	323	1,131	2
3	Fire Alarm System Repair	2003	536		20	27	27	107	3
4	Walk-In Freezer Repair	2003	607		20	30	30	121	4
5	Generator Repair	2003	605		20	30	30	121	5
6	Fire Alarm System Repair	2003	929		20	46	46	178	6
7	Paging System	2003	1,109		20	55	55	213	7
8	Fir Alarm System Repair	2003	1,675		20	84	84	314	8
9	Wire Glass In Door	2003	608		20	30	30	114	9
10	Fir Alarm System Repair	2003	538		20	27	27	92	10
11	Fire Alarm System Repair	2003	554		20	28	28	95	11
12	A/C Repair	2003	885		20	44	44	151	12
13	Generator Repair	2003	1,622		20	81	81	270	13
14	Sprinkler System	2003	1,110		20	56	56	176	14
15	Paging System	2003	520		20	26	26	80	15
16	Hvac Repair	2003	1,065		20	53	53	164	16
17	Fir Hydrant Repair	2003	732		20	37	37	113	17
18	Pump	2003	535		20	27	27	107	18
19	Door Alarm	2003	609		20	30	30	119	19
20	Ballasts	2003	549		20	27	27	96	20
21	Bathroom Grab Bars	2003	763		20	38	38	127	21
22	Signs	2003	1,442		20	72	72	234	22
23	West Addition	2003	4,900		20	245	245	980	23
24	Day Rooms	2003	5,318		20	266	266	1,064	24
25	Bathroom Tile	2003	2,600		20	130	130	520	25
26	Install Day Room Floor	2003	13,825		20	691	691	2,765	26
27	Cubicle Curtains	2003	6,240		20			6,240	27
28	Wood Work	2003	72,210		20	3,611	3,611	14,442	28
29	Fabric	2003	3,886		20	777	777	3,109	29
30	Wall Tile	2003	8,614		20	574	574	2,297	30
31	Electrical Work	2003	605		20	30	30	121	31
32	Electrical Work	2003	435		20	22	22	87	32
33	Flooring	2003	17,930		20	1,195	1,195	4,781	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,932,970	\$ 696,575		\$ 994,283	\$ 297,708	\$ 7,257,764	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 15,932,970	\$ 696,575		\$ 994,283	\$ 297,708	\$ 7,257,764	1
2	Electrical Work	2003	4,635		20	232	232	927	2
3	Carpet	2003	2,084		20	298	298	1,191	3
4	Paint Murals	2003	2,200		20	220	220	880	4
5	Paint Murals	2003	4,400		20	440	440	1,760	5
6	Window Treatments	2003	4,307		20	431	431	1,723	6
7	Wall Covering	2003	2,869		20			2,869	7
8	Flooring	2003	6,088		20	406	406	1,623	8
9	Flooring	2003	2,095		20	140	140	559	9
10	Flooring	2003	17,800		20	1,187	1,187	4,747	10
11	Wall Covering	2003	3,469		20			3,469	11
12	Install Tile	2003	9,754		20	650	650	2,601	12
13	Exit Sign	2003	73		20	10	10	41	13
14	Light Fixtures	2003	1,017		20	102	102	398	14
15	Wood Storage	2003	450		20	90	90	353	15
16	Lighting	2003	19		20	4	4	15	16
17	Electrical Work	2003	2,157		20	108	108	422	17
18	Wall Covering	2003	4,770		20			4,770	18
19	Construction Surveying	2003	2,396		20	120	120	469	19
20	Ceiling Fan	2003	222		20	44	44	174	20
21	Window Treatments	2003	553		20	55	55	216	21
22	Ghrp Bars	2003	4,415		20	883	883	3,458	22
23	Light Fixtures	2003	298		20	60	60	234	23
24	Light Fixtures	2003	1,518		20	304	304	1,189	24
25	Light Fixtures	2003	1,558		20	312	312	1,220	25
26	Light Fixtures	2003	273		20	55	55	214	26
27	Light Fixtures	2003	4,378		20	876	876	3,430	27
28	Flooring	2003	19,230		20	1,282	1,282	5,021	28
29	Wall Tile	2003	1,279		20	85	85	334	29
30	Tile	2003	13,371		20	891	891	3,491	30
31	Window Treatment	2003	1,943		20	194	194	761	31
32	Cubicle Curtains	2003	6,194		20	619	619	2,374	32
33	Window Treatments	2003	4,307		20	431	431	1,651	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 16,063,092	\$ 696,575		\$ 1,004,812	\$ 308,237	\$ 7,310,348	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 16,063,092	\$ 696,575		\$ 1,004,812	\$ 308,237	\$ 7,310,348	1
2	Window Treatments	2003	985		20	98	98	377	2
3	Wall Covering	2003	17,762		20			17,762	3
4	Flooring	2003	19,664		20	1,311	1,311	5,025	4
5	Flooring	2003	20,000		20	1,333	1,333	5,111	5
6	Flooring	2003	1,310		20	87	87	335	6
7	Flooring	2003	4,016		20	268	268	1,026	7
8	Flooring	2003	930		20	62	62	238	8
9	Flooring	2003	8,921		20	595	595	2,280	9
10	Window Coverings	2003	941		20	94	94	361	10
11	Window Coverings	2003	3,844		20	384	384	1,473	11
12	Cubicle Tracks	2003	666		20	67	67	250	12
13	Window Treatments	2003	1,818		20	182	182	682	13
14	Dining Window Treatment	2003	4,665		20	466	466	1,749	14
15	Library Window Treatment	2003	1,355		20	136	136	508	15
16	Wood Work	2003	45,722		20	2,286	2,286	8,573	16
17	Floor Covering	2003	4,966		20	709	709	2,660	17
18	Wall Covering	2003	2,266		20			2,266	18
19	Landscape	2003	1,800		20	120	120	440	19
20	Flowers	2003	1,000		20	67	67	244	20
21	Carpet Install	2003	858		20	123	123	449	21
22	Light Fixtures	2003	6,189		20	1,238	1,238	4,539	22
23	Wall Torch	2003	143		20	14	14	52	23
24	Wall Sconce	2003	651		20	65	65	239	24
25	Light Fixtures	2003	4,091		20	818	818	3,000	25
26	Bathroom Tile	2003	4,550		20	303	303	1,112	26
27	Tapestry	2003	2,220		20	222	222	814	27
28	Extra Cabinets	2003	1,000		20	50	50	179	28
29	Fence In Patio Area	2003	5,157		20	344	344	1,232	29
30	Extended Builders Risk Coverage	2003	1,892		20	95	95	339	30
31	Flowers	2003	1,770		20	118	118	423	31
32	New Cabinet Fixtures	2003	2,000		20	400	400	1,433	32
33	Trees	2003	1,250		20	83	83	299	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 16,237,494	\$ 696,575		\$ 1,016,950	\$ 320,375	\$ 7,375,818	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 16,237,494	\$ 696,575		\$ 1,016,950	\$ 320,375	\$ 7,375,818	1
2	Shrubery	2003	2,345		20	156	156	560	2
3	Edging Around Pond	2003	2,700		20	180	180	645	3
4	Electrical Work	2003	5,065		20	253	253	907	4
5	Trees	2003	6,598		20	440	440	1,576	5
6	Sodd	2003	2,300		20	153	153	549	6
7	Construction	2003	3,500		20	233	233	836	7
8	Shrubery	2003	3,100		20	207	207	723	8
9	Trees	2003	7,745		20	516	516	1,807	9
10	Wood Work	2003	25,354		20	1,268	1,268	4,437	10
11	Painting	2003	15,000		20	750	750	2,625	11
12	Patient Rooms/Corridors	2003	26,274		20	1,314	1,314	4,598	12
13	Deposit For Tub Rooms	2003	9,630		20	482	482	1,685	13
14	Flowers	2003	8,162		20	544	544	1,904	14
15	Painting	2003	13,000		20	1,300	1,300	4,658	15
16	Window Treatments, Cubicle Curtains	2003	24,499		20	2,450	2,450	9,800	16
17	Flooring	2003	28,663		20	1,911	1,911	7,643	17
18	First Painting	2003	10,000		20	1,000	1,000	3,583	18
19	Balance Of Ceramic Tile	2003	4,558		20	456	456	1,671	19
20	Furnish And Install In-Line Exhaust Fan	2003	4,154		20	415	415	1,593	20
21	Limp	2003	2,215		20	111	111	397	21
22	Exterior Signage	2003	10,896		20	1,090	1,090	4,358	22
23	Light Fixtures	2003	2,575		20	515	515	2,060	23
24	Light Fixtures	2003	993		20	199	199	794	24
25	Light Fixtures	2003	574		20	115	115	459	25
26	Light Fixtures	2003	6,033		20	1,207	1,207	3,821	26
27	Light Fixtures	2003	1,255		20	251	251	774	27
28	Light Fixtures	2003	278		20	56	56	171	28
29	Light Fixtures	2003	1,365		20	273	273	842	29
30	Light Fixtures	2003	307		20	61	61	189	30
31	Window Treatments	2003	579		20	58	58	179	31
32	Cubicle Curtains	2003	605		20	60	60	187	32
33	Wall Covering	2003	6,334		20			6,334	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 16,474,150	\$ 696,575		\$ 1,034,974	\$ 338,399	\$ 7,448,183	34

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 16,474,150	\$ 696,575		\$ 1,034,974	\$ 338,399	\$ 7,448,183	1
2	Window Treatments	2003	607		20	61	61	187	2
3	Window Treatments	2003	2,163		20	216	216	667	3
4	Wood Work	2003	29,800		20	1,490	1,490	5,091	4
5	Wood Door	2003	893		20	45	45	175	5
6	Flowers	2003	4,373		20	437	437	1,531	6
7	Light Fixtures	2003	4,258		20	852	852	3,193	7
8	Painting	2003	7,325		20	733	733	2,930	8
9	Patient Room Cabinets	2003	7,000		20	1,400	1,400	5,367	9
10	Crown Molding & French Double Doors	2003	10,000		20	500	500	1,875	10
11	Pond Design & Grading Plan	2003	1,600		20	107	107	391	11
12	Cubicle Track Sets	2003	2,983		20	149	149	547	12
13	Wall Covering	2003	7,232		20			7,232	13
14	Ceramic Tile	2003	4,558		20	304	304	1,114	14
15	Rugs	2003	1,477		20	211	211	774	15
16	Mirror & Fabric	2003	8,042		20	804	804	2,882	16
17	Teacher Office	2003	5,200		20	520	520	1,863	17
18	Nursing Stations' Furniture (5)	2003	33,000		20	6,600	6,600	23,650	18
19	Partitions	2003	6,000		20	300	300	1,075	19
20	Fabric	2003	1,820		20	182	182	652	20
21	Hardware	2003	413		20	83	83	296	21
22	Flooring	2003	585		20	39	39	140	22
23	Tile	2003	12,276		20	818	818	2,933	23
24	Aluminum Fence	2003	6,075		20	405	405	1,418	24
25	Remove & Replace Fence	2003	2,063		20	138	138	481	25
26	Addition To Contract	2003	51,800		20	2,590	2,590	9,065	26
27	Painting	2003	1,300		20	130	130	455	27
28	Shades & Carpet Installation	2003	1,542		20	220	220	771	28
29	Drapery & Fabric	2003	2,762		20	276	276	967	29
30	Carpet & Installation	2003	15,034		20	2,148	2,148	7,517	30
31	Cubicles	2003	40,628		20	2,031	2,031	7,110	31
32	Pleated Shades	2003	1,113		20	111	111	390	32
33	Fabrication & Install Of Oak Wood Base	2003	1,884		20	94	94	330	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 16,749,956	\$ 696,575		\$ 1,058,968	\$ 362,393	\$ 7,541,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number    Glenview Terrace Nursing Ctr

#    0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ 16,749,956	\$ 696,575		\$ 1,058,968	\$ 362,393	\$ 7,541,252	1
2	Clean Alley Way	2003	3,200		20	213	213	747	2
3	Paving	2003	11,308		20	565	565	1,979	3
4	Flooring	2003	4,205		20	280	280	981	4
5	Flooring	2003	6,525		20	435	435	1,523	5
6	Remove & Install Flooring	2003	2,885		20	192	192	673	6
7	Flooring	2003	9,090		20	606	606	2,121	7
8	Trees	2003	8,250		20	550	550	1,925	8
9	Cabinets (122)	2003	28,000		20	1,400	1,400	4,783	9
10	Plant Shrubs & Flowers	2003	10,115		20	674	674	2,304	10
11	Pond Area	2003	13,820		20	921	921	3,148	11
12	Flooring	2003	100,520		20	6,701	6,701	22,896	12
13	Change Order E-3	2003	79,410		20	2,036	2,036	7,296	13
14	Change Order L	2003	52,169		20	1,338	1,338	5,016	14
15	Change Order M	2003	18,979		20	487	487	1,703	15
16	Change Order N	2003	82,125		20	2,106	2,106	7,370	16
17	Change Order O	2003	29,186		20	748	748	2,619	17
18	Change Order P	2003	15,382		20	394	394	1,380	18
19	Change Order Q	2003	43,164		20	1,107	1,107	3,874	19
20	Change Order R	2003	69,784		20	1,789	1,789	6,263	20
21	Change Order S	2003	47,367		20	1,215	1,215	4,251	21
22	Change Order T	2003	105,929		20	2,716	2,716	9,506	22
23	Balance Of Piazza	2003	3,815		20	191	191	620	23
24	Glass Cutters	2003	20,000		20	2,000	2,000	7,167	24
25	Landscaping	2003	17,769		20	1,185	1,185	4,343	25
26	Outdoor Sign	2003	5,293		20	529	529	2,117	26
27	Wallcovering	2003	1,348		20	67	67	270	27
28	Window Treatments	2003	8,784		20	439	439	1,757	28
29	Window Treatments	2003	170		20	9	9	34	29
30	Wallcovering	2003	3,193		20	160	160	612	30
31	Flooring	2003	53,866		20	2,693	2,693	10,324	31
32	Gas Main Repair	2003	3,522		20	176	176	690	32
33	Boiler Repair	2003	1,028		20	51	51	201	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,610,157	\$ 696,575		\$ 1,092,941	\$ 396,366	\$ 7,661,745	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ 17,610,157	\$ 696,575		\$ 1,092,941	\$ 396,366	\$ 7,661,745	1
2	Wallcovering	2003	21,033		20	1,052	1,052	4,031	2
3	Trec Electrical Contractors	2004	10,035		20	1,004	1,004	2,843	3
4	Suburban Elevator	2004	3,400		20	170	170	468	4
5	Three Generations Paving	2004	28,000		20	2,800	2,800	6,300	5
6	J.M.Concrete Work	2004	2,100		20	210	210	473	6
7	Landscaping	2004	500		20	33	33	83	7
8	Landscaping	2004	1,076		20	72	72	173	8
9	Landscaping	2004	1,166		20	78	78	188	9
10	Landscaping	2004	1,189		20	79	79	192	10
11	Landscaping	2004	1,256		20	84	84	202	11
12	Landscaping	2004	1,293		20	86	86	201	12
13	Landscaping	2004	1,517		20	101	101	236	13
14	Landscaping	2004	2,357		20	157	157	354	14
15	Three Generations Paving	2004	1,500		20	100	100	208	15
16	Cooling Equipment Service	2004	650		20	130	130	314	16
17	Cooling Equipment Service	2004	28,350		20	5,670	5,670	13,703	17
18	Insulation	2004	1,203		20	120	120	351	18
19	Insulation	2004	1,501		20	150	150	388	19
20	Paint	2004	646		20	65	65	183	20
21	Fire Alarm Control Pnl	2004	840		20	84	84	210	21
22	Walk-In Freezer Repair	2004	1,544		20	154	154	386	22
23	Reloc Sprinkler Heads	2004	846		20	85	85	247	23
24	Hvac - Compressor	2004	1,444		20	144	144	385	24
25	Hvac - Compressor	2004	1,186		20	119	119	316	25
26	Heating Circuits	2004	1,205		20	121	121	351	26
27	Fire Alarm Control Pnl	2004	1,596		20	160	160	479	27
28	Pump And Motor	2004	1,200		20	120	120	270	28
29	Nurse Call System	2004	2,463		20	246	246	616	29
30	Sidewalk Repair	2004	500		20	50	50	121	30
31	Nurse Call System	2004	4,980		20	498	498	1,121	31
32	Amtech Elevator	2004	36,358		20	3,636	3,636	10,907	32
33	Floors By Tiles Carmelo	2004	2,331		20	233	233	660	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,775,422	\$ 696,575		\$ 1,110,752	\$ 414,177	\$ 7,708,705	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number    Glenview Terrace Nursing Ctr

#    0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12I, Carried Forward</b>		\$ 17,775,422	\$ 696,575		\$ 1,110,752	\$ 414,177	\$ 7,708,705	1
2	Metron Eng. - Rod Oak Wood Door	2004	4,986		20	499	499	1,454	2
3	Marian Janek - Plumbing	2004	8,000		20	800	800	2,400	3
4	Illi Hardware - Doors	2004	2,844		20	284	284	853	4
5	Enga Resource - Survey	2004	4,906		20	491	491	1,472	5
6	Taylorville Glass	2004	27,570		20	2,757	2,757	8,271	6
7	Trostand Mosaic	2004	1,062		20	106	106	319	7
8	Brook Electric - Light Fixture	2004	1,756		20	176	176	527	8
9	Satellite - Cable	2004	7,560		20	756	756	2,205	9
10	Satellite - Cable	2004	8,611		20	861	861	2,440	10
11	Flortech - Floor	2004	57,267		20	5,727	5,727	17,180	11
12	Closing Costs - Poulos	2004	57,784		20	5,778	5,778	17,335	12
13	Refund By Poulos	2004	(172,500)		20	(17,250)	(17,250)	(51,750)	13
14	Boiler	2005	7,500		20	625	625	1,042	14
15	Trees	2005	1,090		20	73	73	109	15
16	Roofing	2005	3,150		20	210	210	315	16
17	Air Handler	2005	29,239		20	2,437	2,437	4,061	17
18	Ac Pumps	2005	5,878		20	490	490	694	18
19	Cooling Equipment Pump	2005	4,126		20	344	344	458	19
20	Walter Filtration System	2005	1,400		20	117	117	146	20
21	Boiler System	2005	1,753		20	146	146	158	21
22	Cooling Equipment Change Order	2005	1,000		20	83	83	139	22
23	Fence	2005	5,000		20	334	334	500	23
24	Fence	2005	1,850		20	123	123	185	24
25	Fence	2005	1,550		20	103	103	155	25
26	Phone System	2005	18,292		20	1,829	1,829	2,591	26
27	Phone System	2005	4,435		20	444	444	480	27
28	Sprinkler System	2005	5,255		20	751	751	1,314	28
29	Sprinkler System	2005	3,950		20	564	564	940	29
30	Elevator Work	2005	2,200		20	440	440	880	30
31	Elevator Work	2005	6,000		20	1,200	1,200	2,300	31
32	Replace Boiler Flow Switch	2005	1,763		20	88	88	110	32
33	Carpeting	2005	3,532		20	177	177	280	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,894,231	\$ 696,575		\$ 1,122,315	\$ 425,740	\$ 7,728,268	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ 17,894,231	\$ 696,575		\$ 1,122,315	\$ 425,740	\$ 7,728,268	1
2	New Cedar Fence	2005	2,100		20	105	105	149	2
3	Alarm System Repair	2005	1,501		20	75	75	106	3
4	1 New Boiler Control System	2006	3,537		20	707	707	707	4
5	3 Electric Wall Heater/Ac Units	2006	1,616		20	27	27	27	5
6	2 Electric Wall Heater A/C Units	2006	1,075		20	18	18	18	6
7	Sprayed Fireproofing Stairs And Mechanical	2006	25,700		20	1,928	1,928	1,928	7
8	2 Chassis Heater For Resident Rooms	2006	3,015		20	553	553	553	8
9	2 Chassis Heaters For Resident Rooms	2006	3,015		20	201	201	201	9
10	Elevator Door	2006	2,650		20	133	133	133	10
11	Acoustical Supplies	2006	3,120		20	156	156	156	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12K, Carried Forward</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	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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18								18
19								19
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21								21
22								22
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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)	\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12M, Carried Forward</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12N, Carried Forward</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12P, Carried Forward</b>	\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 17,941,560	\$ 696,575		\$ 1,126,218	\$ 429,643	\$ 7,732,246		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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22											22
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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											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* <sup>*</sup>	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	ITEX	1993	1993	\$ 384,317	\$ 9,854	35	\$ 10,980	\$ 1,126	\$ 149,151	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Allocation From Itex - A.K. Care		1993	48,358	284	20	2,419	2,135	33,142	9
10	Allocation From Itex - A.K. Care		1994	25,974	676	20	1,299	623	15,950	10
11	Allocation From Itex - A.K. Care		1995	4,427	12	20	221	209	2,479	11
12	Allocation From Itex - A.K. Care		1996	251	-	20	13	13	138	12
13	Allocation From Itex - A.K. Care		1997	7,467	191	20	373	182	3,547	13
14	Allocation From Itex - A.K. Care		1999	829	21	20	41	20	332	14
15	Allocation From Itex - A.K. Care		2005	3,631	872	20	590	(282)	726	15
16										16
17	Allocation From Inter Care Ltd.		2001	147	13	20	7	(6)	39	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	475,401	\$	11,923	\$	15,943	\$	4,020	\$	205,504	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 2,645,252	\$ 347,499	\$ 315,701	\$ (31,798)	10	\$ 1,875,208	71
72	Current Year Purchases	147,185	15,899	14,393	(1,506)	10	14,393	72
73	Fully Depreciated Assets	819,071		445	445	10	819,071	73
74								74
75	TOTALS	\$ 3,611,508	\$ 363,398	\$ 330,539	\$ (32,859)		\$ 2,708,672	75

D. Vehicle Depreciation (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		CHEVY EXPRESS VAN	2001	\$ 27,850	\$ 2,089	\$ 1,857	\$ (232)	5	\$ 27,850	76
77		RUNNING BOARD INSTAL	2001	700	53	58	5	5	700	77
78		LEXUS	2004	25,000	10,378	11,778	1,400	5	34,222	78
79										79
80	TOTALS			\$ 53,550	\$ 12,520	\$ 13,693	\$ 1,173		\$ 62,772	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)	\$ 21,607,982	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,072,493	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,454,984	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 382,491	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,480,149	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	LEXUS - 2004	\$ 26,889	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 26,889	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	<b>TOTAL</b>				\$			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 21,902 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	Facility	2004 Ford Econoline	\$ 549.95	\$ 6,599	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 549.95	\$ 6,599	21

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

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	\$ 241,753		\$	\$		\$ 241,753	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	14,470			36,510		50,980	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	324,506			127,322		451,828	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				1,144,595		1,144,595	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>			107,440			121,322		228,762	13
14	<b>TOTAL</b>			\$ 688,169		\$	\$ 1,429,749		\$ 2,117,918	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 688,896	\$ 908,494	1
2	Cash-Patient Deposits	1,604	1,604	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,566,440	3,566,440	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	454,924	513,598	6
7	Other Prepaid Expenses	25,717	25,717	7
8	Accounts Receivable (owners or related parties)	2,968,135	2,161,327	8
9	Other(specify): <u>See Attached Schedule</u>	540,483	1,231,674	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,246,199	\$ 8,408,854	10
	<b>B. Long-Term Assets</b>			
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	443,562	8,044,839	15
16	Equipment, at Historical Cost	1,090,160	4,524,162	16
17	Accumulated Depreciation (book methods)	(653,240)	(9,917,096)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,500	7,500	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,167)	(4,167)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	532,251	1,072,512	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,416,066	\$ 12,859,413	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,662,265	\$ 21,268,267	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,340,656	\$ 3,350,654	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,236	24,236	28
29	Short-Term Notes Payable	2,845,879	2,845,879	29
30	Accrued Salaries Payable	397,539	397,539	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,104	31,104	31
32	Accrued Real Estate Taxes(Sch.IX-B)		513,640	32
33	Accrued Interest Payable	25,804	120,232	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	5,899	5,899	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,671,117	\$ 7,289,183	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,418	1,418	39
40	Mortgage Payable		15,672,712	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,418	\$ 15,674,130	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,672,535	\$ 22,963,313	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,989,730	\$ (1,695,046)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,662,265	\$ 21,268,267	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,675,839	1
2	Restatements (describe):		2
3	<u>Rounding</u>	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,675,840	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	313,890	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)	\$ 313,890	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,989,730	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/06Ending: 12/31/06**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,385,678	1
2	Discounts and Allowances for all Levels	(2,349,406)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 15,036,272	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,187,708	6
7	Oxygen	10,699	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,198,407	8
<b>C. Other Operating Revenue</b>			
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	6,587	13
14	Non-Patient Meals	4,080	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,452,404	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	184,439	19
20	Radiology and X-Ray		20
21	Other Medical Services	25,947	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,673,457	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	363,208	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 363,208	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	320,234	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 320,234	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 21,591,578	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,095,905	31
32	Health Care	8,862,901	32
33	General Administration	3,882,434	33
<b>B. Capital Expense</b>			
34	Ownership	3,000,828	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,265,773	35
36	Provider Participation Fee	169,847	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 21,277,688	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	313,890	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 313,890	43

\* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenview Terrace Nursing Ctr

# 0026237

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,408	\$ 133,294	\$ 55.35	1
2	Assistant Director of Nursing	5,690	6,240	230,472	36.93	2
3	Registered Nurses	85,809	94,849	2,584,194	27.25	3
4	Licensed Practical Nurses	26,810	29,219	803,471	27.50	4
5	CNAs & Orderlies	240,848	258,607	2,887,057	11.16	5
6	CNA Trainees					6
7	Licensed Therapist	23,101	26,327	688,169	26.14	7
8	Rehab/Therapy Aides	33,326	36,395	836,548	22.99	8
9	Activity Director	1,832	2,152	34,512	16.04	9
10	Activity Assistants	29,056	31,409	362,319	11.54	10
11	Social Service Workers	19,221	21,478	378,958	17.64	11
12	Dietician					12
13	Food Service Supervisor	3,494	3,850	83,001	21.56	13
14	Head Cook	5,105	5,842	75,373	12.90	14
15	Cook Helpers/Assistants	43,239	46,917	493,404	10.52	15
16	Dishwashers					16
17	Maintenance Workers	16,086	17,827	263,791	14.80	17
18	Housekeepers	44,070	48,837	456,633	9.35	18
19	Laundry	21,819	25,146	260,547	10.36	19
20	Administrator	1,888	2,120	136,406	64.34	20
21	Assistant Administrator	1,494	1,656	30,022	18.13	21
22	Other Administrative	1,040	1,040	40,000	38.46	22
23	Office Manager	1,904	2,208	51,784	23.45	23
24	Clerical	13,716	15,900	250,817	15.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,804	6,708	88,088	13.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,251	4,753	122,404	25.75	33
34	TOTAL (lines 1 - 33)	631,635	691,888	\$ 11,291,264 *	\$ 16.32	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,742	01-03	35
36	Medical Director	Monthly	94,750	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	36,000	10-03	38
39	Pharmacist Consultant	Monthly	13,105	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	6,275	11-03	44
45	Social Service Consultant	Monthly	2,875	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 166,971		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Glenview Terrace Nursing Ctr

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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. ILCLTC - \$16,461
- (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? \_\_\_\_\_
- (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. \$ 14,843 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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 169,847  
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? N/A 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. \$ 89,352 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,080
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT