

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	14,019	24,508	30,565	69,092	8
9	SNF/PED					9
10	ICF	33,327	692		34,019	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,346	25,200	30,565	103,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.97%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 12/01/1975

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 314 and days of care provided 24,849

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Glenview Terrace Nursing Ctr # 0026237 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	761,040	121,784	35,201	918,025		918,025	6,465	924,490		1
2	Food Purchase		771,067		771,067	(122,056)	649,011	(6,896)	642,115		2
3	Housekeeping	533,371	106,220		639,591		639,591	12,136	651,727		3
4	Laundry	315,707	46,863		362,570		362,570		362,570		4
5	Heat and Other Utilities			349,633	349,633		349,633	4,892	354,525		5
6	Maintenance	233,938	94,376	257,539	585,853		585,853	24,224	610,077		6
7	Other (specify):*										7
8	TOTAL General Services	1,844,056	1,140,310	642,373	3,626,739	(122,056)	3,504,683	40,821	3,545,504		8
	B. Health Care and Programs										
9	Medical Director			111,500	111,500		111,500		111,500		9
10	Nursing and Medical Records	7,806,371	293,938	25,858	8,126,167		8,126,167	(4,541)	8,121,626		10
10a	Therapy	1,121,042		29,600	1,150,642		1,150,642		1,150,642		10a
11	Activities	344,978	32,354	7,811	385,143		385,143		385,143		11
12	Social Services	431,815		2,600	434,415		434,415		434,415		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	9,704,206	326,292	177,369	10,207,867		10,207,867	(4,541)	10,203,326		16
	C. General Administration										
17	Administrative	275,712		372,136	647,848		647,848	(235,473)	412,375		17
18	Directors Fees										18
19	Professional Services			551,196	551,196		551,196	(421,333)	129,863		19
20	Dues, Fees, Subscriptions & Promotions			293,777	293,777		293,777	(161,063)	132,714		20
21	Clerical & General Office Expenses	529,893	8,795	485,370	1,024,058		1,024,058	(12,655)	1,011,403		21
22	Employee Benefits & Payroll Taxes			2,082,554	2,082,554	122,056	2,204,610	(46,044)	2,158,566		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,910	11,910		11,910	942	12,852		24
25	Other Admin. Staff Transportation			10,514	10,514		10,514		10,514		25
26	Insurance-Prop.Liab.Malpractice			411,109	411,109		411,109	1,710	412,819		26
27	Other (specify):*							83,665	83,665		27
28	TOTAL General Administration	805,605	8,795	4,218,566	5,032,966	122,056	5,155,022	(790,251)	4,364,771		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,353,867	1,475,397	5,038,308	18,867,572		18,867,572	(753,971)	18,113,601		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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			248,095	248,095		248,095	1,080,771	1,328,866			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			614,458	614,458		614,458	164,538	778,996			32
33	Real Estate Taxes			45,353	45,353		45,353	616,352	661,705			33
34	Rent-Facility & Grounds			1,951,000	1,951,000		1,951,000	(1,927,000)	24,000			34
35	Rent-Equipment & Vehicles			60,232	60,232		60,232	3,224	63,456			35
36	Other (specify):*							78,056	78,056			36
37	TOTAL Ownership			2,919,138	2,919,138		2,919,138	15,941	2,935,079			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,051,349	1,904,667		2,956,016		2,956,016		2,956,016			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,915	171,915		171,915		171,915			42
43	Other (specify):*	100,917		14,659	115,576		115,576	(115,576)				43
44	TOTAL Special Cost Centers	1,152,266	1,904,667	186,574	3,243,507		3,243,507	(115,576)	3,127,931			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	13,506,133	3,380,064	8,144,020	25,030,217		25,030,217	(853,606)	24,176,611			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

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	(5,020)	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	482,282	30		9
10	Interest and Other Investment Income	(527,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,876)	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	(102)	21		18
19	Entertainment				19
20	Contributions	(18,599)	20		20
21	Owner or Key-Man Insurance	(644)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,297)	21		24
25	Fund Raising, Advertising and Promotional	(46,619)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,547)	20		28
29	Other-Attach Schedule	(1,684,878)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,906,300)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,052,694		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,052,694		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (853,606)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Glenview Terrace Nursing Ctr

