

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>50112</u></p> <p>Facility Name: <u>Brentwood North Healthcare and Rehabilitation Centre, Inc.</u></p> <p>Address: <u>3705 Deerfield Road</u> <u>Riverwoods</u> <u>60015</u> Number City Zip Code</p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>(847) 459-1200</u> Fax # <u>(847) 459-0113</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9/01/08</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Sidney Glenner</u> (Title) <u>President</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago IL 60606-4650</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Sidney Glenner</u> (Title) <u>President</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago IL 60606-4650</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North Healthcare and Rehabilitation Centre, Inc.

50112 Report Period Beginning: 1/01/2011 Ending: 12/31/2011

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	747	2,684	17,716	21,147	8
9	SNF/PED					9
10	ICF	14,853	7,258	0	22,111	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,600	9,942	17,716	43,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.79%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 14,570

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North Healthcare and Rehabilitati # 50112 Report Period Beginning: 1/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	404,223	44,847	1,625	450,695		450,695		450,695		1
2	Food Purchase		447,233		447,233	(29,927)	417,306	(31,197)	386,109		2
3	Housekeeping		8,640	273,594	282,234		282,234		282,234		3
4	Laundry			184,131	184,131		184,131		184,131		4
5	Heat and Other Utilities			254,517	254,517		254,517	3,553	258,070		5
6	Maintenance	105,006	59,245	86,757	251,008		251,008	3,697	254,705		6
7	Other (specify):* Allocated Employee Benefits							229	229		7
8	TOTAL General Services	509,229	559,965	800,624	1,869,818	(29,927)	1,839,891	(23,718)	1,816,173		8
	B. Health Care and Programs										
9	Medical Director			42,500	42,500		42,500		42,500		9
10	Nursing and Medical Records	3,836,978	365,852	3,467	4,206,297		4,206,297	(64,368)	4,141,929		10
10a	Therapy	88,278	1,245	1,522,033	1,611,556		1,611,556	(274,752)	1,336,804		10a
11	Activities	142,403	8,595	1,200	152,198		152,198		152,198		11
12	Social Services	73,336		2,958	76,294		76,294		76,294		12
13	CNA Training										13
14	Program Transportation			7,109	7,109		7,109		7,109		14
15	Other (specify):* Allocated Employee Benefits							130,068	130,068		15
16	TOTAL Health Care and Programs	4,140,995	375,692	1,579,267	6,095,954		6,095,954	(209,052)	5,886,902		16
	C. General Administration										
17	Administrative	88,928		872,130	961,058		961,058	(855,897)	105,161		17
18	Directors Fees										18
19	Professional Services			99,961	99,961		99,961	(14,504)	85,457		19
20	Dues, Fees, Subscriptions & Promotions			34,012	34,012	100	34,112	902	35,014		20
21	Clerical & General Office Expenses	349,385	72,832	69,411	491,628	(100)	491,528	231,887	723,415		21
22	Employee Benefits & Payroll Taxes			639,878	639,878	29,927	669,805		669,805		22
23	Inservice Training & Education			1,750	1,750		1,750	5,088	6,838		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			15,931	15,931		15,931	(4,652)	11,279		25
26	Insurance-Prop.Liab.Malpractice			99,405	99,405		99,405	1,773	101,178		26
27	Other (specify):* Allocated Employee Benefits							37,236	37,236		27
28	TOTAL General Administration	438,313	72,832	1,832,478	2,343,623	29,927	2,373,550	(598,167)	1,775,383		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,088,537	1,008,489	4,212,369	10,309,395		10,309,395	(830,937)	9,478,458		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Brentwood North Healthcare and Rehabilitation Centre, Inc. #50112

Report Period Beginning:

1/01/2011

Ending:

12/31/2011

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			22,755	22,755		22,755	839,521	862,276			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,120	91,120		91,120	(91,120)				32
33	Real Estate Taxes							163,557	163,557			33
34	Rent-Facility & Grounds			1,559,331	1,559,331		1,559,331	(1,559,331)				34
35	Rent-Equipment & Vehicles			23,331	23,331		23,331	3,891	27,222			35
36	Other (specify):*											36
37	TOTAL Ownership			1,696,537	1,696,537		1,696,537	(643,482)	1,053,055			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		693,410	71,452	764,862		764,862		764,862			39
40	Barber and Beauty Shops			14,002	14,002		14,002		14,002			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			255,335	255,335		255,335	(255,335)				43
44	TOTAL Special Cost Centers		693,410	472,201	1,165,611		1,165,611	(255,335)	910,276			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,088,537	1,701,899	6,381,107	13,171,543		13,171,543	(1,729,754)	11,441,789			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	(649)	21		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	117	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,338)	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	(500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(251,925)	43		24
25	Fund Raising, Advertising and Promotional	(1,435)	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:	(1,344,722)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,600,452)		\$	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)	(129,302)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (129,302)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,729,754)		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		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 and Rehabilitation Centre, Inc.

ID# 50112

Report Period Beginning: 1/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjust Mgt Co. medical supplies"A" to cost	\$ (42,111)	10	1
2	Adjust Mgt Co. medical supplies"other" to cost	(22,257)	10	2
3	Adjust Mgt Co. food to cost	(31,250)	2	3
4	Non-allowable patient clothing	(137)	43	4
5	Non-allowable professional fees	(39,397)	19	5
6	Non-allowable owner interest expense	(1,077,223)	32	6
7	Non-allowable owner interest expense	(89,798)	32	7
8	Non-allowable auto expense - marketing	(8,348)	25	8
9	Non-allowable Illinois Council on Long Term Care Dues	(5,778)	20	9
10	Non-allowable office expense	(41)	43	10
11	Non-allowable miscellaneous expense	(28,382)	21	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
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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	(1,344,722)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brentwood North Healthcare and Rehabilitation Centre, Inc# 50112

Report Period Beginning:

1/01/2011

Ending:

12/31/2011

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	(31,250)	0	0	0	53	0	0	0	0	0	0	(31,197)	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	3,553	0	0	0	0	0	0	0	0	3,553	5
6	Maintenance	0	0	3,697	0	0	0	0	0	0	0	0	3,697	6
7	Other (specify):*	0	0	229	0	0	0	0	0	0	0	0	229	7
8	TOTAL General Services	(31,250)	0	7,479	0	53	0	0	0	0	0	0	(23,718)	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	(64,368)	0	0	0	0	0	0	0	0	0	0	(64,368)	10
10a	Therapy	0	0	0	0	(274,752)	0	0	0	0	0	0	(274,752)	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	130,068	0	0	0	0	0	0	130,068	15
16	TOTAL Health Care and Programs	(64,368)	0	0	0	(144,684)	0	0	0	0	0	0	(209,052)	16
	C. General Administration													
17	Administrative	0	0	(855,897)	0	0	0	0	0	0	0	0	(855,897)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(39,397)	0	17,476	0	7,417	0	0	0	0	0	0	(14,504)	19
20	Fees, Subscriptions & Promotions	(5,778)	0	2,304	0	4,376	0	0	0	0	0	0	902	20
21	Clerical & General Office Expenses	(29,031)	0	247,839	0	13,079	0	0	0	0	0	0	231,887	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	471	0	4,617	0	0	0	0	0	0	5,088	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(8,348)	0	1,912	0	1,784	0	0	0	0	0	0	(4,652)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,773	0	0	0	0	0	0	0	0	1,773	26
27	Other (specify):*	0	0	36,161	0	1,075	0	0	0	0	0	0	37,236	27
28	TOTAL General Administration	(82,554)	0	(547,961)	0	32,348	0	0	0	0	0	0	(598,167)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(178,172)	0	(540,482)	0	(112,283)	0	0	0	0	0	0	(830,937)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brentwood North Healthcare and Rehabilitation Centre, Inc # 50112 Report Period Beginning: 1/01/2011 Ending: 12/31/2011

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	6,266	832,825	430	0	0	0	0	0	0	839,521 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,166,904)	0	0	1,075,784	0	0	0	0	0	0	0	(91,120) 32
33	Real Estate Taxes	0	0	5,826	157,731	0	0	0	0	0	0	0	163,557 33
34	Rent-Facility & Grounds	0	0	0	(1,559,331)	0	0	0	0	0	0	0	(1,559,331) 34
35	Rent-Equipment & Vehicles	0	0	3,891	0	0	0	0	0	0	0	0	3,891 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,166,904)	0	15,983	507,009	430	0	0	0	0	0	0	(643,482) 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):*	(255,376)	0	0	41	0	0	0	0	0	0	0	(255,335) 43
44	TOTAL Special Cost Centers	(255,376)	0	0	41	0	0	0	0	0	0	0	(255,335) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,600,452)	0	(524,499)	507,050	(111,853)	0	0	0	0	0	0	(1,729,754) 45

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
Sidney Glenner	70.00 %	See Attached Page 6-Supplemental		See Attached Schedule A		
Joshua Ray	30.00 %					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Total from Page 6A	\$ 872,130	Glen Health and Home Management, Inc.	A	\$ 347,631	\$ (524,499)	1
2	V							2
3	V	Total from Page 6B	1,559,331	Brentwood Healthcare Real Estate LLC.	B	2,066,381	507,050	3
4	V							4
5	V	Total from Page 6C	1,517,063	Therapy Masters, Inc.	C	1,405,210	(111,853)	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 100.00 % by Sidney Glenner				12
13	V							13
14	Total		\$ 3,948,524			\$ 3,819,222	\$ * (129,302)	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	\$ 872,130	Glen Health and Home Management, Inc.	A	\$	(872,130)	15
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	3,553	3,553	16
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	2,114	2,114	17
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	17,476	17,476	18
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	2,304	2,304	19
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	15,444	15,444	20
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	36,390	36,390	21
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	471	471	22
23	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	1,912	1,912	23
24	V	26	Insurance		Glen Health and Home Management, Inc.	A	1,773	1,773	24
25	V	30	Depreciation		Glen Health and Home Management, Inc.	A	6,266	6,266	25
26	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	5,826	5,826	26
27	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	3,891	3,891	27
28	V	6	Janitorial Salaries		Glen Health and Home Management, Inc.	A	1,583	1,583	28
29	V	17	Officer's Salaries		Glen Health and Home Management, Inc.	A	16,233	16,233	29
30	V	21	Administrative Salaries		Glen Health and Home Management, Inc.	A	232,395	232,395	30
31	V	22	Employee Benefits		Glen Health and Home Management, Inc.	A	(36,390)	(36,390)	31
32	V	7	Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A	229	229	32
33	V	27	Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A	2,362	2,362	33
34	V	27	Employee Benefits - Admin		Glen Health and Home Management, Inc.	A	33,799	33,799	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 872,130			\$ 347,631	\$ * (524,499)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest Expense	\$	Brentwood Healthcare Real Estate LLC	B	\$ 1,075,901	\$ 1,075,901	15
16	V	30	Depreciation		Brentwood Healthcare Real Estate LLC	B	832,825	832,825	16
17	V	33	Real Estate Taxes		Brentwood Healthcare Real Estate LLC	B	157,731	157,731	17
18	V	34	Rental Income	1,559,331	Brentwood Healthcare Real Estate LLC	B		(1,559,331)	18
19	V	32	Interest Income		Brentwood Healthcare Real Estate LLC	B	(117)	(117)	19
20	V	43	Office Expense		Brentwood Healthcare Real Estate LLC	B	41	41	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,559,331			\$ 2,066,381	\$ * 507,050	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Brentwood North Healthcare and Rehabilitation Centre, Inc.

50112

Report Period Beginning:

1/01/2011

Ending: 12/31/2011

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	\$ 1,517,063	Therapy Masters, Inc.	C	\$ 1,242,311	\$ (274,752)
16	V	19 Professional Fees		Therapy Masters, Inc.	C	7,417	7,417
17	V	20 Licenses, Permits and Inspection		Therapy Masters, Inc.	C	207	207
18	V	20 Dues and Subscriptions		Therapy Masters, Inc.	C	178	178
19	V	21 Clerical Salaries		Therapy Masters, Inc.	C	10,246	10,246
20	V	21 Clerical		Therapy Masters, Inc.	C	2,833	2,833
21	V	22 Employee Benefits and Payroll		Therapy Masters, Inc.	C	131,143	131,143
22	V	23 Training and Education		Therapy Masters, Inc.	C	4,617	4,617
23	V	25 Auto Expenses		Therapy Masters, Inc.	C	1,784	1,784
24	V	20 Employment Fees		Therapy Masters, Inc.	C	3,991	3,991
25	V	22 Employee Benefits		Therapy Masters, Inc.	C	(131,143)	(131,143)
26	V	15 Employee Benefits - Therapy		Therapy Masters, Inc.	C	130,068	130,068
27	V	27 Employee Benefits - Clerical		Therapy Masters, Inc.	C	1,075	1,075
28	V	30 Depreciation		Therapy Masters, Inc.	C	430	430
29	V	2 Food Purchase		Therapy Masters, Inc.	C	53	53
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,517,063			\$ 1,405,210	\$ * (111,853)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			1
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Sidney Glenner	100.00 %	GlenBridge Nursing & Rehabilitation	Niles	See Attached Schedule A			2
3			Centre, Ltd.					3
4								4
5	Sidney Glenner	100.00 %	GlenCrest Nursing & Rehabilitation	Chicago				5
6			Centre, Ltd.					6
7								7
8	Sidney Glenner	100.00 %	Glen Elston Nursing & Rehabilitation	Chicago				8
9			Centre, Ltd.					9
10								10
11	Sidney Glenner	100.00 %	Glen Oaks Nursing & Rehabilitation	Northbrook				11
12			Centre, Ltd.					12
13								13
14	Sidney Glenner	100.00 %	GlenShire Nursing & Rehabilitation	Richton Park				14
15			Centre, Ltd.					15
16								16
17	Sidney Glenner	80.00 %	GlenLake Terrace Nursing & Rehabilitation	Waukegan				17
18	Joshua Ray	20.00 %	Centre, Ltd.					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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brentwood North Healthcare and Rehabilita # 50112 Report Period Beginning: 1/01/2011 Ending: 12/31/2011

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 %	189,087	5	7.97 %	Salary	\$ 16,233	Ln 17, Col 7	1
2	Jonathan Glenner	Clerical	Clerical	0.00 %	49,263	3	7.97 %	Salary	4,229	Ln 21, Col 7	2
3	Daniel Glenner	Administrative	Administrative	0.00 %	27,231	3	7.97 %	Salary	2,338	Ln 21, Col 7	3
4	Elliot Glenner	Clerical	Clerical	0.00 %	23,780	3	7.97 %	Salary	2,040	Ln 21, Col 7	4
5	David Weinschneider	Administrative	Administrative	0.00 %	49,009	3	7.97 %	Salary	4,208	Ln 21, Col 7	5
6	Joshua Ray	V.P. of Operations	Administrative	30.00 %	189,087	5	7.97 %	Salary	16,233	Ln 21, Col 7	6
7											7
8											8
9											9
10			See Schedule B								10
11											11
12											12
13								TOTAL	\$ 45,281		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 and Rehabilitation Centre, I # 50112 Report Period Beginning: 1/01/2011 Ending: 2/31/2011

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	547,138	7	\$ 44,943	\$ 43,258	\$ 3,553	1
2	6	Repairs and Maintenance	Resident Days	547,138	7	26,739	43,258	2,114	2
3	19	Professional Fees	Resident Days	547,138	7	221,035	43,258	17,476	3
4	20	Licenses, Permits and Inspection	Resident Days	547,138	7	29,141	43,258	2,304	4
5	21	Clerical	Resident Days	547,138	7	195,341	43,258	15,444	5
6	22	Employee Benefits and Payroll	Resident Days	547,138	7	460,274	43,258	36,390	6
7	23	Training and Education	Resident Days	547,138	7	5,959	43,258	471	7
8	25	Auto Expenses	Resident Days	547,138	7	24,184	43,258	1,912	8
9	26	Insurance	Resident Days	547,138	7	22,424	43,258	1,773	9
10	30	Depreciation	Resident Days	547,138	7	79,259	43,258	6,266	10
11	33	Real Estate Taxes	Resident Days	547,138	7	73,683	43,258	5,826	11
12	35	Equipment and Vehicle Rental	Resident Days	547,138	7	49,215	43,258	3,891	12
13	6	Janitorial Salaries	Resident Days	547,138	7	20,018	20,018	1,583	13
14	17	Officer's Salaries	Resident Days	547,138	7	205,320	205,320	16,233	14
15	21	Administrative Salaries	Resident Days	547,138	7	2,939,391	2,939,391	232,395	15
16	22	Employee Benefits	Payroll					(36,390)	16
17	7	Employee Benefits - Janitorial	Payroll					229	17
18	27	Employee Benefits - Officer's	Payroll					2,362	18
19	27	Employee Benefits - Admin	Payroll					33,799	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,396,926	\$ 3,164,729	\$ 347,631	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
Name of Lender	YES	NO	Original	Balance								
A. Directly Facility Related												
Long-Term												
1	SLG Limited Partnership	X		Mortgage	\$108,054.27	8/28/2008	\$ 15,180,000	\$ 14,526,806	9/01/2033	0.0800	\$ 1,075,901	1
2	Glenner 1995 Family Trust	X		Finance Insurance Policy	\$7,740.80	8/28/2011	90,422	60,781	8/01/2012	0.0500	1,322	2
3												3
4							Non-Allowable owner interest expense:				(1,077,223)	4
5												5
Working Capital												
6	Stockholders	X		Working Capital			4,565,000	4,565,000			89,798	6
7												7
8							Non-Allowable owner interest expense:				(89,798)	8
9	TOTAL Facility Related				\$115,795.07		\$ 19,835,422	\$ 19,152,587			\$	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 19,835,422	\$ 19,152,587			\$	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.)

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 2010 report.		\$	148,000		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.)		\$	149,731		2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,731		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	156,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	157,731		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	131,410	8	FOR BHF USE ONLY	
	2007	132,370	9		
	2008	139,366	10	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2009	144,214	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2010	149,731	12	15	LESS REFUND FROM LINE 6 \$ 15
See Attached Schedule G For Calculation Of 2011 Real Estate Tax Accrual.				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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brentwood North Healthcare and Rehabilitation Centre, Inc. COUNTY Lake

FACILITY IDPH LICENSE NUMBER 50112

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-35-100-003</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>2,327.52</u>	\$ <u>2,327.52</u>
2. <u>15-35-200-001</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>140,767.79</u>	\$ <u>140,767.79</u>
3. <u>15-35-200-016</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>2,139.51</u>	\$ <u>2,139.51</u>
4. <u>15-35-200-002</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>4,496.66</u>	\$ <u>4,496.66</u>
5. <u>Allocated from Management Co:</u>	<u></u>	\$ <u>63,772.67</u>	\$ <u>5,826.00</u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u><u>213,504.15</u></u>	\$ <u><u>155,557.48</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation**. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Brentwood North Healthcare and Rehabilitation Centre, Inc.

50112

Report Period Beginning:

1/01/2011 Ending:

12/31/2011

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	Patient Care			\$ 2,373,245	1
2	Allocated from Management Company:			6,719	2
3	TOTALS			\$ 2,379,964	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	248	2008		\$ 9,170,327	\$ 336,527	15,30 yrs	\$ 336,527	\$	\$ 1,177,844	4
5										5
6	See Attached		1996	165,130			3,777	3,777		6
7	Schedule J									7
8										8
Improvement Type**										
9	Rooftop condenser unit		2008	7,920	792	10	792		2,772	9
10	Ceramic tile installation		2010	3,679	368	10	368		552	10
11	Elevator hydraulic jack assembly		2010	21,500	2,150	10	2,150		3,225	11
12	Installation of roof drains and patch roof		2010	11,400	1,140	10	1,140		1,710	12
13	Install aluminum paneling for exterior substructure		2011	3,135	157	10	157		157	13
14	Furnish and install air-conditioning unit		2011	3,015	151	10	151		151	14
15	Sidewalk and curb concrete project		2011	4,000	200	10	200		200	15
16	Remove wallpaper, plaster and paint medical room and back entrance		2011	5,255	263	10	263		263	16
17	Remove wallpaper, plaster and paint, install laminated floor		2011	6,840	342	10	342		342	17
18	Remove and install carpet, vinyl tile and cove base		2011	30,510	1,526	10	1,526		1,526	18
19	Remove and install wallpaper, painting project		2011	11,861	593	10	593		593	19
20	Remove and install wallpaper, paint resident rooms		2011	5,100	255	10	255		255	20
21	Two Carrier rooftop heating/cooling units		2011	24,569	1,228	10	1,228		1,228	21
22	Remove wallpaper, plaster and painting project		2011	3,425	171	10	171		171	22
23	Remove carpet and install vinyl tile flooring		2011	4,800	240	10	240		240	23
24	Purchase Rheem 120 gallon hot water storage tank		2011	3,135	157	10	157		157	24
25										25
26										26
27										27
28	See Attached Schedule L:									28
29	Leasehold Improvements Allocated from Management Company:		1998	9,094						29
30	Leasehold Improvements Allocated from Management Company:		1999	3,798						30
31	Leasehold Improvements Allocated from Management Company:		2000	455						31
32	Leasehold Improvements Allocated from Management Company:		2008	1,368			119	119	13,220	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$	\$		\$	\$	\$	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
			9,500,316	346,260	350,156	3,896	1,204,606	

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 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	\$ 2,560,219	\$ 505,147	\$ 505,147	\$	5,7,10 years	\$ 1,760,361	71
72	Current Year Purchases	59,148	4,172	4,172		5, 10 years	4,174	72
73	Fully Depreciated Assets							73
74	Allocated from Therapy Masters, Mgt Co:	73,133		1,036	1,036		70,776	74
75	TOTALS	\$ 2,692,500	\$ 509,319	\$ 510,355	\$ 1,036		\$ 1,835,311	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	Allocated from Management Company:			\$ 13,489	\$	\$ 1,765	\$ 1,765		\$ 7,786	76
77										77
78										78
79										79
80	TOTALS			\$ 13,489	\$	\$ 1,765	\$ 1,765		\$ 7,786	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)	\$ 14,586,269	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 855,579	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 862,276	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,697	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,047,703	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

**

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

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

N/A
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: \$ 25,130 Description: Copier\$17,213,Icemaker\$1,200,Postge\$1,643,DishMachine\$1,209,Crane\$2,000,WaterCooler\$66,MgtCo:\$1,79

(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>2,092</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,092</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. _____/2012 \$ _____

13. _____/2013 \$ _____

14. _____/2014 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to hire only certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$	7,920	\$ 449,530	\$ 271	7,920	\$ 449,801	1
2	Licensed Speech and Language Development Therapist	Ln10a, Col 3	hrs		3,417	191,181		3,417	191,181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		15,389	876,352	974	15,389	877,326	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescripts				693,410		693,410	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology and Laboratory Other (specify): <u>Respiratory Therapy</u>	Ln 39, Col 3 Ln10a,Col 1&3	5,933 hours	88,278		71,452 4,970		5,933	71,452 93,248	13
14	TOTAL			\$ 88,278	26,726	\$ 1,593,485	\$ 694,655	32,659	\$ 2,376,418	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 and Rehabilitation Centre, Inc # 50112** Report Period Beginning: **1/01/2011** Ending: **12/31/2011**
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2011** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (363,570)	\$ 107,194	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>228,968</u>)	3,371,507	3,371,507	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,016	100,016	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(23,675)		8
9	Other(specify): <u>Other Receivables</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,084,278	\$ 3,578,717	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,379,964	13
14	Buildings, at Historical Cost		9,335,457	14
15	Leasehold Improvements, at Historical Cost	164,859	164,859	15
16	Equipment, at Historical Cost	117,752	2,705,989	16
17	Accumulated Depreciation (book methods)	(41,034)	(3,047,703)	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)	\$ 241,577	\$ 11,538,566	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,325,855	\$ 15,117,283	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 473,370	\$ 473,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,599	85,599	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	408,659	408,659	30
31	Accrued Taxes Payable (excluding real estate taxes)	536	536	31
32	Accrued Real Estate Taxes(Sch.IX-B)		156,000	32
33	Accrued Interest Payable		88,979	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule E:</u>	471,981	471,981	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,440,145	\$ 1,685,124	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,526,806	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Stockholders:</u>	4,565,000	4,565,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,565,000	\$ 19,091,806	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,005,145	\$ 20,557,613	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,679,290)	\$ (5,440,330)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,325,855	\$ 15,117,283	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (612,883)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (612,883)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,066,407)	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)	\$ (2,066,407)	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)	\$ (2,679,290)	24

* Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 11,182,582	1
2	Discounts and Allowances for all Levels	(5,583,930)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,598,652	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,727,508	6
7	Oxygen	47,085	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,774,593	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	267	12
13	Barber and Beauty Care	2,922	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	568	15
16	Rental of Facility Space		16
17	Sale of Drugs	829,471	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	147,140	19
20	Radiology and X-Ray	30,054	20
21	Other Medical Services	706,273	21
22	Laundry	570	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,717,265	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,626	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,626	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)	\$ 11,105,136	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,869,818	31
32	Health Care	6,095,954	32
33	General Administration	2,343,623	33
B. Capital Expense			
34	Ownership	1,696,537	34
C. Ancillary Expense			
35	Special Cost Centers	1,034,199	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)*	\$ 13,171,543	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,066,407)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,066,407)	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 and Rehabilitation Centre, Inc** # **50112**

Report Period Beginning: **1/01/2011**

Ending: **12/31/2011**

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	1,869	2,086	\$ 97,500	\$ 46.74	1
2	Assistant Director of Nursing	1,997	2,243	78,101	34.82	2
3	Registered Nurses	37,929	41,437	1,238,456	29.89	3
4	Licensed Practical Nurses	28,905	30,427	629,032	20.67	4
5	CNAs & Orderlies	110,093	120,927	1,515,547	12.53	5
6	CNA Trainees					6
7	Licensed Therapist	5,322	5,933	88,278	14.88	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,013	2,086	42,230	20.24	9
10	Activity Assistants	7,028	7,543	100,173	13.28	10
11	Social Service Workers	3,617	3,800	73,336	19.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,683	7,628	121,942	15.99	14
15	Cook Helpers/Assistants	22,533	24,936	282,281	11.32	15
16	Dishwashers					16
17	Maintenance Workers	3,779	4,363	105,006	24.07	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,768	1,840	88,928	48.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,484	15,215	349,385	22.96	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	3,921	4,187	113,647	27.14	31
32	Other Health C: Dialysis Tech/Sprv	5,575	6,222	139,081	22.35	32
33	Other(specify) <u>Ward Clerks</u>	1,867	2,076	25,614	12.34	33
34	TOTAL (lines 1 - 33)	258,383	282,949	\$ 5,088,537 *	\$ 17.98	34

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	\$ 1,625	Ln 1, Col 3	35
36	Medical Director	Monthly	42,500	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	Ln10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,200	Ln11, Col 3	44
45	Social Service Consultant	51	2,958	Ln12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	75	\$ 50,083		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

* This total must agree with page 4, column 1, line 45.

** 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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 and Rehabilitation Centre, Inc.# 50112Report Period Beginning: 1/01/2011Ending: 12/31/2011**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 \$17,550
- (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? 5, 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,218 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. \$ 29,927 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
12/31/2011

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

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	39,247	37,312	35,210	15,036	30,168	32,114	189,087
Jonathan Glenner	10,225	9,721	9,173	3,917	7,860	8,367	49,263
Daniel Glenner	5,652	5,373	5,071	2,165	4,345	4,625	27,231
Elliot Glenner	4,936	4,692	4,428	1,891	3,794	4,039	23,780
David Weinschneider	10,172	9,671	9,126	3,897	7,819	8,324	49,009
Joshua Ray	39,247	37,312	35,210	15,036	30,168	32,114	189,087
Total compensation received from other Nursing Homes	109,479	104,081	98,218	41,942	84,154	89,583	527,457

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	6,168
Point ClickCare	Computers	43,005
EHealth Data Solutions	Computer Services	4,470
RSM McGladrey	Accounting	39,716
Frost, Ruttenberg & Rothblatt	Accounting	375
Much Shelist	Legal	3,416
Prospect Resources Inc	Maintenance Consulting	1,500
Personnel Planners, Inc.	Unemployment Consulting	1,311
Total Schedule V, Line 19, Col. 3		<u>99,961</u>
Allocated from Management Co:		
Point ClickCare - Computer Services		2,679
Health Data Systems, Inc. - Computer Services		389
Clinical Reimbursement Solutions - Accounting		513
RSM McGladrey - Accounting Services		12,208
Harold Geiser - Accounting		756
Frost, Ruttenberg & Rothblatt - Accounting Services		853
Much Shelist - Legal Services		78
Total allocated from Management Co.		<u>17,476</u>
Total allocated from Brentwood Healthcare Real Estate LLC:		<u>0</u>
Total allocated from Therapy Masters:		7,417
Non-Allowable Expenses:		
RSM McGladrey - Accounting Fees		<u>-39,397</u>
Total Non-Allowable Expenses:		<u>-39,397</u>
Total adjustments page 21, Sch C.		<u><u>-14,504</u></u>
Total Schedule V, line 19, column 8		<u><u>85,457</u></u>

See Accountants' Compilation Report

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
 Page 21

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Allocated from Management Co:	
FICA taxes	16,391
FUTA	199
SUTA	541
401K Match	1,196
Insurance - Hospital	15,588
Employee Benefits	1,734
Other Employee Benefits	293
Workers Compensation Insurance	448
	<u>36,390</u>
Total allocated from Management Co.	<u>36,390</u>
Employee Benefits reclassified to Lines 7, 27	-36,390
Allocated from Therapy Masters, Inc.:	
FICA taxes	84,756
FUTA	1,163
SUTA	1,686
401K Match	8,431
Insurance - Hospital	32,069
Workers Compensation Insurance	2,687
Other Employee Benefits	351
Uniform Allowance	0
	<u>131,143</u>
Total allocated from Therapy Masters, Inc. Co.	<u>131,143</u>
Employee Benefits reclassified to Lines 15,27	-131,143
Total allocated to Page 21	<u>0</u>

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2011

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Due to Third Party	158,557
Accrued 401K	2,179
Accrued Profit Sharing	197
Accrued Management Fees	288,972
Accrued Wage Assignment	(1,288)
Due Con Mutual	(371)
Refunds Exchange	23,735
Total, Page 17, Line36	<u><u>471,981</u></u>

See Accountants' Compilation Report

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2011

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

<u>DESCRIPTION</u>	<u>AMOUNT</u>	<u>REFERENCE</u>
Patient clothing	-137	43
Non-allowable owner interest expense	-89,798	32
Non-allowable owner interest expense	-1,077,223	32
Non-allowable professional fees	-39,397	19
Non-allowable office expense	-41	43
Non-allowable miscellaneous expense	-28,382	21
Non-allowable auto expense - marketing	-8,348	25
Non-allowable Illinois Council on Long Term Care Dues	-5,778	20
Adjust mgt co. med supplies - med'A' to cost	-42,111	10
Adjust mgt co. med supplies - med'other' to cost	-22,257	10
Adjust mgt co. food to cost	-31,250	2
Total	<u>-1,344,722</u>	

See Accountants' Compilation Report

**Brentwood Healthcare Real Estate LLC.
Accrued Real Estate Taxes
12/31/2011**

SCHEDULE G

	Accrued 1/01/11	Payments	Expense	Accrued 12/31/11
Balance @ 1/01/2011:	<u>(148,000.00)</u>		<u>(148,000.00)</u>	
2010 real estate taxes paid		149,731.48	149,731.48	
Estimated 2011 real estate taxes:				
2010 taxes	149,731.48			
Estimated increase	4.00 %			
Estimated 2011 taxes	<u>155,720.74</u>			
	USE		156,000.00	(156,000.00)
	<u>156,000.00</u>			
Totals	<u>(148,000.00)</u>	149,731.48	157,731.48	<u>(156,000.00)</u>

Real estate tax history:

Year	Amount	Increase	
		\$	%
2007	132,370.06		
2008	139,365.64	6,995.58	5.28%
2009	144,214.31	4,848.67	3.48%
2010	149,731.48	5,517.17	3.83%

SEE ACCOUNTANTS' COMPILATION REPORT

Provider Name: Brentwood North Healthcare & Rehabilitation Center

Provider I.D. #: 50112

Year Ended: December 31, 2011

SCHEDULE H

Training & Education

Person(s) Attending	Date Attended	Location	Title Sponsor	Total Cost
Tish Evangelista, Raoul Zamora Lynn Bruch, Judith Mott	2/11/2011	Barrington, IL	Advocate Good Shepherd Hospital A Matter of Balance Facilitator Training	180
Carl Kellick, Lisa Orzada	3/16/2011	Des Plaines, IL	Collaborative Healthcare Urgency Group Evacuation & Service Training	400
Social Service & Nursing Staff	9/15/2011	Riverwoods, IL	Social Work PRN/Stanley McCracken Alzheimer's Disease Definition, Diagnosis, Progression, Screening & Treatment	700
Lisa Orzada	6/2/2011	Grayslake, IL	LC Pioneer Coalition 2011 Lake County Pioneer Coalition Annual Seminar	50
Lisa Orzada	7/6/2011	Skokie, IL	Illinois Council on Long Term Care The New Medicaid Integrated Care Program	105
Lisa Orzada, Carl Kellick	7/7/2011	Skokie, IL	Illinois Council on Long Term Care The Most Frequent Life Safety Code Violations	210
Lisa Orzada	1/18/2012	Skokie, IL	Illinois Council on Long Term Care No Contact, No Drug Behavior Escalation	105
			Allocated From Management Company	471
			Allocated From Therapy Masters	4,617
			Total	6,838

SEE ACCOUNTANTS' COMPILATION REPORT

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2011

SCHEDULE I

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

	Gasoline Allowance	Employee Reimbursement: Mileage, Tolls, Parking	Total
Direct Expense	10,038	5,894	15,931
Non-allowable auto expense - marketing			-8,348
Allocated from Management Company			1,912
Allocated from Therapy Masters			1,784
TOTAL	<u>10,038</u>	<u>5,894</u>	<u>11,279</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	23,328
Village of Riverwoods Elevator Inspection	120
Village of Riverwoods Permit Fee	200
Lake County Health Department Annual Food Service Permit Fee	426
Joint Commission Annual Certification, Program Fee	2,275
State Fire Marshall Boiler Inspection	910
Secretary of State Annual Report Fee	125
Employee Reimbursement - License Fee	103
Employment Fees	6,500
Non-allowable Illinois Council on Long Term Care Dues	-5,778
Total allocated to Page 21	<u>28,209</u>

See Accountants' Compilation Report

HEALTH AND HOME MANAGEMENT, INC.
ALLOCATION OF MANAGEMENT COMPANY LEASEHOLD IMPROVEMENTS

SCHEDULE L

ASSET DESCRIPTION	COST	CAPITAL FROM FARGO @ 84.9438 %	ADJUSTED LEASEHOLD IMPROVEMENTS	COST	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					
1998 PARKING LOT REPAVING	5,900	6,647	6,647	6,647										
LEASEHOLD IMPROVEMENTS - ADDITIONAL CONSTRUCTION COSTS FARGO BUILDING	87,339		87,339	87,339										
				<u>99,886</u>	22,363	24,168	22,112	8,945	22,298					
1999 LEASEHOLD IMPROVEMENTS - ADDITIONAL CONSTRUCTION COSTS FARGO BUILDING	41,710		41,710	41,710										
				<u>141,596</u>	31,701	34,260	31,345	12,680	31,609					
2000 AQUATIC WORKS - BUILT IN FISH TAN	5,000		5,000	5,000										
				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
2001 NO ADDITIONS				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
2002 NO ADDITIONS				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
2003 NO ADDITIONS				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
2004 NO ADDITIONS				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
2005 NO ADDITIONS				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
2006 NO ADDITIONS				<u>146,596</u>	32,820	35,470	32,452	13,128	32,725					
RECALCULATION BASED ON 2007 CENSUS - New facility added in 2007 (GlenLake Terrace Nursing Ctr)														
					<u>GLENBRIDGE</u>	<u>GLENCREST</u>	<u>GLEN OAKS</u>	<u>GLEN ELSTON</u>	<u>GLENSHIRE</u>	<u>GLENLAKE</u>	<u>BRENTWOOD</u>	<u>TOTAL</u>		
					93,767	95,262	106,511	40,267	78,093	74,334		488,234		
					0.192053401	0.195115457	0.218155638	0.082474797	0.159949942	0.152250765		100.00%		
2007 NO ADDITIONS				<u>146,596</u>	<u>28,154</u>	<u>28,603</u>	<u>31,981</u>	<u>12,090</u>	<u>23,448</u>	<u>22,319</u>		<u>146,596</u>		
RECALCULATION BASED ON 2008 CENSUS - New facility added in 2008 (Brentwood partial year 9/1/08-12/31/08)														
					<u>GLENBRIDGE</u>	<u>GLENCREST</u>	<u>GLEN OAKS</u>	<u>GLEN ELSTON</u>	<u>GLENSHIRE</u>	<u>GLENLAKE</u>	<u>BRENTWOOD</u>	<u>TOTAL</u>		
					93,929	92,291	105,965	37,609	81,480	76,498	15,564	503,336		
					18.66%	18.34%	21.05%	7.47%	16.19%	15.20%	3.09%	100.00%		
2008 INSTALLATION OF IRRIGATION SYSTEM	15,036			15,036										
				<u>161,632</u>	<u>30,163</u>	<u>29,637</u>	<u>34,028</u>	<u>12,077</u>	<u>26,165</u>	<u>24,565</u>	<u>4,998</u>	<u>161,632</u>		
RECALCULATION BASED ON 2009 CENSUS - New facility added in 2008 (Brentwood) is now allocated over full year in 2009														
					<u>GLENBRIDGE</u>	<u>GLENCREST</u>	<u>GLEN OAKS</u>	<u>GLEN ELSTON</u>	<u>GLENSHIRE</u>	<u>GLENLAKE</u>	<u>BRENTWOOD</u>	<u>TOTAL</u>		
					92,668	90,627	105,904	37,909	82,060	82,504	49,247	540,919		
					17.13%	16.75%	19.58%	7.01%	15.17%	15.25%	9.10%	100.00%		
2009 NO ADDITIONS				<u>161,632</u>	<u>27,690</u>	<u>27,080</u>	<u>31,645</u>	<u>11,328</u>	<u>24,520</u>	<u>24,653</u>	<u>14,715</u>	<u>161,632</u>		
RECALCULATION BASED ON 2009 CENSUS														
					<u>GLENBRIDGE</u>	<u>GLENCREST</u>	<u>GLEN OAKS</u>	<u>GLEN ELSTON</u>	<u>GLENSHIRE</u>	<u>GLENLAKE</u>	<u>BRENTWOOD</u>	<u>TOTAL</u>		
					92,668	90,627	105,904	37,909	82,060	82,504	49,247	540,919		
					17.13%	16.75%	19.58%	7.01%	15.17%	15.25%	9.10%	100.00%		
2010 NO ADDITIONS				<u>161,632</u>	<u>27,690</u>	<u>27,080</u>	<u>31,645</u>	<u>11,328</u>	<u>24,520</u>	<u>24,653</u>	<u>14,715</u>	<u>161,632</u>		
					27,464	26,860	31,387	11,235	24,320	24,452	14,596	160,314		
					-226	-220	-258	-93	-200	-201	-119	-1,318		
					Amounts as reported on cost report:									
					Differences due to error in formula:									
					(Total allocated over 99.18 % not 100.00 %)									
RECALCULATION BASED ON 2009 CENSUS														
					<u>GLENBRIDGE</u>	<u>GLENCREST</u>	<u>GLEN OAKS</u>	<u>GLEN ELSTON</u>	<u>GLENSHIRE</u>	<u>GLENLAKE</u>	<u>BRENTWOOD</u>	<u>TOTAL</u>		
					92,668	90,627	105,904	37,909	82,060	82,504	49,247	540,919		
					17.13%	16.75%	19.58%	7.01%	15.17%	15.25%	9.10%	100.00%		
2011 NO ADDITIONS				<u>161,632</u>	<u>27,690</u>	<u>27,080</u>	<u>31,645</u>	<u>11,328</u>	<u>24,520</u>	<u>24,653</u>	<u>14,715</u>	<u>161,632</u>		

SEE ACCOUNTANTS' COMPILATION REPORT