



Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,911	24,109	24,563	85,583	8
9	SNF/PED					9
10	ICF	6,304		4	6,308	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,215	24,109	24,567	91,891	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.18%

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

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

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

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

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 15,756

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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
	<b>A. General Services</b>										
1	Dietary	1,094,244	88,602	2,200	1,185,046		1,185,046	9,937	1,194,983		1
2	Food Purchase		1,135,846		1,135,846	(197,392)	938,454	(6,735)	931,719		2
3	Housekeeping	594,498	87,525		682,023		682,023	15,090	697,113		3
4	Laundry	92,948	405,130		498,078		498,078		498,078		4
5	Heat and Other Utilities			265,906	265,906		265,906	6,812	272,718		5
6	Maintenance	264,618	121,057	377,498	763,173		763,173	4,186	767,359		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>2,046,308</b>	<b>1,838,160</b>	<b>645,604</b>	<b>4,530,072</b>	<b>(197,392)</b>	<b>4,332,680</b>	<b>29,290</b>	<b>4,361,970</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			166,600	166,600		166,600		166,600		9
10	Nursing and Medical Records	7,564,495	368,552	271,040	8,204,087		8,204,087	(18,001)	8,186,086		10
10a	Therapy	1,975,975			1,975,975		1,975,975		1,975,975		10a
11	Activities	605,796	39,599	4,631	650,026		650,026		650,026		11
12	Social Services	301,390		4,200	305,590		305,590		305,590		12
13	CNA Training										13
14	Program Transportation			3,914	3,914		3,914		3,914		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>10,447,656</b>	<b>408,151</b>	<b>450,385</b>	<b>11,306,192</b>		<b>11,306,192</b>	<b>(18,001)</b>	<b>11,288,191</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	307,982			307,982		307,982		307,982		17
18	Directors Fees										18
19	Professional Services			560,906	560,906	(48,790)	512,116	(246,393)	265,724		19
20	Dues, Fees, Subscriptions & Promotions			354,441	354,441		354,441	(255,285)	99,156		20
21	Clerical & General Office Expenses	559,574	6,949	568,882	1,135,405		1,135,405	(36,496)	1,098,909		21
22	Employee Benefits & Payroll Taxes			1,839,163	1,839,163	197,392	2,036,555	(643)	2,035,912		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,888	13,888		13,888	1,614	15,502		24
25	Other Admin. Staff Transportation			1,160	1,160		1,160		1,160		25
26	Insurance-Prop.Liab.Malpractice			591,526	591,526		591,526	3,235	594,761		26
27	Other (specify):*							109,689	109,689		27
28	<b>TOTAL General Administration</b>	<b>867,556</b>	<b>6,949</b>	<b>3,929,966</b>	<b>4,804,471</b>	<b>148,602</b>	<b>4,953,073</b>	<b>(424,278)</b>	<b>4,528,795</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>13,361,520</b>	<b>2,253,260</b>	<b>5,025,955</b>	<b>20,640,735</b>	<b>(48,790)</b>	<b>20,591,945</b>	<b>(412,989)</b>	<b>20,178,956</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Glenview Terrace Nsg. Ctr

#0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	
	<b>D. Ownership</b>											
30	Depreciation			168,044	168,044		168,044	516,581	684,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			445,352	445,352		445,352	(122,676)	322,676			32
33	Real Estate Taxes			92,819	92,819	48,790	141,609	865,733	1,007,342			33
34	Rent-Facility & Grounds			1,878,000	1,878,000		1,878,000	(1,878,000)				34
35	Rent-Equipment & Vehicles			72,103	72,103		72,103	(15,131)	56,972			35
36	Other (specify):*							74,793	74,793			36
37	<b>TOTAL Ownership</b>			2,656,318	2,656,318	48,790	2,705,108	(558,700)	2,146,407			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,196,439	1,387,386		2,583,825		2,583,825		2,583,825			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			487,480	487,480		487,480		487,480			42
43	Other (specify):*	124,384		10,820	135,204		135,204	(157,304)	(22,100)			43
44	<b>TOTAL Special Cost Centers</b>	1,320,823	1,387,386	498,300	3,206,509		3,206,509	(157,304)	3,049,205			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	14,682,343	3,640,646	8,180,573	26,503,562	(0)	26,503,562	(1,128,994)	25,374,568			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,768)	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	(43,036)	30		9
10	Interest and Other Investment Income	(388,586)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,967)	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	(8,710)	21		18
19	Entertainment				19
20	Contributions	(20,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(420,534)	21		24
25	Fund Raising, Advertising and Promotional	(44,595)	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	(812,352)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,744,798)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	615,804		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 615,804		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,128,994)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52	
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## Glenview Terrace Nsg. Ctr

ID# 0026237

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (578)	21	1
2	Drivers Salary	(18,624)	43	2
3	Marketing Salary	(61,884)	43	3
4	Veterans Expenses	(18,001)	10	4
5	Life Insurance	(643)	22	5
6	Bank Charges	(12,083)	21	6
7	Credit Card Fees	(59,058)	21	7
8	Public Relations	(177,811)	20	8
9	Building Co. - Office Expense	(321)	21	9
10				10
11	Building Co. - Audit	(16,668)	19	11
12	Building Co.- Amort of Loan Cost	(5,532)	36	12
13	Non-allowable Rent	(60,000)	34	13
14	Non- Allowable Auto Lease	(17,889)	35	14
15	State of Illinois Income	(300)	21	15
16	Capitalized R&M	(5,970)	06	16
17	Non Allowable Interest	(220,653)	32	17
18	Non-Allowable Salary	(65,976)	43	18
19	Non-Allowable Legal Fees	(44,516)	19	19
20	PAC Dues	(15,025)	20	20
21	Non-Allowable Auto Expense	(10,820)	43	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	<b>Total</b>	(812,352)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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			9,937									9,937	1
2	Food Purchase	(6,735)											(6,735)	2
3	Housekeeping			15,090									15,090	3
4	Laundry													4
5	Heat and Other Utilities			6,812									6,812	5
6	Maintenance	(5,970)		10,156									4,186	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(12,705)</b>		<b>41,995</b>									<b>29,290</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(18,001)											(18,001)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(18,001)</b>											<b>(18,001)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(61,184)	60,302	(245,511)									(246,393)	19
20	Fees, Subscriptions & Promotions	(257,681)		2,396									(255,285)	20
21	Clerical & General Office Expenses	(501,584)	321	464,767									(36,496)	21
22	Employee Benefits & Payroll Taxes	(643)											(643)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,614									1,614	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			3,235									3,235	26
27	Other (specify):*			109,689									109,689	27
28	<b>TOTAL General Administration</b>	<b>(821,091)</b>	<b>60,623</b>	<b>336,190</b>									<b>(424,278)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(851,797)</b>	<b>60,623</b>	<b>378,185</b>									<b>(412,989)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenview Terrace Nsg. Ctr # 0026237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(43,036)	537,936	21,681									516,581	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(609,239)	467,460	19,103									(122,676)	32
33	Real Estate Taxes		840,871	24,862									865,733	33
34	Rent-Facility & Grounds	(60,000)	(1,818,000)										(1,878,000)	34
35	Rent-Equipment & Vehicles	(17,889)		2,758									(15,131)	35
36	Other (specify):*	(5,532)	80,325										74,793	36
37	<b>TOTAL Ownership</b>	<b>(735,696)</b>	<b>108,592</b>	<b>68,404</b>									<b>(558,700)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(157,304)											(157,304)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(157,304)</b>											<b>(157,304)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(1,744,798)</b>	<b>169,215</b>	<b>446,589</b>									<b>(1,128,994)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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 Rental Income	\$ 1,818,000	Glenview Terrace Property, LLC	100.00%	\$	(1,818,000)	1
2	V	32 Interest	3,647	Glenview Terrace Property, LLC	100.00%	471,107	467,460	2
3	V	21 Office Expense		Glenview Terrace Property, LLC	100.00%	321	321	3
4	V	19 Legal Expense - R/E Tax Appeals		Glenview Terrace Property, LLC	100.00%	43,634	43,634	4
5	V	19 Audit Expense		Glenview Terrace Property, LLC	100.00%	16,668	16,668	5
6	V	36 Amortization of Loan Costs		Glenview Terrace Property, LLC	100.00%	5,532	5,532	6
7	V	33 Real Estate Tax Expense		Glenview Terrace Property, LLC	100.00%	840,871	840,871	7
8	V	36 MIP Insurance		Glenview Terrace Property, LLC	100.00%	74,793	74,793	8
9	V	30 Depreciation		Glenview Terrace Property, LLC	100.00%	537,936	537,936	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,821,647			\$ 1,990,862	\$ * 169,215	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	1 <u>DIETARY</u>	\$	<u>ITEX / AK CARE COMPANY</u>	100.00%	\$ 9,937	\$ 9,937
16	V	3 <u>HOUSEKEEPING</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	15,090	15,090
17	V	5 <u>UTILITIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	6,812	6,812
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	10,156	10,156
19	V	19 <u>PROFESSIONAL FEES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	7,989	7,989
20	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	2,396	2,396
21	V	21 <u>CLERICAL AND GENERAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	72,413	72,413
22	V	24 <u>EDUCATION AND SEMINARS</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	1,614	1,614
23	V	26 <u>INSURANCE</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	3,235	3,235
24	V	30 <u>DEPRECIATION</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	21,681	21,681
25	V	32 <u>INTEREST</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	19,103	19,103
26	V	33 <u>REAL ESTATE TAXES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	23,479	23,479
27	V	33 <u>RE TAX PROTEST FEES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	1,383	1,383
28	V	35 <u>EQUIPMENT RENTAL</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	2,758	2,758
29	V						
30	V						
31	V						
32	V	21 <u>CLERICAL SALARIES</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	392,354	392,354
33	V	27 <u>GEN ADMIN. - EMP. BEN.</u>		<u>ITEX / AK CARE COMPANY</u>	100.00%	109,689	109,689
34	V						
35	V						
36	V	19 <u>BOOKEEPING FEES</u>	253,500	<u>ITEX / AK CARE COMPANY</u>	100.00%		(253,500)
37	V						
38	V						
39	Total		\$ 253,500			\$ 700,089	\$ * 446,589

\* 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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name &amp; ID Number

Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	Mark Hollander	Relative	Administrative	0%	See Attached	27	45.00%	Salary	137,000	17-1	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 137,000		13	

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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	DIETARY	AVAILABLE BED DAYS	270,830	3	\$ 23,483	\$ 114,610	\$ 9,937	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	270,830	3	35,659	114,610	15,090	2
3	5	UTILITIES	AVAILABLE BED DAYS	270,830	3	16,097	114,610	6,812	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	270,830	3	24,000	114,610	10,156	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	270,830	3	18,878	114,610	7,989	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	270,830	3	5,661	114,610	2,396	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	270,830	3	171,117	114,610	72,413	7
8	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	270,830	3	3,813	114,610	1,614	8
9	26	INSURANCE	AVAILABLE BED DAYS	270,830	3	7,643	114,610	3,235	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	270,830	3	51,234	114,610	21,681	10
11	32	INTEREST	AVAILABLE BED DAYS	270,830	3	45,142	114,610	19,103	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	270,830	3	55,482	114,610	23,479	12
13	33	RE TAX PROTEST FEES	AVAILABLE BED DAYS	270,830	3	3,269	114,610	1,383	13
14	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	270,830	3	6,517	114,610	2,758	14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		4	903,445	903,445	392,354	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		4	252,574		109,689	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,624,014	\$ 903,445	\$ 700,089	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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

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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

Facility Name & ID Number

Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD		X	Mortgage			\$	\$ 14,616,479		\$ 471,107	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit				3,582,505		213,384	6									
7	INAC		X	Insurance Financing						11,315	7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 18,198,984		\$ 695,806	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(388,586)	10									
11	Interest Income - Bldg. Co		X							(3,647)	11									
12	Allocated from ITEX		X							19,103	12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (373,130)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 18,198,984		\$ 322,676	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 74,793      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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	<u>977,480</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>957,140</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(20,340)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>978,892</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>48,790</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>92,818</u> For 2013 &amp; <u>###</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>1,007,342</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>723,683</u>	8
	2013	<u>886,032</u>	9
	2014	<u>913,886</u>	10
	2015	<u>930,933</u>	11
	2016	<u>932,278</u>	12

2017 Accrual: \$932,278 x 1.05 = \$978,892 (Rounded)

Allocated from ITEX: \$23,459

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**





Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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:**

A. Land.

	1	2	3	4	
	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	<b>TOTALS</b>			<b>\$ 167,502</b>	<b>3</b>

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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			1975	\$ 2,750,940	\$	35	\$	\$	\$ 2,750,940	4
5				1989	1,453,936		35	36,348	36,348	1,024,436	5
6				2002	4,266,341	537,936	35	106,659	(431,277)	746,613	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1975	28,890		20			28,890	9
10	Various			1977	11,520		20			11,520	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			2,004	14
15	Various			1982	6,604		20			6,604	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			10,997	18
19	Various			1986	2,080		20			2,080	19
20	Various			1987	2,375		20			2,375	20
21	Various			1988	4,955		20			4,955	21
22	Various			1989	111,464		20			111,464	22
23	Various			1990	98,033		20			98,033	23
24	Various			1991	2,229		20			2,229	24
25	Various			1992	3,024		20			3,024	25
26	Various			1993	103,239		20			103,239	26
27	Various			1994	23,033		20			23,033	27
28	Various			1995	44,266		20			44,266	28
29	Various			1996	93,171		20			93,171	29
30	Various			1997	102,244		20	2,623	2,623	73,953	30
31	Various			1998	103,389		20	4,025	4,025	99,738	31
32	Various			1999	150,958		20	3,531	3,531	146,331	32
33	Various			2000	37,198		20	1,860	1,860	32,131	33
34	Various			2001	217,477		20	10,874	10,874	180,424	34
35	Various			2002	5,478,038		20	215,491	215,491	4,595,328	35
36	Various			2003	1,988,331		20	71,916	71,916	1,491,552	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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	\$ 960	\$ 960	\$ 151,692	37
38	Various	2005	112,565		20	3,073	3,073	107,100	38
39	Various	2006	43,728		20			43,728	39
40	Various	2007	78,768		20	4,915	4,915	72,484	40
41	Various	2008	249,755		20	9,937	9,937	245,639	41
42	Various	2009	186,004		20	4,710	4,710	49,496	42
43	Various	2010	61,561		20	3,458	3,458	47,848	43
44	Various	2011	183,417		20	14,773	14,773	140,147	44
45	Various	2012	129,851		20	10,750	10,750	102,796	45
46	Various	2013	16,374		20	1,869	1,869	8,567	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)		899,179	21,390		22,759	1,369	654,004	68
69	Financial Statement Depreciation			168,044			(168,044)		69
70	TOTAL (lines 4 thru 69)		\$ 19,233,993	\$ 727,370		\$ 530,530	\$ (196,840)	\$ 13,334,809	70

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 19,233,993	\$ 727,370		\$ 530,530	\$ (196,840)	\$ 13,334,809	1
2	Wallpaper For Public Restrooms	2014	2,892		20	578	578	1,832	2
3	Replacing 265 Square Feet Of Concrete Sidewalks	2014	3,400		20	227	227	737	3
4	Roof Tear Off And Replacement South Wing	2014	74,260		20	7,426	7,426	29,704	4
5	Roof Repair Around Chiller Unit	2014	38,338		20	3,834	3,834	15,335	5
6	New Heat Pump	2014	4,442		20	888	888	2,739	6
7	Walk In Freezer	2014	6,800		20	1,360	1,360	4,873	7
8	Private Bathrooms Resident Rooms-Install Drywall & Wall Tile, P	2014	29,500		20	1,475	1,475	4,794	8
9	Video Monitoring System 2Nd Floor	2014	3,920		20	784	784	2,548	9
10	3Rd Floor Monitoring System	2014	3,820		20	764	764	2,356	10
11	Wallpaper Project - Hallway	2015	35,504		20	3,550	3,550	8,876	11
12	Door Alerts	2015	4,274		20	611	611	1,425	12
13	Door Alerts	2015	4,274		20	611	611	1,374	13
14	Door Alerts	2015	4,274		20	611	611	1,323	14
15	Wallpaper Project - Hallway	2015	3,278		20	328	328	792	15
16	Shower Wall Tile	2015	3,200		20	160	160	480	16
17	Generator Repair	2015	7,331		20	367	367	825	17
18	Built In Drawers And Tops	2015	3,000		20	600	600	1,750	18
19	Cables And Jacks	2015	5,460		20	273	273	705	19
20	Wallpaper Project - Hallways & Dining Room	2015	8,474		20	424	424	953	20
21	Design Dining/Patient Rm/Wallcovering/Lighting 1St/2Nd Flr Bat	2016	3,540		20	177	177	354	21
22	Wallpaper Dining / Exercise Rooms & Elevators	2016	5,260		20	263	263	526	22
23	Lighting Fixtures In Bathroom/Halls/Patient Rooms	2016	43,036		20	2,152	2,152	4,124	23
24	Install Privacy Panels & Roman Shades In Patient/Exercise Room	2016	56,757		20	2,838	2,838	3,547	24
25	2Nd Floor - Vinyl Tile & Install Wallbase	2016	12,000		20	600	600	1,100	25
26	2Nd Floor - Vinyl Tile	2016	12,917		20	646	646	915	26
27	2Nd Floor - Vinyl Tile	2016	3,293		20	165	165	220	27
28	2Nd Floor - Vinyl Tile In Rooms 254, 269, 282	2016	13,793		20	690	690	862	28
29	Remove Carpet & Install Luxury Vinyl Tile - 2Nd Floor	2016	118,260		20	5,913	5,913	6,898	29
30	Elevator Repair - Modernization	2016	101,283		20	5,064	5,064	7,174	30
31	Taco In Line Circulating Pump	2016	4,300		20	215	215	394	31
32	Ravpak Boiler	2016	12,985		20	649	649	1,190	32
33	Taco In Line Circulating Pump	2016	5,200		20	260	260	325	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 19,873,057	\$ 727,370		\$ 575,030	\$ (152,340)	\$ 13,445,860	34

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 19,873,057	\$ 727,370		\$ 575,030	\$ (152,340)	\$ 13,445,860	1
2	Electrical Work Can Lights All Rooms	2016	6,000		20	300	300	525	2
3	Electrical Work Can Lights All Rooms	2016	5,700		20	285	285	404	3
4	Electrical Work - Elevators	2016	6,147		20	307	307	333	4
5	Signs	2016	4,861		20	243	243	446	5
6	Gas Water Heater	2016	7,941		20	397	397	430	6
7	Handrails	2016	2,500		20	125	125	240	7
8	Wallpaper - 2Nd Floor Corridor, Private/Exercise/Rehab Rooms	2016	29,860		20	1,493	1,493	1,742	8
9	Cable Drops Resident Tv'S	2016	18,000		20	900	900	1,725	9
10	Cable Drops Resident Tv'S	2016	11,813		20	591	591	788	10
11	Wallpaper In Hallways/Doors/Nooks/Nurses Station	2016	2,837		20	567	567	1,135	11
12	Level Parking Area, Asphalt Patch To Holes In Parking Area/Driv	2016	2,550		20	128	128	170	12
13	Repair Sewers In Parking Area With Mortar/Cement; Apply Aspl	2016	2,850		20	143	143	178	13
14	Elevator	2017	21,723		20	1,086	1,086	1,086	14
15	Blacktop Paving	2017	3,475		20	116	116	116	15
16	Switch Replacement	2017	3,146		20	26	26	26	16
17	Compressor Replacement	2017	3,735		20	685	685	685	17
18	Roof Top Compressor Replacement	2017	4,545		20	379	379	379	18
19	Kitchen Blower Replacement	2017	4,106		20	342	342	342	19
20	Compressor Replacement - Heat Pump	2017	3,245		20	270	270	270	20
21	New Condensor Fan Motor	2017	4,113		20	69	69	69	21
22	Wiring Elevator	2017	5,698		20	285	285	285	22
23	Fire Alarm Repairs	2017	9,853		20	1,971	1,971	1,971	23
24	Tower Pump Repairs	2017	3,107		20	155	155	155	24
25	Add More Switch Position Contacts To Elevator Contacts	2017	2,863		20	143	143	143	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 20,043,724	\$ 727,370		\$ 586,035	\$ (141,335)	\$ 13,459,500	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 20,043,724	\$ 727,370		\$ 586,035	\$ (141,335)	\$ 13,459,500	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)	\$ 20,043,724	\$ 727,370		\$ 586,035	\$ (141,335)	\$ 13,459,500	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 20,043,724	\$ 727,370		\$ 586,035	\$ (141,335)	\$ 13,459,500	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)	\$ 20,043,724	\$ 727,370		\$ 586,035	\$ (141,335)	\$ 13,459,500	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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 <b>Building Company</b>		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 <b>Leasehold Improvements:</b>								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 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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							
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23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	<b>TOTAL (lines 1 thru 33)</b>	\$	\$		\$	\$	\$

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from ITEX	1993	678,804	17,405	35	19,394	1,989	476,777	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from ITEX	1993	85,413	502	20		(502)	85,413	9
10	Allocation from ITEX	1994	45,877	1,193	20		(1,193)	45,873	10
11	Allocation from ITEX	1995	7,819	21	20		(21)	7,819	11
12	Allocation from ITEX	1996	443		20			443	12
13	Allocation from ITEX	1997	13,189	338	20	330	(8)	13,189	13
14	Allocation from ITEX	1999	1,465	38	20	73	35	1,391	14
15	Allocation from ITEX	2005	6,413		20	321	321	3,964	15
16	Allocation from ITEX	2007	7,940	185	20	397	212	4,068	16
17	Allocation from ITEX	2008	30,261	776	20	1,000	224	9,578	17
18	Allocation from ITEX	2009	1,649	42	20	165	123	1,401	18
19	Allocation from ITEX	2010	3,522		20	176	176	1,299	19
20	Allocation from ITEX	2014	14,701	847	20	735	(112)	2,593	20
21	Allocation from ITEX	2016	1,683	43	20	168	125	196	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)		\$ 899,179	\$ 21,390		\$ 22,759	\$ 1,369	\$ 654,004	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 899,179	\$ 21,390		\$ 22,759	\$ 1,369	\$ 654,004	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)	\$ 899,179	\$ 21,390		\$ 22,759	\$ 1,369	\$ 654,004	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,565,127	\$ 290	\$ 89,940	\$ 89,650	10	\$ 1,145,455	71
72	Current Year Purchases	58,541		8,361	8,361	10	8,361	72
73	Fully Depreciated Assets	3,327,988		288	288	10	3,327,794	73
74								74
75	TOTALS	\$ 4,951,657	\$ 290	\$ 98,589	\$ 98,299		\$ 4,481,610	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 25,162,883	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 727,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 684,624	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,036)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,941,111	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. _____	/2018	\$	_____
13. _____	/2019	\$	_____
14. _____	/2020	\$	_____

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: \$ 46,547 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Residential Use	Ford Van	\$ 870	\$ 10,425	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 870	\$ 10,425	21

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

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

**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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$ 925,074		\$			\$ 925,074	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	138,725			17,902		156,627	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				1,077,439		1,077,439	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>			132,640			292,045		424,685	13
14	<b>TOTAL</b>			\$ 1,196,439		\$	\$ 1,387,386		\$ 2,583,825	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.

Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237Report Period Beginning: 01/01/17Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 46,036	\$ 343,115	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	4,606,391	4,606,391	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	813,231	813,231	6
7	Other Prepaid Expenses	58,390	58,390	7
8	Accounts Receivable (owners or related parties)	350,909	350,909	8
9	Other(specify): <u>See Attached Schedule</u>	404,186	1,019,785	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,280,643	\$ 7,193,321	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		198,820	13
14	Buildings, at Historical Cost		8,932,844	14
15	Leasehold Improvements, at Historical Cost	1,442,565	9,790,003	15
16	Equipment, at Historical Cost	2,066,813	5,619,729	16
17	Accumulated Depreciation (book methods)	(3,040,918)	(18,224,084)	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>	9,678,594	10,080,679	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 10,147,054	\$ 16,397,991	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 16,427,697	\$ 23,591,312	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,066,928	\$ 2,087,927	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,582,505	3,582,505	29
30	Accrued Salaries Payable	459,278	459,278	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,405	17,405	31
32	Accrued Real Estate Taxes(Sch.IX-B)		978,892	32
33	Accrued Interest Payable	25,255	64,244	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	70,327	421,236	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,221,698	\$ 7,611,487	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,616,479	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>		236,475	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 14,852,954	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,221,698	\$ 22,464,441	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 10,205,999	\$ 1,126,871	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 16,427,697	\$ 23,591,312	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>9,737,067</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Workers Compensation</b>	(425,055)	<b>3</b>
<b>4</b>	<b>State Replacement Tax</b>	(4,809)	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>9,307,203</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	898,796	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>898,796</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>10,205,999</b>	<b>24</b> *

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

Facility Name &amp; ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning: 01/01/17

Ending:

12/31/17

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 26,719,482	1
2	Discounts and Allowances for all Levels	(7,581,051)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 19,138,431	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,725,079	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 5,725,079	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,768	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,603,207	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	334,305	19
20	Radiology and X-Ray		20
21	Other Medical Services	115,286	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,056,566	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	388,586	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 388,586	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	93,696	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 93,696	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 27,402,358	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	4,530,072	31
32	Health Care	11,306,192	32
33	General Administration	4,804,471	33
<b>B. Capital Expense</b>			
34	Ownership	2,656,318	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,719,029	35
36	Provider Participation Fee	487,480	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 26,503,562	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	898,796	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 898,796	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,602,662	44
45	Private Pay - Net Inpatient Revenue	5,853,718	45
46	Medicare - Net Inpatient Revenue	4,107,249	46
47	Other-(specify) <u>Insurance</u>	902,300	47
48	Other-(specify) <u>Veteran, MMAI</u>	4,672,502	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 19,138,431	49

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

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

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

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

Facility Name & ID Number Glenview Terrace Nsg. Ctr

# 0026237

Report Period Beginning: 01/01/17

Ending: 12/31/17

**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	1,729	2,085	\$ 106,642	\$ 51.15	1
2	Assistant Director of Nursing	1,701	2,085	91,387	43.83	2
3	Registered Nurses	96,693	104,456	2,473,266	23.68	3
4	Licensed Practical Nurses	90,068	95,488	2,051,689	21.49	4
5	CNAs & Orderlies	177,730	195,280	2,751,003	14.09	5
6	CNA Trainees					6
7	Licensed Therapist	27,886	32,302	1,196,439	37.04	7
8	Rehab/Therapy Aides	54,078	62,514	1,975,975	31.61	8
9	Activity Director	1,930	2,421	47,339	19.55	9
10	Activity Assistants	48,128	52,722	558,457	10.59	10
11	Social Service Workers	13,441	14,632	301,390	20.60	11
12	Dietician					12
13	Food Service Supervisor	10,181	11,485	291,253	25.36	13
14	Head Cook	9,038	9,988	143,098	14.33	14
15	Cook Helpers/Assistants	52,340	57,724	659,893	11.43	15
16	Dishwashers					16
17	Maintenance Workers	12,196	14,031	264,618	18.86	17
18	Housekeepers	42,559	49,172	594,498	12.09	18
19	Laundry	6,505	7,282	92,948	12.76	19
20	Administrator	1,857	2,085	112,197	53.81	20
21	Assistant Administrator					21
22	Other Administrative	2,509	2,607	195,785	75.10	22
23	Office Manager	3,442	4,032	98,293	24.38	23
24	Clerical	23,143	25,817	461,281	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,009	4,655	90,508	19.44	31
32	Other Health Care(specify)					32
33	Other(specify)	4,330	4,563	124,384	27.26	33
34	TOTAL (lines 1 - 33)	685,493	757,426	\$ 14,682,343 *	\$ 19.38	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	\$ 2,200	01-03	35
36	Medical Director	Monthly	166,600	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	80,580	10-03	38
39	Pharmacist Consultant	Monthly	22,107	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	4,631	11-03	44
45	Social Service Consultant	Monthly	4,200	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 285,118		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,271	\$ 163,553	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,271	\$ 163,553		53



Facility Name & ID Number Glenview Terrace Nsg. Ctr# 0026237

Report Period Beginning:

01/01/17

Ending:

12/31/17**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. ICLTC \$45,530
- (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. \$ 45,079 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 487,480  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 197,392 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,768
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees