

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0048637</u></p> <p>Facility Name: <u>Glenlake Terrace Nursing & Rehab</u></p> <p>Address: <u>2222 West 14th Street</u> <u>Waukegan</u> <u>60085</u> Number City Zip Code</p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>(847) 249-2400</u> Fax # <u>(847) 249-0536</u></p> <p>HFS ID Number: <u>205951640001</u></p> <p>Date of Initial License for Current Owners: <u>8/15/2007</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of any audit adjustments to address above.</p>	<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 type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2007</u> to <u>12/31/2007</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td></td> <td colspan="2">(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago IL 60606-4650</u></td> </tr> <tr> <td></td> <td colspan="2">(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>			(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago IL 60606-4650</u>			(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,560	1
2		Skilled Pediatric (SNF/PED)			2
3	127	Intermediate (ICF)	127	46,355	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	271	TOTALS	271	98,915	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	10,624	516	7,543	18,683	8
9	SNF/PED					9
10	ICF	54,301	1,350	0	55,651	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,925	1,866	7,543	74,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.15%

D. How many bed-hold days during this year were paid by the Department? 0 (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 12/07/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/07/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 71 and days of care provided 7,307

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Glenlake Terrace Nursing & Rehab # 0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	348,479	64,782	19,620	432,881		432,881	9	432,890		1
2	Food Purchase		429,304		429,304	(23,258)	406,046	(28,948)	377,098		2
3	Housekeeping	246,343	68,425		314,768		314,768		314,768		3
4	Laundry	100,963	24,044	12,678	137,685		137,685		137,685		4
5	Heat and Other Utilities			218,888	218,888		218,888	5,046	223,934		5
6	Maintenance	67,283	29,359	74,962	171,604		171,604	7,470	179,074		6
7	Other (specify):* Allocated Employee Benefits							483	483		7
8	TOTAL General Services	763,068	615,914	326,148	1,705,130	(23,258)	1,681,872	(15,940)	1,665,932		8
	B. Health Care and Programs										
9	Medical Director			34,800	34,800		34,800		34,800		9
10	Nursing and Medical Records	3,608,627	702,219	11,858	4,322,704		4,322,704	(201,776)	4,120,928		10
10a	Therapy	35,705	2,579	505,383	543,667		543,667	(120,629)	423,038		10a
11	Activities	131,256	5,072	1,200	137,528		137,528		137,528		11
12	Social Services	90,005		2,845	92,850		92,850		92,850		12
13	CNA Training										13
14	Program Transportation			26	26		26		26		14
15	Other (specify):* Allocated Employee Benefits							43,619	43,619		15
16	TOTAL Health Care and Programs	3,865,593	709,870	556,112	5,131,575		5,131,575	(278,786)	4,852,789		16
	C. General Administration										
17	Administrative	67,087		693,546	760,633		760,633	(623,343)	137,290		17
18	Directors Fees										18
19	Professional Services			51,255	51,255		51,255	(8,564)	42,691		19
20	Dues, Fees, Subscriptions & Promotions			24,723	24,723	3,870	28,593	10,610	39,203		20
21	Clerical & General Office Expenses	326,531	45,266	46,578	418,375	(3,870)	414,505	343,832	758,337		21
22	Employee Benefits & Payroll Taxes			728,087	728,087	23,258	751,345		751,345		22
23	Inservice Training & Education			1,818	1,818		1,818	1,591	3,409		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			15,803	15,803	(9,235)	6,568	6,304	12,872		25
26	Insurance-Prop.Liab.Malpractice			174,399	174,399		174,399	2,256	176,655		26
27	Other (specify):* Allocated Employee Benefits							57,709	57,709		27
28	TOTAL General Administration	393,618	45,266	1,736,209	2,175,093	14,023	2,189,116	(209,605)	1,979,511		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,022,279	1,371,050	2,618,469	9,011,798	(9,235)	9,002,563	(504,331)	8,498,232		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			10,594	10,594		10,594	317,115	327,709			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			253,470	253,470		253,470	459,603	713,073			32
33	Real Estate Taxes							115,968	115,968			33
34	Rent-Facility & Grounds			1,687,433	1,687,433		1,687,433	(1,687,433)				34
35	Rent-Equipment & Vehicles			48,910	48,910	9,235	58,145	7,913	66,058			35
36	Other (specify):*											36
37	TOTAL Ownership			2,000,407	2,000,407	9,235	2,009,642	(786,834)	1,222,808			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		260,326	96,087	356,413		356,413		356,413			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,356	148,356		148,356		148,356			42
43	Other (specify):* Non-Allowable			24,245	24,245		24,245	(24,245)				43
44	TOTAL Special Cost Centers		260,326	268,688	529,014		529,014	(24,245)	504,769			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,022,279	1,631,376	4,887,564	11,541,219		11,541,219	(1,315,410)	10,225,809			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 Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,107)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5)	43		18
19	Entertainment				19
20	Contributions	(500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,186)	43		24
25	Fund Raising, Advertising and Promotional	(250)	43		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 See Attached Schedule F:	(511,377)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (535,433)		\$	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)	(779,977)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (779,977)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,315,410)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Glenlake Terrace Nursing & Rehab

ID# 0048637

Report Period Beginning: 1/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Adjust Mgt Co. medical supplies"A" to cost	\$ (94,833)	10	1
2	Adjust Mgt Co. medical supplies"other" to cost	(106,944)	10	2
3	Adjust Mgt Co. food to cost	(28,978)	2	3
4	Non-allowable patient clothing	(197)	43	4
5	Non-allowable professional fees	(23,500)	19	5
6	Non-allowable IL Council on Long Term Care fee	(3,455)	20	6
7	Non-allowable owner interest expense	(253,470)	32	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(511,377)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	9	0	0	0	0	0	0	9	1
2	Food Purchase	(28,978)	0	0	0	30	0	0	0	0	0	0	(28,948)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	5,046	0	0	0	0	0	0	0	0	5,046	5
6	Maintenance	0	0	7,453	0	17	0	0	0	0	0	0	7,470	6
7	Other (specify):*	0	0	483	0	0	0	0	0	0	0	0	483	7
8	TOTAL General Services	(28,978)	0	12,982	0	56	0	0	0	0	0	0	(15,940)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(201,777)	0	0	0	1	0	0	0	0	0	0	(201,776)	10
10a	Therapy	0	0	0	0	(120,629)	0	0	0	0	0	0	(120,629)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	43,619	0	0	0	0	0	0	43,619	15
16	TOTAL Health Care and Programs	(201,777)	0	0	0	(77,009)	0	0	0	0	0	0	(278,786)	16
	C. General Administration													
17	Administrative	0	0	(623,343)	0	0	0	0	0	0	0	0	(623,343)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,500)	0	14,760	0	176	0	0	0	0	0	0	(8,564)	19
20	Fees, Subscriptions & Promotions	(3,455)	0	11,024	0	3,041	0	0	0	0	0	0	10,610	20
21	Clerical & General Office Expenses	0	0	336,849	1,187	5,796	0	0	0	0	0	0	343,832	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	417	0	1,174	0	0	0	0	0	0	1,591	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	5,726	0	578	0	0	0	0	0	0	6,304	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,256	0	0	0	0	0	0	0	0	2,256	26
27	Other (specify):*	0	0	57,054	0	655	0	0	0	0	0	0	57,709	27
28	TOTAL General Administration	(26,955)	0	(195,257)	1,187	11,420	0	0	0	0	0	0	(209,605)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(257,710)	0	(182,275)	1,187	(65,533)	0	0	0	0	0	0	(504,331)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007

Ending:

12/31/2007

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	21,678	295,437	0	0	0	0	0	0	0	317,115	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(253,478)	0	0	713,081	0	0	0	0	0	0	0	459,603	32
33	Real Estate Taxes	0	0	11,179	104,789	0	0	0	0	0	0	0	115,968	33
34	Rent-Facility & Grounds	0	0	0	(1,687,433)	0	0	0	0	0	0	0	(1,687,433)	34
35	Rent-Equipment & Vehicles	0	0	7,913	0	0	0	0	0	0	0	0	7,913	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(253,478)	0	40,770	(574,126)	0	0	0	0	0	0	0	(786,834)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(24,245)	0	0	0	0	0	0	0	0	0	0	(24,245)	43
44	TOTAL Special Cost Centers	(24,245)	0	0	0	0	0	0	0	0	0	0	(24,245)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(535,433)	0	(141,505)	(572,939)	(65,533)	0	0	0	0	0	0	(1,315,410)	45

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
Sidney Glenner	80.00 %	GlenBridge Nursing & Rehabilitation Centre,Ltd.	Niles	SEE ATTACHED SCHEDULE A		
Joshua Ray	20.00 %	GlenCrest Nursing & Rehabilitation Centre,Ltd.	Chicago			
		Glen Elston Nursing & Rehabilitation Centre,Ltd.	Chicago			
		Glen Oaks Nursing & Rehabilitation Centre,Ltd.	Northbrook			
		GlenShire Nursing & Rehabilitation Centre,Ltd.	Richton Park			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Total from Page 6A	\$ 693,546	Glen Health and Home Management, Inc.	A	\$ 552,041	\$ (141,505)	1
2	V							2
3	V	Total from Page 6B	1,687,433	GlenLake Terrace Realty LLC	B	1,114,494	(572,939)	3
4	V							4
5	V	Total from Page 6C	505,383	Therapy Masters, Inc.	C	439,850	(65,533)	5
6	V							6
7	V							7
8	V			OWNERSHIP REFERENCE:				8
9	V			A: Owned 100.00 % by Sidney Glenner through attribution				9
10	V			B: Owned 80.00 % by Sidney Glenner & 20.00 % by Joshua Ray				10
11	V			C: Owned 80.00 % by Sidney Glenner & 20.00 % by Barry Ray				11
12	V							12
13	V							13
14	Total		\$ 2,886,362			\$ 2,106,385	\$ * (779,977)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenlake Terrace Nursing & Rehab# 0048637Report Period Beginning: 1/01/2007Ending: 12/31/2007

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 Management Fees	\$ 693,546	Glen Health and Home Management, Inc.	A	\$	\$ (693,546)	15
16	V	5 Utilities		Glen Health and Home Management, Inc.	A	5,046	5,046	16
17	V	6 Repairs and Maintenance		Glen Health and Home Management, Inc.	A	4,273	4,273	17
18	V	19 Professional Fees		Glen Health and Home Management, Inc.	A	14,760	14,760	18
19	V	20 Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	11,024	11,024	19
20	V	21 Clerical		Glen Health and Home Management, Inc.	A	33,107	33,107	20
21	V	22 Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	57,537	57,537	21
22	V	23 Training and Education		Glen Health and Home Management, Inc.	A	417	417	22
23	V	25 Auto Expenses		Glen Health and Home Management, Inc.	A	5,726	5,726	23
24	V	26 Insurance		Glen Health and Home Management, Inc.	A	2,256	2,256	24
25	V	30 Depreciation		Glen Health and Home Management, Inc.	A	21,678	21,678	25
26	V	33 Real Estate Taxes		Glen Health and Home Management, Inc.	A	11,179	11,179	26
27	V	35 Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	7,913	7,913	27
28	V	6 Janitorial Salaries		Glen Health and Home Management, Inc.	A	3,180	3,180	28
29	V	17 Officer's Salaries		Glen Health and Home Management, Inc.	A	70,203	70,203	29
30	V	21 Administrative Salaries		Glen Health and Home Management, Inc.	A	303,742	303,742	30
31	V	22 Employee Benefits		Glen Health and Home Management, Inc.	A	(57,537)	(57,537)	31
32	V	7 Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A	483	483	32
33	V	27 Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A	10,713	10,713	33
34	V	27 Employee Benefits - Admin		Glen Health and Home Management, Inc.	A	46,341	46,341	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 693,546			\$ 552,041	\$ * (141,505)	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	21 Clerical	\$	GlenLake Terrace Realty LLC	B	\$ 1,187	\$ 1,187	15
16	V	30 Depreciation		GlenLake Terrace Realty LLC	B	295,437	295,437	16
17	V	32 Interest Income		GlenLake Terrace Realty LLC	B	(67,372)	(67,372)	17
18	V	32 Interest Expense		GlenLake Terrace Realty LLC	B	764,743	764,743	18
19	V	33 Real Estate Taxes		GlenLake Terrace Realty LLC	B	104,789	104,789	19
20	V	34 Rental Income	1,687,433	GlenLake Terrace Realty LLC	B		(1,687,433)	20
21	V	32 Amortization of Mortgage Costs		GlenLake Terrace Realty LLC	B	15,710	15,710	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		\$ 1,687,433			\$ 1,114,494	\$ * (572,939)	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	10a Therapy	\$ 505,383	Therapy Masters, Inc.	C	\$ 384,754	\$ (120,629)	15
16	V	19 Professional Fees		Therapy Masters, Inc.	C	176	176	16
17	V	20 Licenses, Permits and Inspection		Therapy Masters, Inc.	C	57	57	17
18	V	20 Employment Fees		Therapy Masters, Inc.	C	2,984	2,984	18
19	V	6 Plant Supplies		Therapy Masters, Inc.	C	17	17	19
20	V	21 Clerical		Therapy Masters, Inc.	C	346	346	20
21	V	22 Employee Benefits and Payroll		Therapy Masters, Inc.	C	44,274	44,274	21
22	V	23 Training and Education		Therapy Masters, Inc.	C	1,174	1,174	22
23	V	25 Auto Expenses		Therapy Masters, Inc.	C	578	578	23
24	V	2 Food Purchase		Therapy Masters, Inc.	C	30	30	24
25	V	21 Clerical Salaries		Therapy Masters, Inc.	C	5,450	5,450	25
26	V	22 Employee Benefits		Therapy Masters, Inc.	C	(44,274)	(44,274)	26
27	V	15 Employee Benefits - Therapy		Therapy Masters, Inc.	C	43,619	43,619	27
28	V	27 Employee Benefits - Clerical		Therapy Masters, Inc.	C	655	655	28
29	V	10 Nursing Supplies		Therapy Masters, Inc.	C	1	1	29
30	V	1 Dietary Supplies		Therapy Masters, Inc.	C	9	9	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		\$ 505,383			\$ 439,850	\$ * (65,533)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenlake Terrace Nursing & Rehab # 0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

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	Sidney Glenner	President	Administrative	80.00 %	156,359	12	19.8 %	Salary	\$ 28,081	Ln 17,Col 7	1
2	David Glenner	Vice President	Administrative	0.00 %	78,180	8	19.8 %	Salary	14,041	Ln 17,Col 7	2
3	Jonathan Glenner	Clerical	Clerical	0.00 %	40,455	8	19.8 %	Salary	7,265	Ln 21,Col 7	3
4	Daniel Glenner	Clerical	Clerical	0.00 %	25,112	8	19.8 %	Salary	4,510	Ln 21,Col 7	4
5	Joshua Ray	V.P. of Operations	Administrative	20.00 %	156,359	8	19.8 %	Salary	28,081	Ln 21,Col 7	5
6	Barry Ray	Vice President	Administrative	0.00 %	156,359	8	19.8 %	Salary	28,081	Ln 17,Col 7	6
7	David Weinschneider	Administrative	Administrative	0.00 %	25,964	8	19.8 %	Salary	4,663	Ln 21,Col 7	7
8											8
9											9
10			See Schedule B								10
11											11
12											12
13								TOTAL	\$ 114,722		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 Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007

Ending: 2/31/2007

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 Glen Health & Home Management, Inc.
 Street Address 5454 West Fargo Avenue
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 674-5454
 Fax Number (847) 674-8311

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	5	Utilities	Resident Days	488,234	6	\$ 33,143	\$ 74,334	\$ 5,046	1
2	6	Repairs and Maintenance	Resident Days	488,234	6	28,068	74,334	4,273	2
3	19	Professional Fees	Resident Days	488,234	6	96,943	74,334	14,760	3
4	20	Licenses,Permits and Inspection	Resident Days	488,234	6	72,406	74,334	11,024	4
5	21	Clerical	Resident Days	488,234	6	217,451	74,334	33,107	5
6	22	Employee Benefits and Payroll	Resident Days	488,234	6	377,909	74,334	57,537	6
7	23	Training and Education	Resident Days	488,234	6	2,742	74,334	417	7
8	25	Auto Expenses	Resident Days	488,234	6	37,611	74,334	5,726	8
9	26	Insurance	Resident Days	488,234	6	14,819	74,334	2,256	9
10	30	Depreciation	Resident Days	488,234	6	142,381	74,334	21,678	10
11	33	Real Estate Taxes	Resident Days	488,234	6	73,422	74,334	11,179	11
12	35	Equipment and Vehicle Rental	Resident Days	488,234	6	51,971	74,334	7,913	12
13	6	Janitorial Salaries	Resident Days	488,234	6	20,887	20,887	3,180	13
14	17	Officer's Salaries	Resident Days	488,234	6	461,100	461,100	70,203	14
15	21	Administrative Salaries	Resident Days	488,234	6	1,995,010	1,995,010	303,742	15
16	22	Employee Benefits	Payroll					(57,537)	16
17	7	Employee Benefits - Janitorial	Payroll					483	17
18	27	Employee Benefits - Officer's	Payroll					10,713	18
19	27	Employee Benefits - Admin	Payroll					46,341	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,625,863	\$ 2,476,997	\$ 552,041	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	MB Financial Bank, N.A.		X	Mortgage		12/07/06	\$ 8,500,000	\$	8/30/2007	0.0712	\$ 399,660	1								
2	LaSalle Bank, N.A.		X	Mortgage		8/31/07	16,000,000		12/26/2007	0.0654	355,913	2								
3	The PrivateBank		X	Mortgage		12/27/07	16,000,000	16,000,000	12/27/2010	0.0609	9,170	3								
4	MB Financial Bank, N.A.		X	Amortization of mortgage costs							13,662	4								
5	The PrivateBank		X	Amortization of mortgage costs							2,048	5								
Working Capital																				
6	Sidney Glenner	X		Working Capital		12/14/06	3,115,456	3,115,456	12/14/07	0.0712	253,470	6								
7							Non-allowable owner interest expense:				(253,470)	7								
8												8								
9	TOTAL Facility Related						\$ 43,615,456	\$ 19,115,456			\$ 780,453	9								
B. Non-Facility Related*																				
10										Interest Income Offset:	(67,380)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (67,380)	14								
15	TOTALS (line 9+line14)						\$ 43,615,456	\$ 19,115,456			\$ 713,073	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* 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 Glenlake Terrace Nursing & Rehab# 0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	8,500	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.)			\$	8,289	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(211)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	105,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	104,789	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	_____	8			
2003	_____	9			
2004	_____	10			
2005	99,870	11			
2006	101,899	12			
See Attached Schedule G For Calculation of 2007 Real Estate Tax Accrual.					
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenlake Terrace Nursing & Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048637

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2006

(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. 08-32-109-020	2222 14th Street, Waukegan IL	\$ 2,491.39	\$ 2,491.39
2. 08-32-109-021	2222 14th Street, Waukegan IL	\$ 99,408.04	\$ 99,408.04
3. Allocated from Management Company:		\$ 73,422.00	\$ 11,179.00
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>175,321.43</u>	\$ <u>113,078.43</u>

B. Real Estate Tax Cost Allocation:

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2007

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,925 B. General Construction Type: Exterior Brick Frame Concrete and steel Number of Stories Four

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

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

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

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

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Patient Care</u>	<u>79,750</u>	<u>2006</u>	<u>\$ 502,844</u>	1
2				<u>12,937</u>	2
3	TOTALS	<u>79,750</u>		<u>\$ 515,781</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007

Ending:

12/31/2007

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	271		2006	1974	\$ 7,636,686	\$ 254,556	30	\$ 254,556	\$	\$ 275,769	4
5											5
6	Alloc from				276,146			7,819	7,819		6
7	Mgt Comp										7
8	Schedule J										8
	Improvement Type**										
9	HDSI programs and installation		2006		34,305	3,431	10	3,431		5,146	9
10	Furnish and install outdoor signs		2007		10,055	503	10	503		503	10
11	Remove and install vinyl cove base		2007		9,986	499	10	499		499	11
12	Furnish and install light fixture and run new piping		2007		2,672	134	10	134		134	12
13	Replace leaking hydraulic supply lines for elevators		2007		5,000	250	10	250		250	13
14											14
15											15
16											16
17											17
18											18
19	Allocated from Management Company:				22,319			2,131	2,131	19,650	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007 Ending: 12/31/2007

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	TOTAL (lines 4 thru 69)	\$	7,997,169	\$	259,373	\$	269,323	\$	9,950	\$	301,951	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Glenlake Terrace Nursing & Rehab # 0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

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	\$ 411,612	\$ 41,160	\$ 41,160	\$	10 years	\$ 44,708	71
72	Current Year Purchases	29,956	1,498	1,498		10 years	1,498	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company:	118,883		10,074	10,074		109,114	74
75	TOTALS	\$ 560,451	\$ 42,658	\$ 52,732	\$ 10,074		\$ 155,320	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	Patient Care	2001 Ford Bus	2000	\$ 20,000	\$ 4,000	\$ 4,000	\$	5 years	\$ 6,000	76
77										77
78	Allocated from Management Company:			21,183		1,654	1,654		20,627	78
79										79
80	TOTALS			\$ 41,183	\$ 4,000	\$ 5,654	\$ 1,654		\$ 26,627	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)	\$ 9,114,584	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 327,709	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,678	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 483,898	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

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	TOTAL				\$			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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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 N/A
by the length of the lease N/A.

9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 51,806 Description: Copier \$14,116, Ice-maker \$686, Postage meter \$588, Dish machine \$1,725, Generator \$31,795, Mgt Co: \$2,896
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Patient Care</u>	<u>GMAC</u>	\$ <u>769.00</u>	\$ <u>9,235</u>	17
18					18
19	<u>Allocated from Management Company:</u>			<u>5,017</u>	19
20					20
21	TOTAL		\$ <u>769.00</u>	\$ <u>14,252</u>	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 Glenlake Terrace Nursing & Rehab # 0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to hire only certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	Ln10a,Col 2&3	hrs	\$	4,659	\$ 232,877	\$ 506	4,659	\$ 233,383	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		1,316	66,704		1,316	66,704	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		3,651	205,802	2,073	3,651	207,875	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescripts				260,326		260,326	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Radiology, Laboratory & Dialysis Other (specify): <u>Respiratory Therapy</u>	Ln 39, Col 3 Ln10a,Col 1&3	2,368 hours	35,705		96,087		2,368	96,087 35,705	13
14	TOTAL			\$ 35,705	9,626	\$ 601,470	\$ 262,905	11,994	\$ 900,080	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

STATE OF ILLINOIS

Facility Name & ID Number Glenlake Terrace Nursing & Rehab # 0048637 Report Period Beginning: 1/01/2007 Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 622,607	\$ 1,263,180	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>19,200</u>)	3,272,235	3,272,235	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	249,433	249,433	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(150,936)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,993,339	\$ 4,784,848	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		515,781	13
14	Buildings, at Historical Cost		7,912,832	14
15	Leasehold Improvements, at Historical Cost	62,018	84,337	15
16	Equipment, at Historical Cost	52,756	601,634	16
17	Accumulated Depreciation (book methods)	(14,449)	(483,898)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Mortgage Costs (Net)</u>		145,399	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 100,325	\$ 8,776,085	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,093,664	\$ 13,560,933	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 472,319	\$ 472,319	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	327,100	327,100	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,254	6,254	31
32	Accrued Real Estate Taxes(Sch.IX-B)		105,000	32
33	Accrued Interest Payable		9,170	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule E:</u>	614,048	614,048	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,419,721	\$ 1,533,891	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Stockholders:</u>	3,115,456	3,115,456	43
44	<u>Due to Affiliates:</u>	967,110	967,110	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,082,566	\$ 20,082,566	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,502,287	\$ 21,616,457	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,408,623)	\$ (8,055,524)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,093,664	\$ 13,560,933	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,066,447)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,066,447)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(342,176)	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)	\$ (342,176)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,408,623)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenlake Terrace Nursing & Rehab# 0048637Report Period Beginning: 1/01/2007Ending: 12/31/2007**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,567,605	1
2	Discounts and Allowances for all Levels	(1,865,969)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,701,636	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,330,131	6
7	Oxygen	330,030	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,660,161	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	346,249	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,734	19
20	Radiology and X-Ray	7,885	20
21	Other Medical Services	450,986	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 818,854	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	16,204	28
28a	Private Bedhold Income	2,180	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,384	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,199,043	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,705,130	31
32	Health Care	5,131,575	32
33	General Administration	2,175,093	33
B. Capital Expense			
34	Ownership	2,000,407	34
C. Ancillary Expense			
35	Special Cost Centers	380,658	35
36	Provider Participation Fee	148,356	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,541,219	40
41	Income before Income Taxes (line 30 minus line 40)**	(342,176)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (342,176)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning:

1/01/2007

Ending:

12/31/2007

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,993	2,211	\$ 78,031	\$ 35.29	1
2	Assistant Director of Nursing	2,027	2,264	73,705	32.56	2
3	Registered Nurses	53,565	55,858	1,654,695	29.62	3
4	Licensed Practical Nurses	16,138	16,479	442,766	26.87	4
5	CNAs & Orderlies	113,725	120,913	1,242,986	10.28	5
6	CNA Trainees					6
7	Licensed Therapist	2,209	2,379	35,705	15.01	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,002	2,341	34,538	14.75	9
10	Activity Assistants	10,642	11,560	96,718	8.37	10
11	Social Service Workers	7,903	8,210	90,005	10.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,094	12,952	125,651	9.70	14
15	Cook Helpers/Assistants	24,063	25,462	222,828	8.75	15
16	Dishwashers					16
17	Maintenance Workers	3,691	4,316	67,283	15.59	17
18	Housekeepers	27,311	28,684	246,343	8.59	18
19	Laundry	13,178	14,032	100,963	7.20	19
20	Administrator	2,067	2,416	67,087	27.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,290	17,823	326,531	18.32	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerks</u>	10,427	11,093	116,444	10.50	33
34	TOTAL (lines 1 - 33)	319,325	338,993	\$ 5,022,279 *	\$ 14.82	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	\$ 19,620	Ln 1, Col 3	35
36	Medical Director	Monthly	34,800	Ln 9, Col3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,072	Ln10,Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,200	Ln11,Col 3	44
45	Social Service Consultant	55	2,845	Ln12,Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	79	\$ 65,537		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 Glenlake Terrace Nursing & Rehab

0048637

Report Period Beginning: 1/01/2007

Ending: 12/31/2007

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Claussen	Administrator	0.00 %	\$ 67,087	Workers' Compensation Insurance	\$ 125,884	IDPH License Fee	\$ 1,205	
				Unemployment Compensation Insurance	51,515	Advertising: Employee Recruitment	271	
				FICA Taxes	369,547	Health Care Worker Background Check		
				Employee Health Insurance	91,011	(Indicate # of checks performed)		
				Employee Meals	23,258	Patient Background Checks	387 3,870	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Employee Benefits	30,774			
				Union Health and Welfare	20,691	See Attached Schedule K:	19,792	
				Union Pension	35,010	Allocated from Therapy Masters, Inc.:	3,041	
				Uniform Allowance	(1,057)	Allocated from Management Company:	11,024	
				401K Match	4,712	Less: Public Relations Expense	()	
				See Attached Schedule D:	0	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 67,087				\$ 751,345			\$ 39,203	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (eliminated in Column 7)			\$ 693,546				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 693,546				\$			\$	
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
See Attached Schedule C:			42,691					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL	
\$ 42,691				\$			\$	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Glenlake Terrace Nursing & Rehab

Report Period Beginning: 1/01/2007 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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

Facility Name & ID Number Glenlake Terrace Nursing & Rehab**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. Illinois Council on Long Term Care \$12,195
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,725 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 148,356
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,258 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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

GlenLake Terrace Nursing and Rehabilitation Centre, Ltd.
 Provider I.D. # 0048637
 12/31/2007

SCHEDULE A

SCHEDULE VII. RELATED PARTIES

Part A. Col.3

3 OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
Glen Health & Home Management, Inc.	Skokie	Management Company
GlenBar Management Company, Ltd.	Skokie	Management Company
GlenLake Terrace Realty LLC	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Co.
Therapy Masters	Skokie	Therapy company
VNA Home Health of Illinois, Ltd.	Skokie	Home Health agency
VNA Private Duty of Illinois, Ltd.	Skokie	Home Health agency

See Accountants' Compilation Report

GlenLake Terrace Nursing and Rehabilitation Centre, LTD.
 Provider #
 12/31/2007

SCHEDULE B

SCHEDULE VII RELATED PARTIES

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

Name	Compensation Received From Other Nursing Homes					Total
	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Bridge Nursing & Rehab. Centre, Ltd.	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenShire Nursing & Rehab. Centre, Ltd.	
Sidney Glenner	40,237	35,987	35,422	15,212	29,501	156,359
David Glenner	20,118	17,994	17,711	7,606	14,751	78,180
Jonathan Glenner	10,410	9,311	9,165	3,936	7,633	40,455
Daniel Glenner	6,462	5,780	5,689	2,443	4,738	25,112
David Weinschneider	6,681	5,976	5,882	2,526	4,899	25,964
Joshua Ray	40,237	35,987	35,422	15,212	29,501	156,359
Barry Ray	40,237	35,987	35,422	15,212	29,501	156,359
Total compensation received from other Nursing Homes	164,382	147,022	144,713	62,147	120,524	638,788

See Accountants' Compilation Report

GlenLake Terrace Nursing and Rehabilitation Centre, Ltd.
 Provider I.D. # 0048637
 12/31/2007

SCHEDULE C

XIX. SUPPORT SCHEDULES

C. Professional Services
 Page 21

<u>Vendor/Payee</u>	<u>Type</u>	<u>AMOUNT</u>
Health Data Systems, Inc.	Computers	6,501
Kronos	Computers	1,125
E Health Data Solutions	Computers	4,390
RSM McGladrey	Accounting	600
Sachnoff & Weaver, Ltd.	Legal	30,159
Personnel Planners, Inc.	Unemployment Consulting	480
C.P.T.L.	Marketing	8,000
Total Schedule V, Line 19, Col. 3		<u>51,255</u>
Allocated from Management Co:		
Health Data Systems, Inc. - Computer Services		501
RSM McGladrey - Accounting Services		13,901
Frost, Roth & Ruttenberg - Accounting Services		143
Sachnoff, Weaver & Rubenstein - Legal Services		215
Total allocated from Management Co.		<u>14,760</u>
Total allocated from Therapy Masters:		176
Non-Allowable Expenses:		
C.P.T.L. - marketing		-8,000
Sachnoff & Weaver, Ltd. - Legal Services		-15,500
Total Non-Allowable Expenses:		<u>-23,500</u>
Total adjustments page 21, Sch C.		<u><u>-8,564</u></u>
Total Schedule V, line 19, column 8		<u><u>42,691</u></u>

See Accountants' Compilation Report

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Allocated from Management Co:	
FICA taxes	25,195
FUTA	354
SUTA	1,232
401K Match	1,632
Insurance - Hospital	21,969
Employee Benefits	4,030
Other Employee Benefits	1,978
Workers Compensation Insurance	1,147
Total allocated from Management Co.	<u>57,537</u>
Employee Benefits reclassified to Lines 7, 27	-57,537
Allocated from Therapy Masters, Inc.:	
FICA taxes	26,529
FUTA	515
SUTA	1,004
Other	259
401K Match	2,146
Insurance - Hospital	7,822
Workers Compensation Insurance	5,127
Other Employee Benefits	756
Uniform Allowance	116
Total allocated from Therapy Masters, Inc. Co.	<u>44,274</u>
Employee Benefits reclassified to Lines 15,27	-44,274
Total allocated to Page 21	<u>0</u>

See Accountants' Compilation Report

GlenLake Terrace Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0048637
12/31/2007

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Due to Third Party	18,037
Due To Health and Home Management	634,865
Due to Prior Owner	(49,349)
Accrued Union Dues	4,303
Due Con. Mutual	79
Accrued Wage Assignment	8
Refunds Exchange	6,105
Total, Page 17, Line36	<u><u>614,048</u></u>

See Accountants' Compilation Report

GlenLake Terrace Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0048637
12/31/2007

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

<u>DESCRIPTION</u>	<u>AMOUNT</u>	<u>REFERENCE</u>
Patient clothing	-197	43
Non-allowable owner interest expense	-253,470	32
Non-allowable IL Council on Long Term Care fee	-3,455	20
Non-allowable professional fees	-23,500	19
Adjust mgt co. med supplies - med'A' to cost	-94,833	10
Adjust mgt co. med supplies - 'other' to cost	-106,944	10
Adjust mgt co. food to cost	-28,978	2
Total	<u>-511,377</u>	

See Accountants' Compilation Report

**GlenLake Terrace Realty LLC
Accrued Real Estate Taxes
12/31/2007**

SCHEDULE G

	Accrued 1/01/07	Payments	Expense	Accrued 12/31/07
Balance @ 1/01/2007: (Accrual for 12/08/06-12/31/06)	(8,500.00)		(8,500.00)	
2006 real estate taxes paid = \$101,899.43 (\$101,899.43 actual paid less \$93,610.18 credit received at the 12/07/06 closing)		8,289.25	8,289.25	
Estimated 2007 real estate taxes:				
2006 taxes	101,899.43			
Estimated increase	2.50 %			
Estimated 2007 taxes	104,446.92			
USE	105,000.00		105,000.00	(105,000.00)
Totals	(8,500.00)	8,289.25	104,789.25	(105,000.00)

Real estate tax history:

Year	Amount	Increase	
		\$	%
2005	99,869.61		
2006	101,899.43	2,029.82	2.03%

SEE ACCOUNTANTS' COMPILATION REPORT

Provider Name: Glen Lake Terrace Nursing & Rehabilitation Center

Provider I.D. #: 0048637

Year Ended: December 31, 2007

SCHEDULE H

Training & Education

<u>Person(s) Attending</u>	<u>Date Attended</u>	<u>Location</u>	<u>Title Sponsor</u>	<u>Total Cost</u>
Mary Claussen	1/23/07	Skokie, Il	Illinois Council on Long term Care Stages of Dementia	60
Audio Tape-Mary Claussen	1/17/07		Management Resources Effective Customer Service	79
Mary Claussen, Carolyn English, Patricia Adams	3/29/07	Skokie, Il	Illinois Council on Long term Care Effective Quality Assurance for Nursing	285
Mary Claussen, Carolyn English, Patricia Adams Tammy Rosas	5/31/07	Skokie, Il	Illinois Council on Long term Care Effective Tips & Strategies for Maximizing RUGS	435
Nursing Staff	5/20/07	Facility	A-Tech Ambulance CPR Refresher course	75
Jeff Claussen	8/28/07	Chicago, Il	Activity Therapy Assoc Quality Dementia Activities	150
Carolyn English, Patricia Adams	8/22/07	Skokie, Il	Illinois Council on Long term Care OBRA Accident & Supervision of Frequent Falls	190
Nursing Staff	8/13/07	Facility	A-Tech Ambulance CPR Refresher course	75
Nursing Staff	11/20/07	Facility	PEL/VIP Medical Staffing Trach Care	469
			Allocated From Management Company	418
			Allocated From Therapy Masters	1,174
			Total	<u>3,409</u>

SEE ACCOUNTANTS' COMPILATION REPORT

GlenLake Terrace Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0048637
12/31/2007

SCHEDULE I

Page 3, Schedule V, Line 25, Col 8
Other Admin. Staff Transportation

	Gasoline	Licenses/ Stickers	Mileage Reimburse	Total
Direct Expense	1,350	158	5,060	6,568
Allocated from Management Company				5,726
Allocated from Therapy Masters				578
TOTAL	<u>1,350</u>	<u>158</u>	<u>5,060</u>	<u>12,872</u>

SEE ACCOUNTANTS' COMPILATION REPORT

GlenLake Terrace Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0048637
12/31/2007

SCHEDULE K

XIX. SUPPORT SCHEDULES

Page 21

F. Dues, Fees, Subscriptions and Promotions

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Illinois Council on Long Term Care Dues	12,195
Employment Fees	9,442
City of Waukegan Elevator, Escalator/Platform Lift Inspection	1,205
State of Illinois Boiler Inspection	300
Secretary of State Annual Report Fee	105
Non-allowable Illinois Council on Long Term Care Fee	-3,455
Total allocated to Page 21	<u>19,792</u>

See Accountants' Compilation Report