ID# 0026237

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income - State of Illinois	\$ (240)	21	1
2	Legal Support	(40)	19	2
3	Telephone Payments	(72)	21	3
4	Drivers' Salary	(39,740)	43	4
5	Marketing Salary	(61,177)	43	5
6	Veterans' Expenses	(4,541)	10	6
7	Administrative Consultant	(2,000)	19	7
8	Bank Charges	(29,446)	21	8
9	Credit Card Fees	(45,222)	21	9
10	Public Relations	(90,224)	20	10
11	Trust Fees	(100)	20	11
12	COPE Dues	(4,690)	20	12
13	Non-Allowable Interest	(333,962)	32	13
14	Non-Allowable Legal	(21,054)	19	14
15	Non-Allowable Other	(14,659)	43	15
16	Non-Allowable Office Expense	(173,734)	21	16
17	Misc. Employee Benefits	(45,400)	22	17
18	Accounting Fees- Building Company	(17,403)	19	18
19	Legal Fees - Building Company	(16,103)	19	19
20	Licenses & Fees - Building Company	(250)	20	20
21	Amortization - Building Company	(513,089)	36	21
22	Penalties - Building Company	(283,302)	21	22
23	Architectural & Appraisal Fees - Building Co.	(1,750)	19	23
24	Capitalized R/M	(5,886)	06	24
25	Additional R/M	19,206	06	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,684,878)		49

Glenview Terrace Nursing CtrID# 0026237Report Period Beginning: 01/01/09Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				6,465								6,465	1
2	Food Purchase	(6,896)											(6,896)	2
3	Housekeeping				12,136								12,136	3
4	Laundry													4
5	Heat and Other Utilities				4,892								4,892	5
6	Maintenance	13,320			10,904								24,224	6
7	Other (specify):*													7
8	TOTAL General Services	6,424			34,397								40,821	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,541)											(4,541)	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	(4,541)											(4,541)	16
	C. General Administration													
17	Administrative			(68,889)		(166,584)							(235,473)	17
18	Directors Fees													18
19	Professional Services	(58,350)	35,256	556	(402,274)	3,479							(421,333)	19
20	Fees, Subscriptions & Promotions	(165,029)	250		3,716								(161,063)	20
21	Clerical & General Office Expenses	(631,415)	283,302	1,389	334,069								(12,655)	21
22	Employee Benefits & Payroll Taxes	(46,044)											(46,044)	22
23	Inservice Training & Education													23
24	Travel and Seminar				942								942	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				1,710								1,710	26
27	Other (specify):*			1,199	75,534	6,932							83,665	27
28	TOTAL General Administration	(900,838)	318,808	(65,745)	13,697	(156,173)							(790,251)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(898,955)	318,808	(65,745)	48,094	(156,173)							(753,971)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	482,282	579,297		19,192								1,080,771	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(860,962)	980,023		45,477								164,538	32
33	Real Estate Taxes		599,963		16,389								616,352	33
34	Rent-Facility & Grounds		(1,927,000)										(1,927,000)	34
35	Rent-Equipment & Vehicles				3,224								3,224	35
36	Other (specify):*	(513,089)	591,145										78,056	36
37	TOTAL Ownership	(891,769)	823,428		84,282								15,941	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):*	(115,576)											(115,576)	43
44	TOTAL Special Cost Centers	(115,576)											(115,576)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,906,300)	1,142,236	(65,745)	132,376	(156,173)							(853,606)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,927,000	Glenview Terrace Property, LLC	100.00%	\$	\$ (1,927,000)	1
2	V	32 Interest Income	3,084	Glenview Terrace Property, LLC	100.00%		(3,084)	2
3	V	21 Prepayment Penalty		Glenview Terrace Property, LLC	100.00%	283,302	283,302	3
4	V	19 Legal Fees		Glenview Terrace Property, LLC	100.00%	16,103	16,103	4
5	V	19 Accounting Fees		Glenview Terrace Property, LLC	100.00%	17,403	17,403	5
6	V	19 Architectural & Appraisal		Glenview Terrace Property, LLC	100.00%	1,750	1,750	6
7	V	20 Licenses & Fees		Glenview Terrace Property, LLC	100.00%	250	250	7
8	V	32 Mortgage Interest Expense		Glenview Terrace Property, LLC	100.00%	983,107	983,107	8
9	V	33 Real Estate Taxes		Glenview Terrace Property, LLC	100.00%	599,963	599,963	9
10	V	36 M.I.P. Insurance		Glenview Terrace Property, LLC	100%	78,056	78,056	10
11	V	30 Depreciation		Glenview Terrace Property, LLC	100%	579,297	579,297	11
12	V	36 Loan Amortization		Glenview Terrace Property, LLC	100%	513,089	513,089	12
13	V							13
14	Total		\$ 1,930,084			\$ 3,072,320	\$ * 1,142,236	14

* 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	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 11,111	\$	11,111	15
16	V	19 PROFESSIONAL FEES				556		556	16
17	V	21 OFFICE				1,389		1,389	17
18	V	27 PAYROLL TAXES				1,199		1,199	18
19	V								19
20	V	17 C. RAJCHENBACH-COMP.							20
21	V	27 PAYROLL TAXES							21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17 MANAGEMENT FEES	80,000					(80,000)	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		\$ 80,000			\$ 14,255	\$ *	(65,745)	39

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

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/09Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 6,465	\$	6,465	15
16	V	3 HOUSEKEEPING				12,136		12,136	16
17	V	5 UTILITIES				4,892		4,892	17
18	V	6 REPAIRS AND MAINT.				10,904		10,904	18
19	V	19 PROFESSIONAL FEES				16,685		16,685	19
20	V	20 FEES, SUBSCRIPTIONS				3,716		3,716	20
21	V	21 CLERICAL AND GENERAL				46,516		46,516	21
22	V	24 EDUCATION/SEMINARS				942		942	22
23	V	26 INSURANCE				1,710		1,710	23
24	V	30 DEPRECIATION				19,192		19,192	24
25	V	32 INTEREST				45,477		45,477	25
26	V	33 REAL ESTATE TAXES				16,389		16,389	26
27	V	35 EQUIPMENT RENTAL				3,224		3,224	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	21 CLERICAL SALARIES				287,553		287,553	32
33	V	27 GEN ADMIN. - EMP. BEN.				75,534		75,534	33
34	V								34
35	V	19 Administrative Cons	29,250					(29,250)	35
36	V	19 Bookkeeping	384,000					(384,000)	36
37	V	19 Data Processing	5,709					(5,709)	37
38	V								38
39	Total		\$ 418,959			\$ 551,335	\$ *	132,376	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 125,552	\$	125,552	15
16	V	19 PROFESSIONAL FEES				3,479		3,479	16
17	V	27 PAYROLL TAXES				6,932		6,932	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V	17 MANAGEMENT FEES	292,136					(292,136)	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		\$ 292,136			\$ 135,963	\$ *	(156,173)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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

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

Facility Name & ID Number

Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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%	Alloc. Salary	\$ 11,111	17-7	1
2	Bernard Hollander	Owner	Administrative	18.06%	See Attached	25.00	38.46%	Alloc. Salary	125,552	17-7	2
3	Mark Hollander	Relative	Administrative	0.00%	See Attached	27.00	45.00%	Salary	142,300	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 278,963		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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 54	9	\$ 100,000	\$ 100,000	6	\$ 11,111	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 54	9	5,000		6	556	2
3	21	OFFICE	AVG. HOURS WORKED 54	9	12,497	12,497	6	1,389	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED 54	9	10,792		6	1,199	4
5									5
6									6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED 40	1	51,889	51,889			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED 40	1	4,099				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				\$ 184,277	\$ 164,386		\$ 14,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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

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	358,430	4	\$ 20,219	\$ 114,610	\$ 6,465	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	358,430	4	37,953	114,610	12,136	2
3	5	UTILITIES	AVAILABLE BED DAYS	358,430	4	15,300	114,610	4,892	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	358,430	4	34,101	114,610	10,904	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	358,430	4	52,179	114,610	16,685	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	358,430	4	11,623	114,610	3,716	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	358,430	4	145,474	114,610	46,516	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	358,430	4	2,946	114,610	942	8
9	26	INSURANCE	AVAILABLE BED DAYS	358,430	4	5,348	114,610	1,710	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	358,430	4	60,022	114,610	19,192	10
11	32	INTEREST	AVAILABLE BED DAYS	358,430	4	142,224	114,610	45,477	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	358,430	4	51,255	114,610	16,389	12
13	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	358,430	4	10,084	114,610	3,224	13
14									14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	859,236	859,236	287,553	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	225,704		75,534	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,673,668	\$ 859,236	\$ 551,335	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	33	4	\$ 165,728	\$ 165,728	25	\$ 125,552	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	33	4	4,592		25	3,479	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	33	4	9,151		25	6,932	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					\$ 179,471	\$ 165,728		\$ 135,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10												
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
													YES	NO				Original	Balance			
	A. Directly Facility Related																					
	Long-Term																					
1	HUD		X	Mortgage			\$	\$ 15,874,468			\$ 983,107	1										
2												2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	MB Financial		X	Line of Credit				3,250,000			133,285	6										
7	INAC		X	Insurance Financing							9,904	7										
8	See Supplemental Schedule							1,699,803			418,609	8										
9	TOTAL Facility Related						\$	\$ 20,824,271			\$ 1,544,905	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(527,000)	10										
11	Interest Income - Bldg. Co.		X								(3,084)	11										
12												12										
13	See Supplemental Schedule										(235,825)	13										
14	TOTAL Non-Facility Related						\$	\$			\$ (765,909)	14										
15	TOTALS (line 9+line14)						\$	\$ 20,824,271			\$ 778,996	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,056 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Shareholder Loan	X								\$ 98,939										
9	Related Parties	X								136,886										
10	Union Audit		X							4,697										
11	Omnicare		X				1,699,803			132,610										
12	Allocated From ITEX		X							45,477										
13																				
14	TOTAL Working Capital									1,699,803										
B. Non-Facility Related*																				
15	Shareholder/Rel. Party Int.	X								\$ (235,825)										
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related									(235,825)										

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Glenview Terrace Nursing Ctr

0026237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 144,415		\$ 68,774	\$ (75,641)	\$ 2,294,450	4
5			1989	1,453,936			36,346	36,346	733,652	5
6			2002	4,266,341			462,432	462,432	3,415,421	6
7			2004	37,074			3,709	3,709	21,944	7
8										8
Improvement Type**										
9	Various		1975	28,890		20			28,890	9
10	Various		1977	11,520		20			6,484	10
11	Various		1978	1,209		20			1,209	11
12	Various		1979	4,832		20			4,832	12
13	Various		1980	6,097		20			6,097	13
14	Various		1981	2,004		20			1,610	14
15	Various		1982	6,604		20			2,943	15
16	Various		1983	5,607		20			5,607	16
17	Various		1984	4,233		20			4,233	17
18	Various		1985	10,997		20			9,125	18
19	Various		1986	2,080		20			2,071	19
20	Various		1987	2,375		20			1,655	20
21	Various		1988	4,955		20			4,169	21
22	Various		1989	111,464		20	4,527	4,527	107,015	22
23	Various		1990	98,033		20	4,903	4,903	83,499	23
24	Various		1991	2,229		20	111	111	1,851	24
25	Various		1992	3,024		20	151	151	2,514	25
26	Various		1993	103,239		20	5,163	5,163	86,284	26
27	Various		1994	23,033		20	1,152	1,152	17,072	27
28	Various		1995	44,266		20	2,214	2,214	31,912	28
29	Various		1996	93,171		20	4,659	4,659	63,243	29
30	Various		1997	102,244		20	3,706	3,706	46,632	30
31	Various		1998	103,389		20	4,030	4,030	67,537	31
32	Various		1999	150,958		20	5,832	5,832	118,086	32
33	Various		2000	37,198		20	1,860	1,860	17,251	33
34	Various		2001	217,477		20	10,876	10,876	93,434	34
35	Various		2002	5,478,039		20	294,595	294,595	2,463,405	35
36	Various		2003	1,988,331		20	102,334		827,064	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

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 Various	2004	\$ 154,078	\$	20	\$ 15,328	\$ 15,328	\$ 96,448	37
38 Various	2005	112,564		20	10,758	10,758	49,384	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 Related Building Company (Pages 12F & 12G)								67
68 Related Party Allocations (Pages 12H & 12I)		664,379	16,752		22,706	5,954	340,683	68
69 Financial Statement Depreciation			449,305			(449,305)		69
70 TOTAL (lines 4 thru 69)		\$ 18,086,810	\$ 610,472		\$ 1,066,166	\$ 353,360	\$ 11,057,706	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:

01/01/09

Ending:

12/31/09**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		\$ 18,086,810	\$ 610,472		\$ 1,066,166	\$ 455,694	\$ 11,057,706	1
2	1 New Boiler Control System	2006	3,537		20	707	707	2,829	2
3	3 Electric Wall Heater/Ac Units	2006	1,616		20	323	323	997	3
4	2 Electric Wall Heater A/C Units	2006	1,075		20	215	215	663	4
5	Sprayed Fireproofing Stairs And Mechanical	2006	25,700		20	2,570	2,570	9,638	5
6	2 Chassis Heater For Resident Rooms	2006	3,015		20	603	603	2,362	6
7	2 Chassis Heaters For Resident Rooms	2006	3,015		20	603	603	2,010	7
8	Elevator Door	2006	2,650		20	265	265	994	8
9	Acoustical Supplies	2006	3,120		20	312	312	1,170	9
10	Installing Durkan Carpeting	2007	6,449		20	645	645	1,344	10
11	Tie Boilers To Storage Tank	2007	3,100		20	310	310	930	11
12	Roof Repairs	2007	1,900		20	127	127	327	12
13	Carpeting	2007	20,584		20	2,058	2,058	4,803	13
14	Electric Wall Heater	2007	1,762		20	176	176	382	14
15	Electric Wall Heater	2007	1,762		20	176	176	382	15
16	3 Electric Wall Heaters	2007	1,766		20	177	177	397	16
17	Concrete Stairs & Leak Repair	2007	4,450		20	297	297	816	17
18	Concrete Driveway	2007	6,500		20	433	433	1,192	18
19	Sinks And Faucets	2007	11,929		20	795	795	2,386	19
20	Doors And Crown	2007	4,100		20	410	410	1,059	20
21	2 Suburban Units- Heat Unit	2007	3,070		20	307	307	896	21
22	1 Suburban Unit- Heat Unit	2007	1,535		20	154	154	371	22
23	2 Suburban Units- Heat Unit	2007	3,070		20	307	307	665	23
24	Cable In Walls Between Rooms	2007	3,450		20	345	345	1,035	24
25	Interior Fabric	2007	2,573		20	257	257	536	25
26	Pump And Motor	2007	2,667		20	267	267	578	26
27	Carpeting Hallways & Patient Rooms	2008	99,922		20	19,984	19,984	26,646	27
28	Carpeting	2008	3,952		20	790	790	988	28
29	Wallcovering	2008	6,224		20	1,245	1,245	1,764	29
30	Wallcovering	2008	2,142		20	428	428	607	30
31	Draperies & Cornice Boards	2008	9,522		20	1,904	1,904	2,539	31
32	Window Treatments	2008	9,218		20	1,844	1,844	1,997	32
33	Parking Lot Seal & Paint	2008	4,000		20	267	267	400	33
34	TOTAL (lines 1 thru 33)		\$ 18,346,185	\$ 610,472		\$ 1,105,467	\$ 494,995	\$ 11,131,409	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:

01/01/09

Ending:

12/31/09**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		\$ 18,346,185	\$ 610,472		\$ 1,105,467	\$ 494,995	\$ 11,131,409	1
2	Door Releases	2008	2,449		20	245	245	469	2
3	Electric Wall Heaters	2008	1,840		20	368	368	675	3
4	Electric Wall Heaters	2008	2,436		20	487	487	853	4
5	Conversion Of Resident Rooms / Bathrooms	2008	89,640		20	8,964	8,964	16,434	5
6	Kitchen Shelves	2008	2,633		20	527	527	1,053	6
7	Aquabath Shower Unit	2008	10,231		20	2,046	2,046	4,092	7
8	Doors And Installation	2008	5,200		20	520	520	910	8
9	Design Work Room Design	2008	1,638		20	328	328	655	9
10	Sprinkler Heads	2008	2,795		20	186	186	279	10
11	Carpet Rooms 102 & 100	2009	3,272		20	109	109	109	11
12	Tree Cutting & Asphalt	2009	12,000		20	200	200	200	12
13	7 New Private Baths	2009	50,000		20	1,250	1,250	1,250	13
14	9 New Private Baths	2009	45,000		20	1,125	1,125	1,125	14
15	9 New Private Baths	2009	52,466		20	109	109	109	15
16	Fireproofing Spray	2009	2,500		20	52	52	52	16
17	2 Aquabath Shower Units	2009	8,020		20	33	33	33	17
18	Remove Cabinets From 2008 Bill	2009	(9,000)		20	(225)	(225)	(225)	18
19	Canvas Wall Panels	2009	3,450		20	86	86	86	19
20	Repiping And New Valves	2009	3,475		20	29	29	29	20
21	5 New Smoke Dampers	2009	4,035		20	605	605	605	21
22	New Maxton Valve & Packing - Elevator	2009	4,900		20	817	817	817	22
23	Alarm Repair	2009	2,909		20	85	85	85	23
24	Damper Installation	2009	2,977		20	25	25	25	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)		\$ 18,651,051	\$ 610,472		\$ 1,123,438	\$ 512,966	\$ 11,161,129	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:

01/01/09

Ending:

12/31/09

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 12C, Carried Forward		\$ 18,651,051	\$ 610,472		\$ 1,123,438	\$ 512,966	\$ 11,161,129	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)		\$ 18,651,051	\$ 610,472		\$ 1,123,438	\$ 512,966	\$ 11,161,129	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 18,651,051	\$ 610,472		\$ 1,123,438	\$ 512,966	\$ 11,161,129	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)	\$ 18,651,051	\$ 610,472		\$ 1,123,438	\$ 512,966	\$ 11,161,129	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company Information								1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocation From ITEX</u>	1993	512,905	13,152	35	14,654	1,502	243,018	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocation From ITEX</u>	1993	64,538	380	20	3,227	2,847	53,911	9
10	<u>Allocation From ITEX</u>	1994	34,665	902	20	1,733	831	26,486	10
11	<u>Allocation From ITEX</u>	1995	5,908	16	20	295	279	4,193	11
12	<u>Allocation From ITEX</u>	1996	334		20	17	17	235	12
13	<u>Allocation From ITEX</u>	1997	9,966	256	20	498	242	6,229	13
14	<u>Allocation From ITEX</u>	1999	1,107	28	20	55	27	609	14
15	<u>Allocation From ITEX</u>	2005	4,846	558	20	787	229	3,332	15
16	<u>Allocation From ITEX</u>	2007	5,999	244	20	623	379	1,412	16
17	<u>Allocation From ITEX</u>	2008	22,865	586	20	755	169	1,196	17
18	<u>Allocation From ITEX</u>	2009	1,246	630	20	62	(568)	62	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								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 (12H & 12I lines 1 thru 33)	\$ 664,379	\$ 16,752		\$ 22,706	\$ 5,954	\$ 340,683	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:

01/01/09

Ending:

12/31/09

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	\$ 2,167,824	\$ 236,113	\$ 199,427	\$ (36,686)	10	\$ 1,682,969	71
72	Current Year Purchases	42,646		2,590	2,590	10	2,590	72
73	Fully Depreciated Assets	1,834,534		3,412	3,412	10	1,834,534	73
74								74
75	TOTALS	\$ 4,045,004	\$ 236,113	\$ 205,429	\$ (30,684)		\$ 3,520,093	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				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 22,863,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 846,585	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,328,867	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 482,282	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,681,222	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	Topographic Survey	\$ 3,309	92
93			93
94			94
95		\$ 3,309	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	Rent & Storage			24,000			5
6							6
7	TOTAL			\$ 24,000			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: \$ 33,108 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility/Residential	2004 Ecoline	\$	\$ 23,400	17
18	Lease BBH			6,948	18
19					19
20					20
21	TOTAL		\$	\$ 30,348	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 397,905		\$		\$			\$	397,905			1	
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	183,596					58,535			242,131			2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 01	hrs	353,012					163,124			516,136			4	
5	Physician Care		visits												5	
6	Dental Care		visits												6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy	39 - 02	# of prescrpts						1,497,358			1,497,358			9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify):														12	
13	Other (specify): <u>See Supplemental</u>			116,836					185,650			302,486			13	
14	TOTAL			\$ 1,051,349		\$		\$	1,904,667		\$	2,956,016			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: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 20,983	\$ 276,109	1
2	Cash-Patient Deposits	69,926	69,926	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,162,409	3,162,409	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	459,418	459,418	6
7	Other Prepaid Expenses	170,065	236,718	7
8	Accounts Receivable (owners or related parties)	5,385,291	5,385,291	8
9	Other(specify): <u>See Attached Schedule</u>	1,105,300	1,373,056	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,373,392	\$ 10,962,927	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	929,878	8,531,155	15
16	Equipment, at Historical Cost	1,413,377	4,847,379	16
17	Accumulated Depreciation (book methods)	(1,243,741)	(12,620,619)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	558,680	1,392,862	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,658,194	\$ 11,282,440	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,031,586	\$ 22,245,367	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,452,252	\$ 2,463,753	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68,426	68,426	28
29	Short-Term Notes Payable	3,890,488	3,890,488	29
30	Accrued Salaries Payable	604,433	604,433	30
31	Accrued Taxes Payable (excluding real estate taxes)	46,610	46,610	31
32	Accrued Real Estate Taxes(Sch.IX-B)		658,300	32
33	Accrued Interest Payable	16,148	88,906	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	12,275	28,930	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,090,632	\$ 7,849,846	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,059,315	1,059,315	39
40	Mortgage Payable		15,874,468	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)	\$ 1,059,315	\$ 16,933,783	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,149,947	\$ 24,783,629	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,881,639	\$ (2,538,262)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,031,586	\$ 22,245,367	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,471,661	1
2	Restatements (describe):		2
3	Rounding Adjustment	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,471,658	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	589,981	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)	\$ 409,981	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)	\$ 3,881,639	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenview Terrace Nursing Ctr# 0026237Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 20,984,893	1
2	Discounts and Allowances for all Levels	(4,370,871)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,614,022	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,059,155	6
7	Oxygen	5,553	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,064,708	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	25	13
14	Non-Patient Meals	5,020	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,915,381	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	267,887	19
20	Radiology and X-Ray		20
21	Other Medical Services	173,321	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,361,634	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	527,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 527,000	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	52,834	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,834	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 25,620,198	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,626,739	31
32	Health Care	10,207,867	32
33	General Administration	5,032,966	33
B. Capital Expense			
34	Ownership	2,919,138	34
C. Ancillary Expense			
35	Special Cost Centers	3,071,592	35
36	Provider Participation Fee	171,915	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 25,030,217	40
41	Income before Income Taxes (line 30 minus line 40)**	589,981	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 589,981	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:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,779	3,379	\$ 153,095	\$ 45.31	1
2	Assistant Director of Nursing	10,500	10,535	380,760	36.14	2
3	Registered Nurses	92,135	102,674	2,903,380	28.28	3
4	Licensed Practical Nurses	39,099	42,309	1,109,089	26.21	4
5	CNAs & Orderlies	237,991	263,681	3,159,914	11.98	5
6	CNA Trainees					6
7	Licensed Therapist	37,887	42,197	1,051,349	24.92	7
8	Rehab/Therapy Aides	37,183	40,973	1,121,042	27.36	8
9	Activity Director	1,776	2,080	38,756	18.63	9
10	Activity Assistants	22,555	25,147	306,222	12.18	10
11	Social Service Workers	18,922	20,800	431,815	20.76	11
12	Dietician					12
13	Food Service Supervisor	3,757	4,005	94,389	23.57	13
14	Head Cook	5,871	6,439	91,269	14.17	14
15	Cook Helpers/Assistants	45,903	50,126	575,382	11.48	15
16	Dishwashers					16
17	Maintenance Workers	13,397	15,021	233,938	15.57	17
18	Housekeepers	42,928	48,620	533,371	10.97	18
19	Laundry	25,416	28,872	315,707	10.93	19
20	Administrator	1,872	2,080	119,559	57.48	20
21	Assistant Administrator	659	690	13,853	20.08	21
22	Other Administrative	1,404	1,404	142,300	101.35	22
23	Office Manager	1,864	2,184	53,583	24.53	23
24	Clerical	24,631	27,151	476,310	17.54	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	6,171	6,914	100,133	14.48	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,872	4,160	100,917	24.26	33
34	TOTAL (lines 1 - 33)	678,572	751,441	\$ 13,506,133 *	\$ 17.97	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	\$ 35,201	01-03	35
36	Medical Director	Monthly	111,500	09-03	36
37	Medical Records Consultant	Monthly	4,328	10-03	37
38	Nurse Consultant	Monthly	4,115	10-03	38
39	Pharmacist Consultant	Monthly	17,415	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	7,811	11-03	44
45	Social Service Consultant	Monthly	2,600	12-03	45
46	Other(specify)				46
47	<u>Rehab Nursing Consultant</u>	Monthly	29,600	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 212,570		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ian Cook	Administrator	0.00%	\$ 119,559	Workers' Compensation Insurance	\$ 244,400	IDPH License Fee	\$	
Mark Hollander	Executive Dir.	0.00%	142,300	Unemployment Compensation Insurance	69,201	Advertising: Employee Recruitment	79,127	
Elan Bleichman	Asst. Admin.	0.00%	13,853	FICA Taxes	1,019,435	Health Care Worker Background Check		
				Employee Health Insurance	562,682	(Indicate # of checks performed <u>225</u>)	2,710	
				Employee Meals	122,056	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	21,044	
				Christmas Expense	3,873	Licenses	1,713	
				401(K) Expense	25,562	Association Dues	24,404	
				Pension Plan	106,773	Advertising and Public Relations	141,390	
				Other Employee Benefits	4,585	See Supplemental Schedule	3,716	
						Less: Public Relations Expense	(90,224)	
						Non-allowable advertising	(46,619)	
						Yellow page advertising	(4,547)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 275,712			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 2,158,567	
Description				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
				Description			Description	
Amount				Line #			Amount	
				Amount			Amount	
Shaymark Management Fees							Out-of-State Travel	
\$ 292,136							\$	
JLR Management Fees								
80,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			In-State Travel	
\$ 372,136								
C. Professional Services							Seminar Expense	
Vendor/Payee							Allocation from ITEX	
Type							942	
Amount								
							Entertainment Expense	
Frost, Ruttenberg, & Rothblatt							(
Accounting							(agree to Sch. V, line 24, col. 8)	
11,411							\$ 12,852	
Union Audit								
Accounting								
29,250								
AK Care								
Administrative Consult.								
2,000								
Healthcare Horizons								
Admin. Consult. (Adj. Pg 5)								
4,135								
Randall Kane								
Architects								
2,751								
Brinkerhoff								
Architects								
299								
Power Software								
Data Processing								
5,634								
Giftrap								
Data Processing								
5,709								
AK Care								
Data Processing								
4,169								
ADL Data								
Data Processing								
384,000								
AK Care								
Centralized Bookkeeping								
56,185								
See Supplemental Schedule								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 551,197								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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# 0026237Report Period Beginning: 01/01/09Ending: 12/31/09**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 \$3,660 & ILCLTC \$ 20,744
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,976 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 171,915
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. \$ 122,056 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,020
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
- 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? N/A
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.