

Facility Name & ID Number Brentwood North HealthCare & Rehabilitation Centre

0050112 Report Period Beginning: 1/01/2009 Ending: 12/31/2009

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	248	Skilled (SNF)	248	90,520	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	248	TOTALS	248	90,520	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	1,782	2,552	15,499	19,833	8
9	SNF/PED					9
10	ICF	18,746	10,302	366	29,414	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,528	12,854	15,865	49,247	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.40%

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 9/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/01/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 248 and days of care provided 12,027

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRAUAL 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 Brentwood North HealthCare & Rehabilitati # 0050112 Report Period Beginning: 1/01/2009 Ending: 12/31/2009

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	387,341	49,776	660	437,777		437,777		437,777		1
2	Food Purchase		418,190		418,190	(25,299)	392,891	70	392,961		2
3	Housekeeping		5,288	280,074	285,362		285,362		285,362		3
4	Laundry			187,978	187,978		187,978		187,978		4
5	Heat and Other Utilities			272,648	272,648		272,648	2,859	275,507		5
6	Maintenance	101,852	43,627	107,684	253,163		253,163	4,244	257,407		6
7	Other (specify):* Allocated Employee Benefits							276	276		7
8	TOTAL General Services	489,193	516,881	849,044	1,855,118	(25,299)	1,829,819	7,449	1,837,268		8
	B. Health Care and Programs										
9	Medical Director			37,000	37,000		37,000		37,000		9
10	Nursing and Medical Records	3,585,505	381,895	2,556	3,969,956		3,969,956	(41,759)	3,928,197		10
10a	Therapy	66,283	2,441	1,133,755	1,202,479		1,202,479	(154,668)	1,047,811		10a
11	Activities	140,384	9,109	960	150,453		150,453		150,453		11
12	Social Services	74,245		2,970	77,215		77,215		77,215		12
13	CNA Training										13
14	Program Transportation			102	102		102		102		14
15	Other (specify):* Allocated Employee Benefits							101,258	101,258		15
16	TOTAL Health Care and Programs	3,866,417	393,445	1,177,343	5,437,205		5,437,205	(95,169)	5,342,036		16
	C. General Administration										
17	Administrative	119,994		330,096	450,090		450,090	(296,876)	153,214		17
18	Directors Fees										18
19	Professional Services			45,141	45,141		45,141	949	46,090		19
20	Dues, Fees, Subscriptions & Promotions			66,981	66,981	730	67,711	5,257	72,968		20
21	Clerical & General Office Expenses	422,683	83,084	29,669	535,436	(730)	534,706	262,575	797,281		21
22	Employee Benefits & Payroll Taxes			751,288	751,288	25,299	776,587		776,587		22
23	Inservice Training & Education			1,821	1,821		1,821	2,928	4,749		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			9,361	9,361		9,361	1,055	10,416		25
26	Insurance-Prop.Liab.Malpractice			189,323	189,323		189,323	1,075	190,398		26
27	Other (specify):* Allocated Employee Benefits							40,603	40,603		27
28	TOTAL General Administration	542,677	83,084	1,423,680	2,049,441	25,299	2,074,740	17,566	2,092,306		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,898,287	993,410	3,450,067	9,341,764		9,341,764	(70,154)	9,271,610		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,814	5,814		5,814	822,693	828,507			30
31	Amortization of Pre-Op. & Org.							54	54			31
32	Interest			27,487	27,487		27,487	(27,487)				32
33	Real Estate Taxes							148,100	148,100			33
34	Rent-Facility & Grounds			1,544,007	1,544,007		1,544,007	(1,544,007)				34
35	Rent-Equipment & Vehicles			11,223	11,223		11,223	4,086	15,309			35
36	Other (specify):*											36
37	TOTAL Ownership			1,588,531	1,588,531		1,588,531	(596,561)	991,970			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		469,772	36,246	506,018		506,018		506,018			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,412	131,412		131,412		131,412			42
43	Other (specify):* Non-Allowable			80,378	80,378		80,378	(80,378)				43
44	TOTAL Special Cost Centers		469,772	248,036	717,808		717,808	(80,378)	637,430			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,898,287	1,463,182	5,286,634	11,648,103		11,648,103	(747,093)	10,901,010			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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	233	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,634)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,812)	43		24
25	Fund Raising, Advertising and Promotional	(13,732)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule F:	(1,218,938)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,298,883)		\$	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)	551,790		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 551,790		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (747,093)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North HealthCare & Rehabilitation Centre

ID# 0050112

Report Period Beginning: 1/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjust Mgt Co. medical supplies "A" to cost	\$ (41,759)	10	1
2	Non-allowable auto expense - marketing	(3,412)	25	2
3	Non-allowable Illinois Council on Long Term Care Dues	(3,373)	20	3
4	Non-allowable patient clothing	(200)	43	4
5	Non-allowable professional fees	(33,992)	19	5
6	Non-allowable owner interest expense	(1,108,440)	32	6
7	Non-allowable owner interest expense	(27,487)	32	7
8	Non-allowable office expense	(275)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,218,938)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brentwood North HealthCare & Rehabilitation Centre

0050112

Report Period Beginning:

1/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	70	0	0	0	0	0	0	70	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,859	0	0	0	0	0	0	0	0	2,859	5
6	Maintenance	0	0	4,244	0	0	0	0	0	0	0	0	4,244	6
7	Other (specify):*	0	0	276	0	0	0	0	0	0	0	0	276	7
8	TOTAL General Services	0	0	7,379	0	70	0	0	0	0	0	0	7,449	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(41,759)	0	0	0	0	0	0	0	0	0	0	(41,759)	10
10a	Therapy	0	0	0	0	(154,668)	0	0	0	0	0	0	(154,668)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	101,258	0	0	0	0	0	0	101,258	15
16	TOTAL Health Care and Programs	(41,759)	0	0	0	(53,410)	0	0	0	0	0	0	(95,169)	16
	C. General Administration													
17	Administrative	0	0	(296,876)	0	0	0	0	0	0	0	0	(296,876)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,992)	0	19,629	14,930	382	0	0	0	0	0	0	949	19
20	Fees, Subscriptions & Promotions	(3,373)	0	3,675	0	4,955	0	0	0	0	0	0	5,257	20
21	Clerical & General Office Expenses	0	0	249,574	0	13,001	0	0	0	0	0	0	262,575	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	373	0	2,555	0	0	0	0	0	0	2,928	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(3,412)	0	3,548	0	919	0	0	0	0	0	0	1,055	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,075	0	0	0	0	0	0	0	0	1,075	26
27	Other (specify):*	0	0	39,694	0	909	0	0	0	0	0	0	40,603	27
28	TOTAL General Administration	(40,777)	0	20,692	14,930	22,721	0	0	0	0	0	0	17,566	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,536)	0	28,071	14,930	(30,619)	0	0	0	0	0	0	(70,154)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brentwood North HealthCare & Rehabilitation Centre# 0050112

Report Period Beginning:

1/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	6,335	816,158	200	0	0	0	0	0	0	822,693	30
31	Amortization of Pre-Op. & Org.	0	0	54	0	0	0	0	0	0	0	0	54	31
32	Interest	(1,135,694)	0	0	1,108,207	0	0	0	0	0	0	0	(27,487)	32
33	Real Estate Taxes	0	0	5,693	142,407	0	0	0	0	0	0	0	148,100	33
34	Rent-Facility & Grounds	0	0	0	(1,544,007)	0	0	0	0	0	0	0	(1,544,007)	34
35	Rent-Equipment & Vehicles	0	0	4,086	0	0	0	0	0	0	0	0	4,086	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,135,694)	0	16,168	522,765	200	0	0	0	0	0	0	(596,561)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(80,653)	0	0	275	0	0	0	0	0	0	0	(80,378)	43
44	TOTAL Special Cost Centers	(80,653)	0	0	275	0	(80,378)	44						
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,298,883)	0	44,239	537,970	(30,419)	0	0	0	0	0	0	(747,093)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sidney Glenner		GlenBridge Nursing & Rehabilitation Centre,Ltd.	Niles	SEE ATTACHED SCHEDULE A		
Joshua Ray		GlenCrest Nursing & Rehabilitation Centre,Ltd.	Chicago			
		Glen Elston Nursing & Rehabilitation Centre,Ltd.	Chicago			
		Glen Oaks Nursing & Rehabilitation Centre,Ltd.	Northbrook			
		GlenShire Nursing & Rehabilitation Centre,Ltd.	Richton Park			
		GlenLake Terrace Nursing & Rehabilitation Centre,Ltc	Waukegan			

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	Total from Page 6A	\$ 330,096	Glen Health and Home Management, Inc.	A	\$ 374,335	\$ 44,239	1
2	V							2
3	V	Total from Page 6B	1,544,007	Brentwood Healthcare Real Estate LLC.	B	2,081,977	537,970	3
4	V							4
5	V	Total from Page 6C	1,128,744	Therapy Masters, Inc.	C	1,098,325	(30,419)	5
6	V							6
7	V							7
8	V							8
9	V			OWNERSHIP REFERENCE:				9
10	V			A: Owned 100.00 % by Sidney Glenner through attribution				10
11	V			B: Owned 70.00 % by Sidney Glenner & 30.00 % by Joshua Ray				11
12	V			C: Owned 80.00 % by Sidney Glenner & 20.00 % by Barry Ray				12
13	V							13
14	Total		\$ 3,002,847			\$ 3,554,637	\$ * 551,790	14

* 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 Management Fees	\$ 330,096	Glen Health and Home Management, Inc.	A	\$	\$(330,096)
16	V	5 Utilities		Glen Health and Home Management, Inc.	A	2,859	2,859
17	V	6 Repairs and Maintenance		Glen Health and Home Management, Inc.	A	2,418	2,418
18	V	19 Professional Fees		Glen Health and Home Management, Inc.	A	19,629	19,629
19	V	20 Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	3,675	3,675
20	V	21 Clerical		Glen Health and Home Management, Inc.	A	21,396	21,396
21	V	22 Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	39,970	39,970
22	V	23 Training and Education		Glen Health and Home Management, Inc.	A	373	373
23	V	25 Auto Expenses		Glen Health and Home Management, Inc.	A	3,548	3,548
24	V	26 Insurance		Glen Health and Home Management, Inc.	A	1,075	1,075
25	V	30 Depreciation		Glen Health and Home Management, Inc.	A	6,335	6,335
26	V	31 Amortization		Glen Health and Home Management, Inc.	A	54	54
27	V	33 Real Estate Taxes		Glen Health and Home Management, Inc.	A	5,693	5,693
28	V	35 Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	4,086	4,086
29	V	6 Janitorial Salaries		Glen Health and Home Management, Inc.	A	1,826	1,826
30	V	17 Officer's Salaries		Glen Health and Home Management, Inc.	A	33,220	33,220
31	V	21 Administrative Salaries		Glen Health and Home Management, Inc.	A	228,178	228,178
32	V	22 Employee Benefits		Glen Health and Home Management, Inc.	A	(39,970)	(39,970)
33	V	7 Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A	276	276
34	V	27 Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A	5,044	5,044
35	V	27 Employee Benefits - Admin		Glen Health and Home Management, Inc.	A	34,650	34,650
36	V						
37	V						
38	V						
39	Total		\$ 330,096			\$ 374,335	\$ * 44,239

* 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	43 Clerical	\$	Brentwood Healthcare Real Estate LLC	B	\$ 275	\$ 275	15
16	V	30 Depreciation		Brentwood Healthcare Real Estate LLC	B	816,158	816,158	16
17	V	32 Interest Income		Brentwood Healthcare Real Estate LLC	B	(233)	(233)	17
18	V	32 Interest Expense		Brentwood Healthcare Real Estate LLC	B	1,108,440	1,108,440	18
19	V	33 Real Estate Taxes		Brentwood Healthcare Real Estate LLC	B	142,407	142,407	19
20	V	34 Rental Income	1,544,007	Brentwood Healthcare Real Estate LLC	B		(1,544,007)	20
21	V	19 Professional Fees		Brentwood Healthcare Real Estate LLC	B	14,930	14,930	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,544,007			\$ 2,081,977	\$ * 537,970	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	10a Therapy	\$ 1,128,744	Therapy Masters, Inc.	C	\$ 974,076	\$ (154,668)
16	V	19 Professional Fees		Therapy Masters, Inc.	C	382	382
17	V	20 Licenses, Permits and Inspection		Therapy Masters, Inc.	C	151	151
18	V	20 Employment Fees		Therapy Masters, Inc.	C	4,804	4,804
19	V	21 Clerical Salaries		Therapy Masters, Inc.	C	8,541	8,541
20	V	21 Clerical		Therapy Masters, Inc.	C	4,460	4,460
21	V	22 Employee Benefits and Payroll		Therapy Masters, Inc.	C	102,167	102,167
22	V	23 Training and Education		Therapy Masters, Inc.	C	2,555	2,555
23	V	25 Auto Expenses		Therapy Masters, Inc.	C	919	919
24	V	2 Food Purchase		Therapy Masters, Inc.	C	70	70
25	V	22 Employee Benefits		Therapy Masters, Inc.	C	(102,167)	(102,167)
26	V	15 Employee Benefits - Therapy		Therapy Masters, Inc.	C	101,258	101,258
27	V	27 Employee Benefits - Clerical		Therapy Masters, Inc.	C	909	909
28	V	30 Depreciation		Therapy Masters, Inc.	C	200	200
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,128,744			\$ 1,098,325	\$ * (30,419)

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

Facility Name & ID Number Brentwood North HealthCare & Rehabilitati # 0050112 Report Period Beginning: 1/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	70.00 %	177,138	12	19.80 %	Salary	\$ 17,743	Ln 17, Col 7	1
2	Jonathan Glenner	Clerical	Clerical	0.00 %	48,775	8	19.80 %	Salary	4,885	Ln 21, Col 7	2
3	Daniel Glenner	Administrative	Administrative	0.00 %	26,859	8	19.80 %	Salary	2,690	Ln 21, Col 7	3
4	Elliot Glenner	Clerical	Clerical	0.00 %	9,507	8	19.80 %	Salary	952	Ln 21, Col 7	4
5	David Weinschneider	Administrative	Administrative	0.00 %	47,717	8	19.80 %	Salary	4,779	Ln 21, Col 7	5
6	Joshua Ray	V.P. of Operations	Administrative	30.00 %	177,138	8	19.80 %	Salary	17,743	Ln 21, Col 7	6
7	Barry Ray	Vice President	Administrative	0.00 %	154,523	8	19.80 %	Salary	15,477	Ln 17, Col 7	7
8											8
9											9
10			See Schedule B								10
11											11
12											12
13								TOTAL	\$ 64,269		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 Brentwood North HealthCare & Rehabilitation Centre # 0050112 Report Period Beginning: 1/01/2009 Ending: 2/31/2009

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	540,919	7	\$ 31,402	\$ 49,247	\$ 2,859	1
2	6	Repairs and Maintenance	Resident Days	540,919	7	26,561	49,247	2,418	2
3	19	Professional Fees	Resident Days	540,919	7	215,599	49,247	19,629	3
4	20	Licenses, Permits and Inspection	Resident Days	540,919	7	40,365	49,247	3,675	4
5	21	Clerical	Resident Days	540,919	7	235,006	49,247	21,396	5
6	22	Employee Benefits and Payroll	Resident Days	540,919	7	439,026	49,247	39,970	6
7	23	Training and Education	Resident Days	540,919	7	4,102	49,247	373	7
8	25	Auto Expenses	Resident Days	540,919	7	38,975	49,247	3,548	8
9	26	Insurance	Resident Days	540,919	7	11,803	49,247	1,075	9
10	30	Depreciation	Resident Days	540,919	7	69,580	49,247	6,335	10
11	31	Amortization	Resident Days	540,919	7	598	49,247	54	11
12	33	Real Estate Taxes	Resident Days	540,919	7	62,534	49,247	5,693	12
13	35	Equipment and Vehicle Rental	Resident Days	540,919	7	44,880	49,247	4,086	13
14	6	Janitorial Salaries	Resident Days	540,919	7	20,053	49,247	1,826	14
15	17	Officer's Salaries	Resident Days	540,919	7	364,880	49,247	33,220	15
16	21	Administrative Salaries	Resident Days	540,919	7	2,506,264	49,247	228,178	16
17	22	Employee Benefits	Payroll					(39,970)	17
18	7	Employee Benefits - Janitorial	Payroll					276	18
19	27	Employee Benefits - Officer's	Payroll					5,044	19
20	27	Employee Benefits - Admin	Payroll					34,650	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,111,628	\$ 2,891,197		\$ 374,335	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	SLG Limited Partnership	X		Mortgage	\$108,054.27	8/28/08	\$ 15,180,000	\$ 14,448,578	9/01/2033	0.0800	\$ 1,108,440	1							
2							Non-allowable owner interest expense:				(1,108,440)	2							
3												3							
4												4							
5												5							
Working Capital																			
6	AMJED Trust	X									27,487	6							
7							Non-allowable owner interest expense:				(27,487)	7							
8												8							
9	TOTAL Facility Related				\$108,054.27		\$ 15,180,000	\$ 14,448,578			\$	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 15,180,000	\$ 14,448,578			\$	15							

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

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,758 B. General Construction Type: Exterior Brick/Masonry Frame Metal Number of Stories One

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>Patient Care</u>			\$ <u>2,373,245</u>	1
2	<u>Allocated from Management Company:</u>			<u>7,730</u>	2
3	TOTALS			\$ 2,380,975	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	248	2008		\$ 8,670,327	\$ 319,860	15,30 yrs	\$ 319,860	\$	\$ 479,791
5									
6	See Attached			165,130			4,523	4,523	
7	Schedule J								
8									
Improvement Type**									
9	Rooftop condenser unit	2008		7,920	792	10	792		1,188
10									
11									
12									
13									
14									
15									
16	Leasehold Improvements Allocated from Mangement Company			14,715			372	372	12,781
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		8,858,092	320,652		325,547	4,895	493,760	

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 2,534,333	\$ 501,041	\$ 501,041	\$	5,7,10 years	\$ 751,560	71
72	Current Year Purchases	5,593	280	280		10 years	280	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company:	71,090		933	933		69,439	74
75	TOTALS	\$ 2,611,016	\$ 501,321	\$ 502,254	\$ 933		\$ 821,279	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	Allocated from Management Company:			\$ 8,124	\$	\$ 706	\$ 706		\$ 4,256	76
77										77
78										78
79										79
80	TOTALS			\$ 8,124	\$	\$ 706	\$ 706		\$ 4,256	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)	\$ 13,858,207	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 821,973	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 828,507	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,534	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,319,295	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,972 Description: Copier\$5,280,Postage\$2,263,Icemaker\$1,500,Cooler\$198,DishMachine\$1,282,Crane\$700,MgtCo:\$1,749

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Management Company:</u>		\$	\$ <u>2,337</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,337</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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>It is the policy of this facility to hire only certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln10a,Col 2&3	hrs	\$	6,864	\$ 351,640	\$ 1,400	6,864	\$ 353,040	1
2	Licensed Speech and Language Development Therapist	Ln10a, Col 3	hrs		2,029	113,665		2,029	113,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		12,831	663,439	1,041	12,831	664,480	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				469,772		469,772	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, Laboratory & Dialysis Other (specify): <u>Respiratory Therapy</u>	Ln 39, Col 3 Ln10a,Col 1&3	3,759 hours	66,283		36,246 5,011		3,759	36,246 71,294	13
14	TOTAL			\$ 66,283	21,724	\$ 1,170,001	\$ 472,213	25,483	\$ 1,708,497	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 **Brentwood North HealthCare & Rehabilitation Centre**# **0050112**Report Period Beginning: **1/01/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(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	\$ 281,752	\$ 531,044	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>56,970</u>)	2,616,771	2,616,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	145,851	145,851	6
7	Other Prepaid Expenses	9,642	9,642	7
8	Accounts Receivable (owners or related parties)	(2,026,394)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,027,622	\$ 3,303,308	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,380,975	13
14	Buildings, at Historical Cost		8,835,457	14
15	Leasehold Improvements, at Historical Cost	52,357	22,635	15
16	Equipment, at Historical Cost	8,588	2,619,140	16
17	Accumulated Depreciation (book methods)	(8,583)	(1,319,295)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 52,362	\$ 12,538,912	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,079,984	\$ 15,842,220	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 8,140	\$ 8,140	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,608	6,608	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	360,515	360,515	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,076	4,076	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,000	32
33	Accrued Interest Payable		91,791	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule E:</u>	421,704	421,704	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 801,043	\$ 1,035,834	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,448,578	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 14,448,578	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 801,043	\$ 15,484,412	46
47	TOTAL EQUITY(page 18, line 24)	\$ 278,941	\$ 357,808	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,079,984	\$ 15,842,220	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (133,194)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (133,194)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,135	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 412,135	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)	\$ 278,941	24

* Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North HealthCare & Rehabilitation Cer # 0050112 Report Period Beginning: 1/01/2009

Ending: 12/31/2009

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	\$ 11,393,305	1
2	Discounts and Allowances for all Levels	(4,009,154)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,384,151	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,019,600	6
7	Oxygen	45,668	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,065,268	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	930	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	707,752	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	58,389	19
20	Radiology and X-Ray	19,521	20
21	Other Medical Services	816,770	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,603,362	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,457	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,457	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,060,238	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,855,118	31
32	Health Care	5,437,205	32
33	General Administration	2,049,441	33
B. Capital Expense			
34	Ownership	1,588,531	34
C. Ancillary Expense			
35	Special Cost Centers	586,396	35
36	Provider Participation Fee	131,412	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,648,103	40
41	Income before Income Taxes (line 30 minus line 40)**	412,135	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 412,135	43

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

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

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

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

Facility Name & ID Number **Brentwood North HealthCare & Rehabilitation Centre**

0050112

Report Period Beginning: **1/01/2009**

Ending:

12/31/2009

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	1,845	2,086	\$ 95,096	\$ 45.59	1
2	Assistant Director of Nursing	2,005	2,145	120,142	56.01	2
3	Registered Nurses	44,675	48,886	1,438,216	29.42	3
4	Licensed Practical Nurses	18,437	19,324	385,084	19.93	4
5	CNAs & Orderlies	98,394	106,736	1,390,441	13.03	5
6	CNA Trainees					6
7	Licensed Therapist	3,759	4,185	66,283	15.84	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,961	2,086	42,230	20.24	9
10	Activity Assistants	6,889	7,494	98,154	13.10	10
11	Social Service Workers	3,345	3,695	74,245	20.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,886	6,638	109,586	16.51	14
15	Cook Helpers/Assistants	22,705	24,697	277,755	11.25	15
16	Dishwashers					16
17	Maintenance Workers	3,698	4,181	101,852	24.36	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,001	2,150	92,788	43.16	20
21	Assistant Administrator	600	600	27,206	45.34	21
22	Other Administrative	15,032	16,233	422,683	26.04	22
23	Office Manager					23
24	Clerical					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	4,061	4,348	120,768	27.78	31
32	Other Health C: Dialysis Techs	793	795	13,999	17.61	32
33	Other(specify) <u>Ward Clerks</u>	1,748	1,950	21,759	11.16	33
34	TOTAL (lines 1 - 33)	237,834	258,229	\$ 4,898,287 *	\$ 18.97	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	\$ 660	Ln 1, Col 3	35
36	Medical Director	Monthly	37,000	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	936	Ln10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	960	Ln11, Col 3	44
45	Social Service Consultant	53	2,970	Ln12, Col 3	45
46	Other(specify)				46
47	<u>Medical Librarian</u>	Monthly	1,620	Ln10, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	69	\$ 44,146		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	
Michael Elkes	Administrator	0.00 %	\$ 92,788	Workers' Compensation Insurance	\$ 101,849	IDPH License Fee	\$ 1,022	
Philip Thompson	Administrator	0.00 %	27,206	Unemployment Compensation Insurance	47,504	Advertising: Employee Recruitment	419	
				FICA Taxes	357,413	Health Care Worker Background Check		
				Employee Health Insurance	232,750	(Indicate # of checks performed <u>58</u>)	580	
				Employee Meals	25,299	Patient Background Checks <u>15</u>	150	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Employee Benefits	3,441			
				Uniform Allowance	274	See Attached Schedule K:	62,167	
				401K Match	8,057	Allocated from Therapy Masters, Inc.:	4,955	
						Allocated from Management Company:	3,675	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,994					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,994	See Attached Schedule D:	0			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,994					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,994	TOTAL (agree to Schedule V, line 22, col.8)	\$ 776,587	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 72,968	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (eliminated in Column 7)			\$ 330,096				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 330,096				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 330,096				Seminar Expense	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 330,096				Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 330,096				TOTAL (agree to Sch. V, line 24, col. 8)	\$
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount					
See Attached Schedule C:			46,090					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 46,090					

* 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	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 Brentwood North HealthCare & Rehabilitation Centre# 0050112Report Period Beginning: 1/01/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$5,771
- (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. \$ 51,341 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. \$ 131,412
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. \$ 25,299 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2009

SCHEDULE A

SCHEDULE VII. RELATED PARTIES

Part A. Col.3

3 OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
Glen Health & Home Management, Inc.	Skokie	Management Company
GlenBar Management Company, Ltd.	Skokie	Management Company
Brentwood Healthcare Real Estate LLC.	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Co.
Therapy Masters	Skokie	Therapy company

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
 Provider I.D. # 50112
 12/31/2009

SCHEDULE B

SCHEDULE VII RELATED PARTIES

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

Name	Compensation Received From Other Nursing Homes						Total
	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Bridge Nursing & Rehab. Centre, Ltd.	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenShire Nursing & Rehab. Centre, Ltd.	GlenLake Terrace Nursing & Rehab. Centre, Ltd.	
Sidney Glenner	38,155	32,651	33,386	13,658	29,564	29,724	177,138
Jonathan Glenner	10,506	8,990	9,193	3,761	8,140	8,185	48,775
Daniel Glenner	5,785	4,951	5,062	2,071	4,483	4,507	26,859
Elliot Glenner	2,048	1,752	1,792	733	1,587	1,595	9,507
David Weinschneider	10,278	8,795	8,994	3,679	7,964	8,007	47,717
Joshua Ray	38,155	32,651	33,386	13,658	29,564	29,724	177,138
Barry Ray	33,284	28,482	29,124	11,914	25,790	25,929	154,523
Total compensation received from other Nursing Homes	138,211	118,272	120,937	49,474	107,092	107,671	641,657

See Accountants' Compilation Report

SCHEDULE C

XIX. SUPPORT SCHEDULES

C. Professional Services

Page 21

<u>Vendor/Payee</u>	<u>Type</u>	<u>AMOUNT</u>
Health Data Systems, Inc.	Computers	6,361
E Health Data Solutions	Computers	4,470
Advanced Answers on Demand	Computers	2,055
RSM McGladrey	Accounting	22,109
Frost, Ruttenberg & Rothblatt	Accounting	433
ReedSmith LLC	Legal	1,483
Much Shelist	Legal	4,590
Prospect Resources Inc	Maintenance Consulting	1,500
Personnel Planners, Inc.	Unemployment Consulting	1,021
Health Information Consulting	Health Information Consultant	1,080
Commitment Consulting	A/R Collections	39
Total Schedule V, Line 19, Col. 3		<u>45,141</u>
Allocated from Management Co:		
Health Data Systems, Inc. - Computer Services		542
RSM McGladrey - Accounting Services		17,526
ReedSmith Sachnoff & Weaver - Legal Services		435
Frost, Ruttenberg & Rothblatt - Accounting Services		1,046
Much Shelist - Legal Services		80
Total allocated from Management Co.		<u>19,629</u>
Allocated from Brentwood Healthcare Real Estate LLC:		
RSM McGladrey - Accounting Fees		11,930
JBA & Associates - Legal		3,000
Total allocated from Brentwood Healthcare Real Estate LLC:		<u>14,930</u>
Total allocated from Therapy Masters:		382

Non-Allowable Expenses:

Commitment Consulting - A/R Collections	-39
RSM McGladrey - Accounting Fees	-19,023
RSM McGladrey - Brentwood Healthcare Real Estate LLC - Accounting Fees	-11,930
JBA & Associates - Brentwood Healthcare Real Estate LLC - out of period	-3,000
Total Non-Allowable Expenses:	<u>-33,992</u>

Total adjustments page 21, Sch C. 949

Total Schedule V, line 19, column 8 46,090

See Accountants' Compilation Report

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Allocated from Management Co:	
FICA taxes	18,051
FUTA	247
SUTA	561
401K Match	1,190
Insurance - Hospital	12,909
Employee Benefits	1,654
Other Employee Benefits	957
Workers Compensation Insurance	4,401
Total allocated from Management Co.	<u>39,970</u>
Employee Benefits reclassified to Lines 7, 27	-39,970
Allocated from Therapy Masters, Inc.:	
FICA taxes	64,658
FUTA	976
SUTA	1,217
401K Match	6,204
Insurance - Hospital	16,971
Workers Compensation Insurance	11,915
Other Employee Benefits	226
Total allocated from Therapy Masters, Inc. Co.	<u>102,167</u>
Employee Benefits reclassified to Lines 15,27	-102,167
Total allocated to Page 21	<u>0</u>

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2009

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Due to Third Party	67,939
Accrued Wage Assignment	(220)
Due Con Mutual	(374)
Accrued Management Fees	330,096
Refunds Exchange	24,263
Total, Page 17, Line36	<u><u>421,704</u></u>

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2009

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

<u>DESCRIPTION</u>	<u>AMOUNT</u>	<u>REFERENCE</u>
Patient clothing	-200	43
Non-allowable owner interest expense	-1,108,440	32
Non-allowable owner interest expense	-27,487	32
Non-allowable office expense	-275	43
Non-allowable professional fees	-33,992	19
Non-allowable auto expense - marketing	-3,412	25
Non-allowable Illinois Council on Long Term Care Dues	-3,373	20
Adjust mgt co. med supplies - med'A' to cost	-41,759	10
Total	<u>-1,218,938</u>	

See Accountants' Compilation Report

Provider Name: Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. #: 50112
Year Ended: December 31, 2009

SCHEDULE H

Training & Education

Person(s) Attending	Date Attended	Location	Title Sponsor	Total Cost
Nursing & Respiratory Staff	1/22/09	Facility	PEL/VIP MEDICAL STAFFING Trach Care	195
Tish Evangelista	3/26/09	Chicago, Il	RUSH ALZHEIMERS CENTER Alzheimer's & Dementia and Overview	60
Eileen Duffy	4/15/09	Waukegan, Il	LAKE COUNTY HEALTH DEPT Dietary Sanitation	100
Lynn Bruch	5/21/09	Lincolnshire, Il	LAKE COUNTY ACUTE CARE Bold New Directions for Long Term Care	25
Department Heads, Nursing Staff Social Service Staff	8/19/2009	Facility	SOCIALWORK CONSULTATION GROUP Legal & Ethical Issues for Social Service and Nursing Professionals	560
L. Bruch, M. Elkes, T Evangelista J Scott	9/3/2009	Skokie, Il	ILLINOIS PIONEER COALITION A Tale of Transformation-Long Term Care	140
T Evangelista	9/17-9/18/09	Chicago, Il	Synergicare WOUND CARE 101	198
Department Heads, Nursing Staff Social Service Staff	10/19/09	Facility	SOCIAL WORK PRN Adherence Issues: Motivation & Change	250
Nursing & Respiratory Staff	10/13/09	Facility	PEL/VIP MEDICAL STAFFING Trach Care	293
			Allocated From Management Company	373
			Allocated From Therapy Masters	2,555
			Total	4,749

SEE ACCOUNTANTS' COMPILATION REPORT

**Brentwood Healthcare Real Estate LLC.
Accrued Real Estate Taxes
12/31/2009**

SCHEDULE G

	Accrued 1/01/09	Payments	Expense	Accrued 12/31/09
Balance @ 1/01/2009:	<u>(139,959.00)</u>		<u>(139,959.00)</u>	
2008 real estate taxes paid		139,365.64	139,365.64	
Estimated 2009 real estate taxes:				
2008 taxes	139,365.64			
Estimated increase	2.50 %			
Estimated 2009 taxes	<u>142,849.78</u>			
	USE		143,000.00	(143,000.00)
	<u>143,000.00</u>			
Totals	<u>(139,959.00)</u>	139,365.64	142,406.64	<u>(143,000.00)</u>

Real estate tax history:

Year	Amount	\$	Increase	%
2007	132,370.06			
2008	139,365.64	6,995.58	5.28%	

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2009

SCHEDULE I

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

	Gasoline	Mileage Reimburse	Parking	Tolls	Total
Direct Expense	5,400	3,771	101	89	9,361
Non-allowable auto expense - marketing					-3,412
Allocated from Management Company					3,548
Allocated from Therapy Masters					919
TOTAL	5,400	3,771	101	89	10,416

SEE ACCOUNTANTS' COMPILATION REPORT

HEALTH AND HOME MANAGEMENT, INC.
ALLOCATION OF MANAGEMENT COMPANY BUILDING

SCHEDULE J

ASSET DESCRIPTION	COST 6/30/1999	ADJUSTMENTS TO CAPITAL PROJECTION	ADJUSTED CAPITAL PROJECTION 6/30/1999	ADDITIONS		NURSING HOME PERCENTAGE 84.9438%	GLENBRIDGE 103,052/460,292 0.223883969	GLENCREST 111,372/460,292 0.241959452	GLEN OAKS 101,895/460,292 0.221370348	GLEN ELSTON 41,220/460,292 0.08955185	GLENSHIRE 102,753/460,292 0.223234382		
				7/1/99- 12/31/2004	COST 12/31/2000								
1996 BUILDING PURCHASE	230,000		230,000		<u>230,000</u>	195,371	43,740	47,272	-	43,249	-	17,496	43,614
1998 BUILDING RENOVATION													
GENERAL CONTRACTOR	957,570		957,570		957,570								
ELECTRICAL CONTRACTOR	275,576		275,576		275,576								
HVAC CONTRACTOR	182,130		182,130		182,130								
PLUMBING CONTRACTOR	68,599		68,599		68,599								
ARCHITECT FEES	115,968		115,968		115,968								
OTHER FEES AND PERMITS	33,024		33,024		33,024								
SECURITY SYSTEM	17,953		17,953		17,953								
TELEPHONE SYSTEM	12,500		12,500		12,500								
MISC. BUILDING COMPONENTS	24,226		24,226		24,226								
CAPITALIZED INTEREST	121,387	-15,261	106,126		106,126								
LANDSCAPING	30,000		30,000		30,000								
SPRINKLER SYSTEM	10,720		10,720		10,720								
HVAC SYSTEMS	24,749	-24,749	0		0								
WALL CONSTRUCTION	10,235	-10,235	0		0								
ELECTRICAL	10,634	-10,634	0		0								
MISC. IMPROVEMENTS	26,075	-26,075	0		0								
ASPHALT DRIVEWAY	5,900	-5,900	0		0								
					<u>2,064,392</u>	1,753,573	392,597	424,294	-	388,189	-	157,036	391,458
1999 ACCORD ELECTRIC				17,929	17,929								
HMS + ASSOCIATES-INTERIOR				31,505	31,505								
SAM MORMINO-LANDSCAPING				1,050	1,050								
ARCHITECTURAL DYNAMICS-ARCHITECT FEES				1,468	1,468								
MISC.				11,076	11,076								
					<u>2,127,420</u>	1,807,111	404,583	437,248	-	400,041	-	161,830	403,409
2000 AQUATIC WORKS - BUILT IN FISH TANK				5,000	5,000								
					<u>2,132,420</u>	1,811,359	405,534	438,275	-	400,981	-	162,211	404,358
2001 NO ADDITIONS													
2002 NO ADDITIONS					<u>2,132,420</u>	1,811,359	405,534	438,275	-	400,981	-	162,211	404,358
2003 SEAL COAT CORPORATION - SEAL PARKING LOT				2825	2825								
					<u>2,135,245</u>	1,813,758	406,071	438,856	-	401,512	-	162,425	404,893
2004 NO ADDITIONS					<u>2,135,245</u>	1,813,758	406,071	438,856	-	401,512	-	162,425	404,893
2005 NO ADDITIONS					<u>2,135,245</u>	1,813,758	406,071	438,856	-	401,512	-	162,425	404,893
2006 NO ADDITIONS					<u>2,135,245</u>	1,813,758	406,071	438,856	-	401,512	-	162,425	404,893

NURSING HOME	RECALCULATION BASED ON 2007 CENSUS							TOTAL
	GLENBRIDGE	GLENCREST	GLEN OAKS	GLEN ELSTON	GLENSHIRE	GLENLAKE		
PERCENTAGE	93767	95,262	106,511	40,267	78,093	74,334	488,234	
84.9438%	0.192053401	0.195115457	0.218155638	0.082474797	0.159949942	0.152250765	1	

2007 NO ADDITIONS	<u>2,135,245</u>	1,813,758	<u>348,338</u>	<u>353,892</u>	<u>395,682</u>	<u>149,589</u>	<u>290,111</u>	<u>276,146</u>	<u>1,813,758</u>
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NURSING HOME	RECALCULATION BASED ON 2008 CENSUS							TOTAL
	GLENBRIDGE	GLENCREST	GLEN OAKS	GLEN ELSTON	GLENSHIRE	GLENLAKE	BRENTWOOD	
PERCENTAGE	93929	92,291	105,965	37,609	81,480	76,498	15,564	503,336
84.9438%	18.66%	18.34%	21.05%	7.47%	16.19%	15.20%	3.09%	1

2008 NO ADDITIONS	<u>2,135,245</u>	1,813,758	<u>338,471</u>	<u>332,568</u>	<u>381,842</u>	<u>135,523</u>	<u>293,611</u>	<u>275,659</u>	<u>56,084</u>	<u>1,813,758</u>
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NURSING HOME	RECALCULATION BASED ON 2009 CENSUS							TOTAL
	GLENBRIDGE	GLENCREST	GLEN OAKS	GLEN ELSTON	GLENSHIRE	GLENLAKE	BRENTWOOD	
PERCENTAGE	92,668	90,627	105,904	37,909	82,060	82,504	49,247	540,919
84.9438%	17.13%	16.75%	19.58%	7.01%	15.17%	15.25%	9.10%	100.00%

2009 NO ADDITIONS	<u>2,135,245</u>	1,813,758	<u>310,726</u>	<u>303,882</u>	<u>355,107</u>	<u>127,113</u>	<u>275,156</u>	<u>276,645</u>	<u>165,130</u>	<u>1,813,758</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2009

SCHEDULE K

XIX. SUPPORT SCHEDULES

Page 21

F. Dues, Fees, Subscriptions and Promotions

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Illinois Council on Long Term Care Dues	9,144
Coalition on Aging Dues	1,897
Joint Commission Annual Certification Fee	1,070
Joint Commission Long Term Care Program Fee	4,130
CLIA Laboratory Program Certificate of Waiver User Fee	150
State Fire Marshall Boiler Inspection Fees	1,395
Lake County Health Department Food Service Permit Fee	332
Secretary of State Annual Report Fee	150
Employment Fees	47,272
Non-allowable Illinois Council on Long Term Care Dues	-3,373
Total allocated to Page 21	<u>62,167</u>

See Accountants' Compilation Report