

		FOR BHF USE					

LL1

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.

I. IDPH License 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: 11/1/1975

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
IRS Exemption Code _____	<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 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & 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: 01/01/07 Ending: 12/31/07

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 04/09/2007

	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>313</u>	Skilled (SNF)	<u>314</u>	<u>114,512</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>313</u>	TOTALS	<u>314</u>	<u>114,512</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>25,614</u>	<u>23,935</u>	<u>27,821</u>	<u>77,370</u>	8
9	SNF/PED					9
10	ICF	<u>26,101</u>	<u>1,275</u>	<u>360</u>	<u>27,736</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,715</u>	<u>25,210</u>	<u>28,181</u>	<u>105,106</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.79%

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)

NoneF. 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 12/01/1975

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 23,189Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	659,563	119,045	22,556	801,164		801,164	5,642	806,806			1
2	Food Purchase		661,924		661,924	(102,784)	559,140	(8,016)	551,124			2
3	Housekeeping	421,706	97,531		519,237		519,237	15,772	535,009			3
4	Laundry	322,288	37,604		359,892		359,892		359,892			4
5	Heat and Other Utilities			403,798	403,798		403,798	2,995	406,793			5
6	Maintenance	256,034	104,528	186,761	547,323		547,323	3,802	551,125			6
7	Other (specify):*											7
8	TOTAL General Services	1,659,591	1,020,632	613,115	3,293,338	(102,784)	3,190,554	20,195	3,210,749			8
	B. Health Care and Programs											
9	Medical Director			109,000	109,000		109,000		109,000			9
10	Nursing and Medical Records	7,058,952	346,681	44,164	7,449,797		7,449,797	(1,570)	7,448,227			10
10a	Therapy	913,831			913,831		913,831		913,831			10a
11	Activities	328,007	23,923	6,621	358,551		358,551		358,551			11
12	Social Services	406,425		2,400	408,825		408,825		408,825			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,707,215	370,604	162,185	9,240,004		9,240,004	(1,570)	9,238,434			16
	C. General Administration											
17	Administrative	201,568		310,987	512,555		512,555	(154,175)	358,380			17
18	Directors Fees											18
19	Professional Services			595,513	595,513		595,513	(416,629)	178,884			19
20	Dues, Fees, Subscriptions & Promotions			252,546	252,546		252,546	(149,608)	102,938			20
21	Clerical & General Office Expenses	426,148	7,717	345,119	778,984		778,984	105,634	884,618			21
22	Employee Benefits & Payroll Taxes			1,795,780	1,795,780	102,784	1,898,564	(1,014)	1,897,550			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,365	10,365		10,365	2,038	12,403			24
25	Other Admin. Staff Transportation			3,069	3,069		3,069		3,069			25
26	Insurance-Prop.Liab.Malpractice			416,459	416,459		416,459	1,374	417,833			26
27	Other (specify):*							88,566	88,566			27
28	TOTAL General Administration	627,716	7,717	3,729,838	4,365,271	102,784	4,468,055	(523,814)	3,944,241			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,994,522	1,398,953	4,505,138	16,898,613		16,898,613	(505,189)	16,393,424			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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			185,471	185,471	185,471	1,239,096	1,424,567			30
31	Amortization of Pre-Op. & Org.						42	42			31
32	Interest			433,479	433,479	433,479	633,699	1,067,178			32
33	Real Estate Taxes						521,666	521,666			33
34	Rent-Facility & Grounds			2,340,000	2,340,000	2,340,000	(2,340,000)				34
35	Rent-Equipment & Vehicles			37,774	37,774	37,774	3,625	41,399			35
36	Other (specify):*			2,500	2,500	2,500	93,017	95,517			36
37	TOTAL Ownership			2,999,224	2,999,224	2,999,224	151,145	3,150,369			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	793,328	1,537,578		2,330,906	2,330,906		2,330,906			39
40	Barber and Beauty Shops	3,416		4,805	8,221	8,221		8,221			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			171,768	171,768	171,768		171,768			42
43	Other (specify):*	92,222		23,844	116,066	116,066	(116,066)				43
44	TOTAL Special Cost Centers	888,966	1,537,578	200,417	2,626,961	2,626,961	(116,066)	2,510,895			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,883,488	2,936,531	7,704,779	22,524,798	22,524,798	(470,110)	22,054,688			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: 01/01/07

Ending: 12/31/07

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	(6,435)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	383,874	30		9
10	Interest and Other Investment Income	(363,489)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,581)	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	(424)	21		18
19	Entertainment				19
20	Contributions	(16,077)	20		20
21	Owner or Key-Man Insurance	(1,014)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,223)	21		24
25	Fund Raising, Advertising and Promotional	(50,234)	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	(596,590)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (704,193)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	234,083		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 234,083		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (470,110)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0026237
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Loss on Sale of Assets	\$ (3,010)	21	1
2 Miscellaneous Income	81	21	2
3 Drivers Salary	(39,818)	43	3
4 Marketing Salary	(52,404)	43	4
5 Venetian Expenses	(1,570)	10	5
6 Administrative Consultant	(4,000)	19	6
7 Bank Charges	(12,679)	21	7
8 Credit Card Fees	(52,299)	21	8
9 Public Relations	(86,799)	20	9
10 Non-Allowable Office Expense	(107,788)	21	10
11 Accounting Fees- Building Company	(12,212)	19	11
12 Licenses and Fees- Building Company	(28)	20	12
13 Non-Allowable Interest	(195,343)	32	13
14 Non-Allowable Other	(21,144)	43	14
15 Marketing Expense	(2,900)	43	15
16 Non-Allowable Legal	(17,843)	19	16
17 R&M Adjustment	(5,240)	06	17
18 Non-Allowable Seminar	(800)	24	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			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			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(596,590)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237

Report Period Beginning:

01/01/07

Ending:

12/31/07**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				5,642								5,642	1
2	Food Purchase	(8,016)											(8,016)	2
3	Housekeeping				15,772								15,772	3
4	Laundry													4
5	Heat and Other Utilities				2,995								2,995	5
6	Maintenance	(5,240)			9,042								3,802	6
7	Other (specify):*													7
8	TOTAL General Services	(13,256)			33,451								20,195	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,570)											(1,570)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,570)											(1,570)	16
	C. General Administration													
17	Administrative			8,935		(103,646)	(60,964)	1,500					(154,175)	17
18	Directors Fees													18
19	Professional Services	(34,055)	12,212	546	(397,614)	2,907	(750)	125					(416,629)	19
20	Fees, Subscriptions & Promotions	(153,270)	250		3,309		95	8					(149,608)	20
21	Clerical & General Office Expenses	(209,504)		1,245	310,941	630	2,268	54					105,634	21
22	Employee Benefits & Payroll Taxes	(1,014)											(1,014)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(500)			2,538								2,038	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				1,374								1,374	26
27	Other (specify):*			1,051	72,425	5,071	9,890	129					88,566	27
28	TOTAL General Administration	(398,343)	12,462	11,777	(7,027)	(95,038)	(49,461)	1,816					(523,814)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(413,169)	12,462	11,777	26,424	(95,038)	(49,461)	1,816					(505,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	383,874	838,012		17,210								1,239,096	30
31	Amortization of Pre-Op. & Org.				42								42	31
32	Interest	(558,832)	1,152,415		40,116								633,699	32
33	Real Estate Taxes		507,379		14,287								521,666	33
34	Rent-Facility & Grounds		(2,340,000)										(2,340,000)	34
35	Rent-Equipment & Vehicles				3,625								3,625	35
36	Other (specify):*		93,017										93,017	36
37	TOTAL Ownership	(174,958)	250,823		75,280								151,145	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(116,066)											(116,066)	43
44	TOTAL Special Cost Centers	(116,066)											(116,066)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(704,193)	263,285	11,777	101,704	(95,038)	(49,461)	1,816					(470,110)	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
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	3,064	Glenview Terrace Property, LLC	100.00%		(3,064)	2
3	V	19 Accounting Fees		Glenview Terrace Property, LLC	100.00%	12,212	12,212	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%	1,129,572	1,129,572	5
6	V	33 Real Estate Taxes		Glenview Terrace Property, LLC	100.00%	507,379	507,379	6
7	V	36 MIP Insurance		Glenview Terrace Property, LLC	100.00%	78,114	78,114	7
8	V	30 Depreciation		Glenview Terrace Property, LLC	100.00%	838,012	838,012	8
9	V	32 Interest Expense		Glenview Terrace Property, LLC	100.00%	25,907	25,907	9
10	V	36 Loan Amortization Cost		Glenview Terrace Property, LLC	100.00%	14,903	14,903	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,343,064			\$ 2,606,349	\$ * 263,285	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: 01/01/07Ending: 12/31/07**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				1,051	1,051	18
19	V							19
20	V	C. RAJCHENBACH-COMP.						20
21	V	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		\$			\$ 11,777	\$ * 11,777	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: 01/01/07Ending: 12/31/07

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%	\$ 96,354	\$ 96,354	15
16	V	19	PROFESSIONAL FEES				2,907	2,907	16
17	V	21	OFFICE				630	630	17
18	V	27	PAYROLL TAXES				5,071	5,071	18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	200,000				(200,000)	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			\$ 200,000			\$ 104,962	\$ * (95,038)	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: 01/01/07Ending: 12/31/07**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%	\$ 50,023	\$ 50,023	15
16	V	19 PROFESSIONAL FEES				(750)	(750)	16
17	V	20 DUES AND SUBSCRIPRTIONS				95	95	17
18	V	21 CLERICAL AND GENERAL				2,268	2,268	18
19	V	27 GEN ADMIN.- EMP. BEN.				9,890	9,890	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	110,987				(110,987)	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		\$ 110,987			\$ 61,526	\$ * (49,461)	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%	\$ 1,500	\$ 1,500	15	
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	125	125	16	
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	8	8	17	
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	54	54	18	
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	129	129	19	
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			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			\$			\$ 1,816	\$ *	1,816	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: 01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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%	Allocated	\$ 8,935	17-7	1
2	Bernard Hollander	Owner	Administrative	18.06%	See Attached	25.00	38.46%	Allocated	96,354	17-7	2
3	Mark Hollander	Relative	Administrative	0.00%	See Attached	17.00	28.33%	Salary	80,000	17-1	3
4	Yosef Davis	Owner	Administrative	9.80%	See Attached	1.00	2.86%	Allocated	1,500	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 186,789		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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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	9,634		6	1,051	4
5										5
6										6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED	40	1	59,667	59,667			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED	40	1	4,736				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					\$ 172,351	\$ 152,981		\$ 11,777	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	412,656	5	\$ 20,328	\$ 114,536	\$ 5,642	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	412,656	5	56,825	114,536	15,772	2
3	5	UTILITIES	AVAILABLE BED DAYS	412,656	5	10,791	114,536	2,995	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	412,656	5	32,579	114,536	9,042	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	412,656	5	40,078	114,536	11,124	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	412,656	5	11,921	114,536	3,309	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	412,656	5	136,311	114,536	37,834	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	412,656	5	9,145	114,536	2,538	8
9	26	INSURANCE	AVAILABLE BED DAYS	412,656	5	4,952	114,536	1,374	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	412,656	5	62,006	114,536	17,210	10
11	31	AMORTIZATION	AVAILABLE BED DAYS	412,656	5	152	114,536	42	11
12	32	INTEREST	AVAILABLE BED DAYS	412,656	5	144,533	114,536	40,116	12
13	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	412,656	5	51,475	114,536	14,287	13
14	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	412,656	5	13,061	114,536	3,625	14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	1,004,580	1,004,580	273,107	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	266,404		72,425	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,865,141	\$ 1,004,580	\$ 510,442	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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

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	43	5	\$ 165,728	\$ 165,728	25	\$ 96,354	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	43	5	5,000		25	2,907	2
3	21	OFFICE	AVG. HOURS WORKED	43	5	1,083	1,083	25	630	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	43	5	8,721		25	5,071	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					\$ 180,532	\$ 166,811		\$ 104,962	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	388,800	9	\$ 175,237	\$ 175,237	110,987	\$ 50,023	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	388,800	9	(2,628)		110,987	(750)	2
3	20	DUES AND SUBSCRIPRTIONS	CARE PATH FEES	388,800	9	332		110,987	95	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	388,800	9	7,946		110,987	2,268	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	388,800	9	34,646		110,987	9,890	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					\$ 215,533	\$ 175,237		\$ 61,526	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	20	6	\$ 30,000	\$ 30,000	1	\$ 1,500	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	20	6	2,500		1	125	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	20	6	166		1	8	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	20	6	1,073		1	54	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	20	6	2,587		1	129	5
6	30	DEPRECIATION	AVG. HOURS WORKED	20	6			1		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					\$ 36,326	\$ 30,000		\$ 1,816	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning: 01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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			
A. Directly Facility Related																	
Long-Term																	
1	HUD		X	Mortgage			\$	\$ 15,580,633			\$ 1,129,572	1					
2	McGrath		X	Auto Loan							737	2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	Bank One		X	Line of Credit				2,834,518			228,497	6					
7	INAC		X	Insurance Financing							8,903	7					
8	See Supplemental Schedule										261,365	8					
9	TOTAL Facility Related						\$	\$ 18,415,151			\$ 1,629,074	9					
B. Non-Facility Related*																	
10	Interest Income		X								(363,489)	10					
11	Interest Income- Bldg Co.		X								(3,064)	11					
12												12					
13	See Supplemental Schedule										(195,343)	13					
14	TOTAL Non-Facility Related						\$	\$			\$ (561,896)	14					
15	TOTALS (line 9+line14)						\$	\$ 18,415,151			\$ 1,067,178	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,114 Line # 36

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

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

Facility Name & ID Number

Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

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

	1	2		3	4	5	6		7	8	9	10						
		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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term											7						
Working Capital																		
8	Shareholder Loan	X					\$	\$			\$	87,894	8					
9	Related Parties	X										107,448	9					
10	Building Company		X									25,907	10					
11	Allocate ITEX		X									40,116	11					
12													12					
13													13					
14	TOTAL Working Capital											14						
B. Non-Facility Related*																		
15	Shareholder/Rel. Party Int	X					\$	\$			\$	(195,343)	15					
16													16					
17													17					
18													18					
19													19					
20	TOTAL Non-Facility Related											20						

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

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

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, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-28-401-042-0000</u>	<u>Long Term Care Property</u>	\$ <u>498,058.24</u>	\$ <u>498,058.24</u>
2. <u>10-35-312-022-0000</u>	<u>Central Office</u>	\$ <u>53,843.93</u>	\$ <u>14,287.24</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>551,902.17</u>	\$ <u>512,345.48</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 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.

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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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:

01/01/07 Ending:

12/31/07

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: 42 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1978</u>	<u>\$ 167,502</u>	1
2					2
3	TOTALS			\$ 167,502	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	314		1978	1975	\$ 2,750,940	\$ 253,135		\$ 68,774	\$ (184,361)	\$ 2,156,902	4
5				1989	1,453,936			36,346	36,346	660,960	5
6				2002	4,266,341			462,432	462,432	2,490,557	6
7				2004	37,074			3,709	3,709	14,526	7
8											8
	Improvement Type**										
9	Various			1975	28,890		20			28,890	9
10	Various			1977	11,520		20			6,484	10
11	Various			1978	1,209		20			1,209	11
12	Various			1979	4,832		20			4,832	12
13	Various			1980	6,097		20			6,097	13
14	Various			1981	2,004		20			1,610	14
15	Various			1982	6,604		20			2,943	15
16	Various			1983	5,607		20			5,607	16
17	Various			1984	4,233		20			4,233	17
18	Various			1985	10,997		20			9,125	18
19	Various			1986	2,080		20			2,071	19
20	Various			1987	2,375		20	109	109	1,655	20
21	Various			1988	4,955		20	248	248	3,942	21
22	Various			1989	111,464		20	5,574	5,574	96,916	22
23	Various			1990	98,033		20	4,903	4,903	73,697	23
24	Various			1991	2,229		20	111	111	1,628	24
25	Various			1992	3,024		20	151	151	2,211	25
26	Various			1993	103,239		20	5,163	5,163	75,961	26
27	Various			1994	23,033		20	1,152	1,152	14,769	27
28	Various			1995	44,266		20	2,214	2,214	27,485	28
29	Various			1996	93,171		20	4,659	4,659	53,928	29
30	Various			1997	102,244		20	3,706	3,706	39,227	30
31	Various			1998	103,389		20	6,252	6,252	58,653	31
32	Various			1999	150,958		20	11,569	11,569	100,693	32
33	Various			2000	37,198		20	1,860	1,860	13,532	33
34	Various			2001	217,477		20	10,876	10,876	71,690	34
35	Various			2002	5,478,039		20	309,639	309,639	1,872,737	35
36	Various			2003	1,988,331		20	120,862	120,862	615,789	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 Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			555,772	14,265	18,605	4,340	256,625	68				
69				423,579		(423,579)		69				
70		\$	17,711,561	\$	690,979	\$	1,078,914	\$	387,935	\$	8,777,184	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12D, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12A, Carried Forward		\$ 17,711,561	\$ 690,979		\$ 1,078,914	\$ 387,935	\$ 8,777,184	1
2	Amtech Elevator	2004	36,358		20	3,636	3,636	14,543	2
3	Floors By Tiles Carmelo	2004	2,331		20	233	233	894	3
4	Metron Eng. - Rod Oak Wood Door	2004	4,986		20	499	499	1,953	4
5	Marian Janek - Plumbing	2004	8,000		20	800	800	3,200	5
6	Illi Hardware - Doors	2004	2,844		20	284	284	1,138	6
7	Enga Resource - Survey	2004	4,906		20	491	491	1,962	7
8	Taylorville Glass	2004	27,570		20	2,757	2,757	11,028	8
9	Trostand Mosaic	2004	1,062		20	106	106	425	9
10	Brook Electric - Light Fixture	2004	1,756		20	176	176	702	10
11	Satellite - Cable	2004	7,560		20	756	756	2,961	11
12	Satellite - Cable	2004	8,611		20	861	861	3,301	12
13	Flortech - Floor	2004	57,267		20	5,727	5,727	22,907	13
14	Closing Costs - Poulos	2004	57,784		20	5,778	5,778	23,114	14
15	Refund By Poulos	2004	(172,500)		20	(17,250)	(17,250)	(69,000)	15
16	Trec Electrical Contractors	2004	10,035		20	1,004	1,004	3,847	16
17	Suburban Elevator	2004	3,400		20	170	170	638	17
18	Three Generations Paving	2004	28,000		20	2,800	2,800	9,100	18
19	J.M.Concrete Work	2004	2,100		20	210	210	683	19
20	Landscaping	2004	500		20	33	33	117	20
21	Landscaping	2004	1,076		20	72	72	245	21
22	Landscaping	2004	1,166		20	78	78	266	22
23	Landscaping	2004	1,189		20	79	79	271	23
24	Landscaping	2004	1,256		20	84	84	286	24
25	Landscaping	2004	1,293		20	86	86	287	25
26	Landscaping	2004	1,517		20	101	101	337	26
27	Landscaping	2004	2,357		20	157	157	511	27
28	Three Generations Paving	2004	1,500		20	100	100	308	28
29	Cooling Equipment Service	2004	650		20	130	130	444	29
30	Cooling Equipment Service	2004	28,350		20	5,670	5,670	19,373	30
31	Insulation	2004	1,203		20	120	120	471	31
32	Insulation	2004	1,501		20	150	150	538	32
33	Paint	2004	646		20	65	65	248	33
34	TOTAL (lines 1 thru 33)		\$ 17,847,835	\$ 690,979		\$ 1,094,877	\$ 403,898	\$ 8,834,282	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12B, Carried Forward		\$ 17,847,835	\$ 690,979		\$ 1,094,877	\$ 403,898	\$ 8,834,282	1
2	Fire Alarm Control Pnl	2004	840		20	84	84	294	2
3	Walk-In Freezer Repair	2004	1,544		20	154	154	540	3
4	Reloc Sprinkler Heads	2004	846		20	85	85	331	4
5	Hvac - Compressor	2004	1,444		20	144	144	529	5
6	Hvac - Compressor	2004	1,186		20	119	119	435	6
7	Heating Circuits	2004	1,205		20	121	121	472	7
8	Fire Alarm Control Pnl	2004	1,596		20	160	160	638	8
9	Pump And Motor	2004	1,200		20	120	120	390	9
10	Nurse Call System	2004	2,463		20	246	246	862	10
11	Sidewalk Repair	2004	500		20	50	50	171	11
12	Nurse Call System	2004	4,980		20	498	498	1,619	12
13	Boiler	2005	7,500		20	625	625	1,667	13
14	Trees	2005	1,090		20	73	73	182	14
15	Roofing	2005	3,150		20	210	210	525	15
16	Air Handler	2005	29,239		20	2,437	2,437	6,498	16
17	Ac Pumps	2005	5,878		20	490	490	1,184	17
18	Cooling Equipment Pump	2005	4,126		20	344	344	802	18
19	Water Filtration System	2005	1,400		20	117	117	263	19
20	Boiler System	2005	1,753		20	146	146	304	20
21	Cooling Equipment Change Order	2005	1,000		20	83	83	222	21
22	Fence	2005	5,000		20	334	334	834	22
23	Fence	2005	1,850		20	123	123	308	23
24	Fence	2005	1,550		20	103	103	258	24
25	Phone System	2005	18,292		20	1,829	1,829	4,421	25
26	Phone System	2005	4,435		20	444	444	924	26
27	Sprinkler System	2005	5,255		20	751	751	2,064	27
28	Sprinkler System	2005	3,950		20	564	564	1,505	28
29	Elevator Work	2005	2,200		20	440	440	1,320	29
30	Elevator Work	2005	6,000		20	1,200	1,200	3,500	30
31	Replace Boiler Flow Switch	2005	1,763		20	88	88	198	31
32	Carpeting	2005	3,532		20	177	177	456	32
33	New Cedar Fence	2005	2,100		20	105	105	254	33
34	TOTAL (lines 1 thru 33)		\$ 17,976,702	\$ 690,979		\$ 1,107,341	\$ 416,362	\$ 8,868,252	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12C, Carried Forward		\$ 17,976,702	\$ 690,979		\$ 1,107,341	\$ 416,362	\$ 8,868,252	1
2	Alarm System Repair	2005	1,501		20	75	75	181	2
3	1 New Boiler Control System	2006	3,537		20	707	707	1,415	3
4	3 Electric Wall Heater/Ac Units	2006	1,616		20	323	323	350	4
5	2 Electric Wall Heater A/C Units	2006	1,075		20	215	215	233	5
6	Sprayed Fireproofing Stairs And Mechanical	2006	25,700		20	2,570	2,570	4,498	6
7	2 Chassis Heater For Resident Rooms	2006	3,015		20	603	603	1,156	7
8	2 Chassis Heaters For Resident Rooms	2006	3,015		20	603	603	804	8
9	Elevator Door	2006	2,650		20	265	265	464	9
10	Acoustical Supplies	2006	3,120		20	312	312	546	10
11	Installing Durkan Carpeting	2007	6,449		20	54	54	54	11
12	Tie Boilers To Storage Tank	2007	3,100		20	310	310	310	12
13	Roof Repairs	2007	1,900		20	74	74	74	13
14	Carpeting	2007	20,584		20	686	686	686	14
15	Electric Wall Heater	2007	1,762		20	29	29	29	15
16	Electric Wall Heater	2007	1,762		20	29	29	29	16
17	3 Electric Wall Heaters	2007	1,766		20	44	44	44	17
18	Concrete Stairs & Leak Repair	2007	4,450		20	223	223	223	18
19	Concrete Driveway	2007	6,500		20	325	325	325	19
20	Sinks And Faucets	2007	11,929		20	795	795	795	20
21	Doors And Crown	2007	4,100		20	239	239	239	21
22	2 Suburban Units- Heat Unit	2007	3,070		20	281	281	281	22
23	1 Suburban Unit- Heat Unit	2007	1,535		20	64	64	64	23
24	2 Suburban Units- Heat Unit	2007	3,070		20	51	51	51	24
25	Cable In Walls Between Rooms	2007	3,450		20	345	345	345	25
26	Interior Fabric	2007	2,573		20	129	129	129	26
27	Pump And Motor	2007	2,667		20	133	133	133	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12E, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12F, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12G, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12H, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12I, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12K, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12L, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12M, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12N, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12O, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

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	Totals from Page 12P, Carried Forward		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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)		\$ 18,102,598	\$ 690,979		\$ 1,116,825	\$ 425,846	\$ 8,881,710	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

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:

01/01/07

Ending:

12/31/07

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)		\$	\$	\$	\$	\$	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:

01/01/07

Ending:

12/31/07

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	Allocate: ITEX		1993	1993	\$ 445,218	\$ 11,416	35	\$ 12,720	\$ 1,304	\$ 185,506	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocate: ITEX		1993		56,021	676	20	2,801	2,125	41,194	9
10	Allocate: ITEX		1994		30,090	783	20	1,505	722	19,981	10
11	Allocate: ITEX		1995		5,128	14	20	256	242	3,127	11
12	Allocate: ITEX		1996		290	-	20	15	15	175	12
13	Allocate: ITEX		1997		8,651	222	20	433	211	4,542	13
14	Allocate: ITEX		1999		961	25	20	48	23	432	14
15	Allocate: ITEX		2005		4,206	1,010	20	684	(326)	1,525	15
16	Allocate: ITEX		2007		5,207	119	20	143	24	143	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

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:

01/01/07

Ending:

12/31/07

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)	\$	555,772	\$	14,265	\$	18,605	\$	4,340	\$	256,625	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: 01/01/07 Ending: 12/31/07

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	\$ 2,706,950	\$ 333,679	\$ 293,899	\$ (39,780)	10	\$ 2,096,726	71
72	Current Year Purchases	88,375	10,846	9,047	(1,799)	10	9,047	72
73	Fully Depreciated Assets	929,897		1,263	1,263	10	929,897	73
74								74
75	TOTALS	\$ 3,725,222	\$ 344,525	\$ 304,209	\$ (40,316)		\$ 3,035,670	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	\$	\$	\$	5	\$ 27,850	76
77		RUNNING BOARD INSTAL	2001	700				5	700	77
78		LEXUS	2004		5,189	3,533	(1,656)			78
79										79
80	TOTALS			\$ 28,550	\$ 5,189	\$ 3,533	\$ (1,656)		\$ 28,550	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)	\$ 22,023,872	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,040,693	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,424,567	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 383,874	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,945,930	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

**

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: \$ 21,582 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	<u>Facility/Residential</u>	<u>2004 Ford Ecoline</u>	\$ <u>549.95</u>	\$ <u>6,599</u>	17
18	<u>Lease BBH</u>		<u>1,300.00</u>	<u>13,218</u>	18
19					19
20					20
21	TOTAL		\$ <u>1,849.95</u>	\$ <u>19,817</u>	21

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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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.

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. 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	39 - 01	hrs	\$ 344,064		\$	\$		\$ 344,064	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	19,077			37,395		56,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	325,150			80,106		405,256	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				1,294,054		1,294,054	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>			105,037			126,023		231,060	13
14	TOTAL			\$ 793,328		\$	\$ 1,537,578		\$ 2,330,906	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: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ (54,115)	\$ 172,401	1
2	Cash-Patient Deposits	33,442	33,442	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,078,949	3,078,949	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	481,712	540,033	6
7	Other Prepaid Expenses	47,204	47,204	7
8	Accounts Receivable (owners or related parties)	3,866,643	3,523,537	8
9	Other(specify): <u>See Attached Schedule</u>	679,466	1,407,209	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,133,301	\$ 8,802,775	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		198,820	13
14	Buildings, at Historical Cost		8,932,843	14
15	Leasehold Improvements, at Historical Cost	498,824	8,100,101	15
16	Equipment, at Historical Cost	1,140,659	4,574,661	16
17	Accumulated Depreciation (book methods)	(804,832)	(10,906,700)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,500	7,500	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,667)	(6,667)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	541,897	1,067,255	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,377,381	\$ 11,967,813	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,510,682	\$ 20,770,588	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,664,198	\$ 2,674,698	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,838	31,838	28
29	Short-Term Notes Payable	2,834,518	2,834,518	29
30	Accrued Salaries Payable	432,591	432,591	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,661	32,661	31
32	Accrued Real Estate Taxes(Sch.IX-B)		522,961	32
33	Accrued Interest Payable	22,984	116,857	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	150,448	150,448	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,169,238	\$ 6,796,572	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,580,633	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,580,633	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,169,238	\$ 22,377,205	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,341,444	\$ (1,606,617)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,510,682	\$ 20,770,588	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,989,730	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,989,726	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	531,718	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	(180,000)	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)	\$ 351,718	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)	\$ 3,341,444	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 18,847,489	1
2	Discounts and Allowances for all Levels	(3,105,760)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,741,729	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,986,364	6
7	Oxygen	15,572	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,001,936	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	4,915	13
14	Non-Patient Meals	6,435	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,687,115	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	200,007	19
20	Radiology and X-Ray		20
21	Other Medical Services	35,757	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,934,229	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	363,489	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 363,489	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	15,133	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,133	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,056,516	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,293,338	31
32	Health Care	9,240,004	32
33	General Administration	4,365,271	33
B. Capital Expense			
34	Ownership	2,999,224	34
C. Ancillary Expense			
35	Special Cost Centers	2,455,193	35
36	Provider Participation Fee	171,768	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,524,798	40
41	Income before Income Taxes (line 30 minus line 40)**	531,718	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 531,718	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:

01/01/07

Ending:

12/31/07

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	1,906	2,496	\$ 132,019	\$ 52.89	1
2	Assistant Director of Nursing	5,200	6,120	266,824	43.60	2
3	Registered Nurses	90,998	101,111	2,714,578	26.85	3
4	Licensed Practical Nurses	30,646	33,154	900,446	27.16	4
5	CNAs & Orderlies	233,202	252,992	2,948,673	11.66	5
6	CNA Trainees					6
7	Licensed Therapist	27,854	29,462	793,328	26.93	7
8	Rehab/Therapy Aides	47,329	52,672	913,831	17.35	8
9	Activity Director	1,904	2,232	40,181	18.00	9
10	Activity Assistants	23,625	25,684	287,826	11.21	10
11	Social Service Workers	21,013	23,204	406,425	17.52	11
12	Dietician					12
13	Food Service Supervisor	3,476	3,868	92,046	23.80	13
14	Head Cook	6,283	6,859	81,535	11.89	14
15	Cook Helpers/Assistants	40,733	44,608	485,982	10.89	15
16	Dishwashers					16
17	Maintenance Workers	14,834	16,704	256,034	15.33	17
18	Housekeepers	41,689	47,050	421,706	8.96	18
19	Laundry	24,488	26,938	322,288	11.96	19
20	Administrator	1,872	2,096	121,568	58.00	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	80,000	76.92	22
23	Office Manager	1,889	2,185	52,125	23.86	23
24	Clerical	18,121	19,995	374,023	18.71	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	6,203	6,947	96,412	13.88	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,005	4,302	95,638	22.23	33
34	TOTAL (lines 1 - 33)	648,310	711,719	\$ 11,883,488 *	\$ 16.70	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	\$ 22,556	01-03	35
36	Medical Director	Monthly	109,000	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	24,000	10-03	38
39	Pharmacist Consultant	Monthly	15,940	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	6,621	11-03	44
45	Social Service Consultant	Monthly	2,400	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 184,741		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: 01/01/07 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 Glenview Terrace Nursing Ctr**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. ILAHC \$5,185 & ILCLTC \$15688
- (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. \$ 17,126 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 171,768
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. \$ 102,784 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,435
- (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? 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. \$ 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