

		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>0035014</u></p> <p>Facility Name: <u>GlenBridge Nursing and Rehabilitation Centre, Ltd.</u></p> <p>Address: <u>8333 West Golf Road</u> <u>Niles</u> <u>60714</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 966-9190</u> Fax # <u>(847) 966-4455</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/01/1989</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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 GlenBridge Nursing and Rehabilitation Centre, Ltd.

0035014 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	151	Skilled (SNF)	151	55,115	1
2		Skilled Pediatric (SNF/PED)			2
3	151	Intermediate (ICF)	151	55,115	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	302	TOTALS	302	110,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	20,600	503	9,628	30,731	8
9	SNF/PED					9
10	ICF	61,059	1,432	605	63,096	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	81,659	1,935	10,233	93,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.12%

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 3/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/01/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 140 and days of care provided 8,641

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: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centr # 0035014 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	487,295	81,335	52,562	621,192		621,192		621,192		1
2	Food Purchase		709,264		709,264	(31,128)	678,136	(74,576)	603,560		2
3	Housekeeping	292,366	49,899		342,265		342,265		342,265		3
4	Laundry	136,486	15,780	10,144	162,410		162,410		162,410		4
5	Heat and Other Utilities			299,415	299,415		299,415	7,707	307,122		5
6	Maintenance	97,515	28,890	89,292	215,697		215,697	8,018	223,715		6
7	Other (specify):* Allocated Employee Benefits							497	497		7
8	TOTAL General Services	1,013,662	885,168	451,413	2,350,243	(31,128)	2,319,115	(58,354)	2,260,761		8
	B. Health Care and Programs										
9	Medical Director			145,200	145,200		145,200		145,200		9
10	Nursing and Medical Records	4,425,865	993,444	283,410	5,702,719		5,702,719	(299,625)	5,403,094		10
10a	Therapy	430,841	3,142	1,782,944	2,216,927		2,216,927	(349,748)	1,867,179		10a
11	Activities	185,544	5,045	2,400	192,989		192,989		192,989		11
12	Social Services	225,698		9,058	234,756		234,756		234,756		12
13	CNA Training										13
14	Program Transportation			4,995	4,995		4,995		4,995		14
15	Other (specify):* Allocated Employee Benefits							150,052	150,052		15
16	TOTAL Health Care and Programs	5,267,948	1,001,631	2,228,007	8,497,586		8,497,586	(499,321)	7,998,265		16
	C. General Administration										
17	Administrative	168,779		1,977,783	2,146,562		2,146,562	(1,942,573)	203,989		17
18	Directors Fees										18
19	Professional Services			181,283	181,283	(59,990)	121,293	8,229	129,522		19
20	Dues, Fees, Subscriptions & Promotions			82,224	82,224	3,420	85,644	2,721	88,365		20
21	Clerical & General Office Expenses	305,728	55,604	106,305	467,637	(3,420)	464,217	533,740	997,957		21
22	Employee Benefits & Payroll Taxes			1,090,596	1,090,596	31,128	1,121,724		1,121,724		22
23	Inservice Training & Education			2,404	2,404		2,404	6,448	8,852		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			12,570	12,570	(1,900)	10,670	5,398	16,068		25
26	Insurance-Prop.Liab.Malpractice			495,473	495,473		495,473	3,845	499,318		26
27	Other (specify):* Allocated Employee Benefits							79,675	79,675		27
28	TOTAL General Administration	474,507	55,604	3,948,638	4,478,749	(30,762)	4,447,987	(1,302,517)	3,145,470		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,756,117	1,942,403	6,628,058	15,326,578	(61,890)	15,264,688	(1,860,192)	13,404,496		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

GlenBridge Nursing and Rehabilitation Centre, Ltd.

#0035014

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			231,180	231,180		231,180	207,630	438,810			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,350	24,350		24,350	1,062,081	1,086,431			32
33	Real Estate Taxes					59,990	59,990	681,278	741,268			33
34	Rent-Facility & Grounds			2,873,242	2,873,242		2,873,242	(2,873,242)				34
35	Rent-Equipment & Vehicles			20,842	20,842	1,900	22,742	8,440	31,182			35
36	Other (specify):* Mortgage Insurance							91,999	91,999			36
37	TOTAL Ownership			3,149,614	3,149,614	61,890	3,211,504	(821,814)	2,389,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		532,258	205,602	737,860		737,860		737,860			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,348	165,348		165,348		165,348			42
43	Other (specify):* Non-Allowable			351,362	351,362		351,362	(351,362)				43
44	TOTAL Special Cost Centers		532,258	722,312	1,254,570		1,254,570	(351,362)	903,208			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,756,117	2,474,661	10,499,984	19,730,762		19,730,762	(3,033,368)	16,697,394			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	(19,196)	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	(7,797)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,266)	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	(4,800)	43		18
19	Entertainment				19
20	Contributions	(1,600)	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	(315,926)	43		24
25	Fund Raising, Advertising and Promotional	(27,770)	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 <u>See Attached Schedule F:</u>	(845,458)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,223,813)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,809,555)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,809,555)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,033,368)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

GlenBridge Nursing and Rehabilitation Centre, Ltd.

ID# 0035014

Report Period Beginning: 1/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjust Mgt Co. med supplies - "other" to cost	\$ (202,044)	10	1
2	Adjust Mgt Co. med supplies - med"A" to cost	(97,581)	10	2
3	Adjust Mgt Co. food to cost	(74,638)	2	3
4	Non-allowable professional fees	(97,698)	19	4
5	Non-allowable auto expense - marketing	(845)	25	5
6	Non-allowable bank charges	(15)	43	6
7	Non-allowable IL Council on Long Term Care Fee	(7,420)	20	7
8	Non-allowable related party interest expense	(24,350)	32	8
9	Non-allowable clerical expense	(270)	43	9
10	Non-allowable loss on early extinguishment of debt	(340,597)	43	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
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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	(845,458)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

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	(74,638)	0	0	0	0	62	0	0	0	0	0	(74,576)	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	7,707	0	0	0	0	0	0	0	0	7,707	5
6	Maintenance	0	0	8,018	0	0	0	0	0	0	0	0	8,018	6
7	Other (specify):*	0	0	497	0	0	0	0	0	0	0	0	497	7
8	TOTAL General Services	(74,638)	0	16,222	0	0	62	0	0	0	0	0	(58,354)	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	(299,625)	0	0	0	0	0	0	0	0	0	0	(299,625)	10
10a	Therapy	0	0	0	0	0	(349,748)	0	0	0	0	0	(349,748)	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	0	150,052	0	0	0	0	0	150,052	15
16	TOTAL Health Care and Programs	(299,625)	0	0	0	0	(199,696)	0	0	0	0	0	(499,321)	16
	C. General Administration													
17	Administrative	0	0	(1,128,808)	(813,765)	0	0	0	0	0	0	0	(1,942,573)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(97,698)	0	37,905	0	59,305	8,717	0	0	0	0	0	8,229	19
20	Fees, Subscriptions & Promotions	(7,420)	0	4,997	0	0	5,144	0	0	0	0	0	2,721	20
21	Clerical & General Office Expenses	(19,196)	0	537,565	0	0	15,371	0	0	0	0	0	533,740	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	1,022	0	0	5,426	0	0	0	0	0	6,448	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(845)	0	4,147	0	0	2,096	0	0	0	0	0	5,398	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,845	0	0	0	0	0	0	0	0	3,845	26
27	Other (specify):*	0	0	78,434	0	0	1,241	0	0	0	0	0	79,675	27
28	TOTAL General Administration	(125,159)	0	(460,893)	(813,765)	59,305	37,995	0	0	0	0	0	(1,302,517)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(499,422)	0	(444,671)	(813,765)	59,305	(161,639)	0	0	0	0	0	(1,860,192)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

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	13,592	0	193,533	505	0	0	0	0	0	207,630 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(32,147)	0	0	0	1,094,228	0	0	0	0	0	0	1,062,081 32
33	Real Estate Taxes	0	0	12,636	0	668,642	0	0	0	0	0	0	681,278 33
34	Rent-Facility & Grounds	0	0	0	0	(2,873,242)	0	0	0	0	0	0	(2,873,242) 34
35	Rent-Equipment & Vehicles	0	0	8,440	0	0	0	0	0	0	0	0	8,440 35
36	Other (specify):*	0	0	0	0	91,999	0	0	0	0	0	0	91,999 36
37	TOTAL Ownership	(32,147)	0	34,668	0	(824,840)	505	0	0	0	0	0	(821,814) 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):*	(692,244)	0	0	0	340,882	0	0	0	0	0	0	(351,362) 43
44	TOTAL Special Cost Centers	(692,244)	0	0	0	340,882	0	0	0	0	0	0	(351,362) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,223,813)	0	(410,003)	(813,765)	(424,653)	(161,134)	0	0	0	0	0	(3,033,368) 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
<u>Sidney Glenner</u>	<u>100.00 %</u>	<u>See Page 6 - Supplemental</u>		<u>See Attached Schedule A</u>		

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		
	V		\$			\$		1
	V	<u>Total from Page 6A</u>	<u>1,164,018</u>	<u>Glen Health and Home Management, Inc.</u>	<u>A</u>	<u>754,015</u>	<u>(410,003)</u>	2
	V							3
	V	<u>Total from Page 6B</u>	<u>813,765</u>	<u>GlenBar Management Company, Ltd.</u>	<u>B</u>		<u>(813,765)</u>	4
	V							5
	V	<u>Total from Page 6C</u>	<u>2,873,242</u>	<u>GlenBridge Real Estate and Development, L.L.C.</u>	<u>C</u>	<u>2,448,589</u>	<u>(424,653)</u>	6
	V							7
	V	<u>Total from Page 6D</u>	<u>1,782,944</u>	<u>Therapy Masters, Inc.</u>	<u>D</u>	<u>1,621,810</u>	<u>(161,134)</u>	8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$ <u>6,633,969</u>			\$ <u>4,824,414</u>	\$ * <u>(1,809,555)</u>	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014Report Period Beginning: 1/01/2011Ending: 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	17 Management Fees	\$ 1,164,018	Glen Health and Home Management, Inc.	A	\$		\$ (1,164,018)	15
16	V	5 Utilities		Glen Health and Home Management, Inc.	A		7,707	7,707	16
17	V	6 Repairs and Maintenance		Glen Health and Home Management, Inc.	A		4,585	4,585	17
18	V	19 Professional Fees		Glen Health and Home Management, Inc.	A		37,905	37,905	18
19	V	20 Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A		4,997	4,997	19
20	V	21 Clerical		Glen Health and Home Management, Inc.	A		33,498	33,498	20
21	V	22 Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A		78,931	78,931	21
22	V	23 Training and Education		Glen Health and Home Management, Inc.	A		1,022	1,022	22
23	V	25 Auto Expenses		Glen Health and Home Management, Inc.	A		4,147	4,147	23
24	V	26 Insurance		Glen Health and Home Management, Inc.	A		3,845	3,845	24
25	V	30 Depreciation		Glen Health and Home Management, Inc.	A		13,592	13,592	25
26	V	33 Real Estate Taxes		Glen Health and Home Management, Inc.	A		12,636	12,636	26
27	V	35 Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A		8,440	8,440	27
28	V	6 Janitorial Salaries		Glen Health and Home Management, Inc.	A		3,433	3,433	28
29	V	17 Officer's Salaries		Glen Health and Home Management, Inc.	A		35,210	35,210	29
30	V	21 Administrative Salaries		Glen Health and Home Management, Inc.	A		504,067	504,067	30
31	V	22 Employee Benefits		Glen Health and Home Management, Inc.	A		(78,931)	(78,931)	31
32	V	7 Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A		497	497	32
33	V	27 Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A		5,123	5,123	33
34	V	27 Employee Benefits - Admin		Glen Health and Home Management, Inc.	A		73,311	73,311	34
35	V								35
36	V								36
37	V								37
38	V			A - OWNERSHIP: Sidney Glenner - 100 % through attribution					38
39	Total		\$ 1,164,018			\$	754,015	\$ * (410,003)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	\$ 813,765	GlenBar Management Company, Ltd.	B	\$	\$ (813,765)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V				B - OWNERSHIP: 100.00 % Sidney Glenner				34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 813,765			\$ 0	\$ *	(813,765) 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	10a Therapy	\$ 1,782,944	Therapy Masters, Inc.	D	\$ 1,433,196	\$	(349,748)	15
16	V	19 Professional Fees		Therapy Masters, Inc.	D	8,717		8,717	16
17	V	20 Licenses, Permits and Inspection		Therapy Masters, Inc.	D	243		243	17
18	V	20 Dues and Subscriptions		Therapy Masters, Inc.	D	210		210	18
19	V	21 Clerical		Therapy Masters, Inc.	D	3,330		3,330	19
20	V	22 Employee Benefits and Payroll		Therapy Masters, Inc.	D	151,293		151,293	20
21	V	23 Training and Education		Therapy Masters, Inc.	D	5,426		5,426	21
22	V	25 Auto Expenses		Therapy Masters, Inc.	D	2,096		2,096	22
23	V	20 Employment Fees		Therapy Masters, Inc.	D	4,691		4,691	23
24	V	21 Clerical Salaries		Therapy Masters, Inc.	D	12,041		12,041	24
25	V	22 Employee Benefits		Therapy Masters, Inc.	D	(151,293)		(151,293)	25
26	V	15 Employee Benefits - Therapy		Therapy Masters, Inc.	D	150,052		150,052	26
27	V	27 Employee Benefits - Clerical		Therapy Masters, Inc.	D	1,241		1,241	27
28	V	30 Depreciation		Therapy Masters, Inc.	D	505		505	28
29	V	2 Food Purchase		Therapy Masters, Inc.	D	62		62	29
30	V								30
31	V								31
32	V								32
33	V			D - OWNERSHIP: 100.00 % Sidney Glenner					33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,782,944			\$ 1,621,810	\$ *	(161,134)	39

* 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 %	GlenCrest Nursing & Rehabilitation	Chicago	See Attached Schedule A			2
3			Centre, Ltd.					3
4								4
5	Sidney Glenner	100.00 %	Glen Elston Nursing & Rehabilitation	Chicago				5
6			Centre, Ltd.					6
7								7
8	Sidney Glenner	100.00 %	Glen Oaks Nursing & Rehabilitation	Northbrook				8
9			Centre, Ltd,					9
10								10
11	Sidney Glenner	100.00 %	GlenShire Nursing & Rehabilitation	Richton Park				11
12			Centre, Ltd.					12
13								13
14	Sidney Glenner	80.00 %	GlenLake Terrace Nursing & Rehabilitation	Waukegan				14
15	Joshua Ray	20.00 %	Centre, Ltd,					15
16								16
17	Sidney Glenner	70.00 %	Brentwood North Healthcare & Rehabilitation	Riverwoods				17
18	Joshua Ray	30.00 %	Centre, Inc.					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 GlenBridge Nursing and Rehabilitation Cent # 0035014 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	100.00 %	170,110	10	16.62 %	Salary	\$ 35,210	Ln 17, Co 7	1
2	Jonathan Glenner	Clerical	Clerical	0.00 %	44,319	7	16.62 %	Salary	9,173	Ln 21, Co 7	2
3	Daniel Glenner	Administrative	Administrative	0.00 %	24,498	7	16.62 %	Salary	5,071	Ln 21, Co 7	3
4	Elliot Glenner	Administrative	Administrative	0.00 %	21,392	7	16.62 %	Salary	4,428	Ln 21, Co 7	4
5	David Weinschneider	Administrative	Administrative	0.00 %	44,091	7	16.62 %	Salary	9,126	Ln 21, Co 7	5
6	Joshua Ray	V.P. of Operations	Administrative	0.00 %	170,110	10	16.62 %	Salary	35,210	Ln 21, Co 7	6
7											7
8											8
9											9
10			See Schedule B								10
11											11
12											12
13								TOTAL	\$ 98,218		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 GlenBridge Nursing and Rehabilitation Centre, Ltd. # 0035014 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 and 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	\$ 93,827	\$ 7,707	1
2	6	Repairs and Maintenance	Resident Days	547,138	7	26,739	93,827	4,585	2
3	19	Professional Fees	Resident Days	547,138	7	221,035	93,827	37,905	3
4	20	Licenses, Permits and Inspection	Resident Days	547,138	7	29,141	93,827	4,997	4
5	21	Clerical	Resident Days	547,138	7	195,341	93,827	33,498	5
6	22	Employee Benefits and Payroll	Resident Days	547,138	7	460,274	93,827	78,931	6
7	23	Training and Education	Resident Days	547,138	7	5,959	93,827	1,022	7
8	25	Auto Expenses	Resident Days	547,138	7	24,184	93,827	4,147	8
9	26	Insurance	Resident Days	547,138	7	22,424	93,827	3,845	9
10	30	Depreciation	Resident Days	547,138	7	79,259	93,827	13,592	10
11	33	Real Estate Taxes	Resident Days	547,138	7	73,683	93,827	12,636	11
12	35	Equipment and Vehicle Rental	Resident Days	547,138	7	49,215	93,827	8,440	12
13	6	Janitorial Salaries	Resident Days	547,138	7	20,018	20,018	3,433	13
14	17	Officer's Salaries	Resident Days	547,138	7	205,320	205,320	35,210	14
15	21	Administrative Salaries	Resident Days	547,138	7	2,939,391	2,939,391	504,067	15
16	22	Employee Benefits	Payroll					(78,931)	16
17	7	Employee Benefits - Janitorial	Payroll					497	17
18	27	Employee Benefits - Officer's	Payroll					5,123	18
19	27	Employee Benefits - Admin	Payroll					73,311	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,396,926	\$ 3,164,729	\$ 754,015	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	Midland Loan Services		X	Mortgage	\$121,125.03	5/27/2008	\$ 20,631,900	\$	2/17/2011	0.0625	\$ 210,056	1
2	Midland Loan Services		X	Amortization of mortgage costs							1,358	2
3	Oppenheimer MHHF, Inc.		X	Mortgage	\$106,424.85	2/17/2011	20,432,100	20,237,255	6/01/2043	0.0500	881,354	3
4	Oppenheimer MHHF, Inc.		X	Amortization of mortgage costs							2,810	4
5												5
Working Capital												
6	Sidney Glenner	X									24,350	6
7							Non-allowable related party interest:				(24,350)	7
8												8
9	TOTAL Facility Related				\$227,549.88		\$ 41,064,000	\$ 20,237,255			\$ 1,095,578	9
B. Non-Facility Related*												
10									Interest Income Offset:		(9,147)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (9,147)	14
15	TOTALS (line 9+line14)						\$ 41,064,000	\$ 20,237,255			\$ 1,086,431	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 91,999 Line # 36

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

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

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.	\$	<u>573,000</u>		1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>608,642</u>		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	<u>35,642</u>		3
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>633,000</u>		4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	<u>59,990</u>		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. 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.	\$	<u>728,632</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	<u>535,626</u>	8	
		2007	<u>680,600</u>	9	
		2008	<u>692,818</u>	10	
		2009	<u>558,272</u>	11	
		2010	<u>608,642</u>	12	
<u>See Attached Schedule G For Calculation of 2011 Real Estate Tax Accrual.</u>					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GlenBridge Nursing and Rehabilitation Centre, Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035014

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>09-14-200-029-0000</u>	<u>8333 West Golf Road</u>	\$ <u>3,936.93</u>	\$ <u>3,936.93</u>
2. <u>09-14-200-032-0000</u>	<u>8333 West Golf Road</u>	\$ <u>604,705.56</u>	\$ <u>604,705.56</u>
3. <u>Allocated from Management Company:</u>		\$ <u>63,772.67</u>	\$ <u>12,636.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>672,415.16</u></u>	\$ <u><u>621,278.49</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 GlenBridge Nursing and Rehabilitation Centre, Ltd.

0035014

Report Period Beginning:

1/01/2011 Ending:

12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,058 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories Three

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>58,949</u>	<u>1989</u>	<u>\$ 263,180</u>	<u>1</u>
2	<u>Allocated from Management Company:</u>			<u>14,568</u>	<u>2</u>
3	TOTALS	58,949		\$ 277,748	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

Report Period Beginning:

1/01/2011

Ending:

12/31/2011**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	302		1989	1970	\$ 6,703,340	\$	35	\$ 191,524	\$ 191,524	\$ 4,341,211	4
5											5
6	Mgt Comp			1996	310,726			8,192	8,192		6
7	Allocation										7
8	Schedule J										8
	Improvement Type**										
9	Building Improvements		1989		66,436		35	1,898	1,898	43,023	9
10	Building Improvements		1990		7,195		35	206	206	4,666	10
11	Building Improvements		1990		3,885		35	111	111	2,406	11
12	Building Improvements		1990		35,167		10			35,167	12
13	Building Improvements		1991		8,342		10			8,342	13
14	Building Improvements		1991		12,621		10			12,621	14
15	Building Improvements		1992		78,993		10			78,993	15
16	Building Improvements		1993		5,350		10			5,350	16
17	Building Improvements		1993		109,105		10			109,105	17
18	Land Improvements		1993		45,615		15			45,615	18
19	Building Improvements		1993		53,394		10			53,394	19
20	Land Improvements		1993		10,717		15			10,717	20
21	Building Improvements		1995		29,767		10			29,767	21
22	Electrical wiring work to 2nd floor from basement		1996		23,000		10			23,000	22
23	Dialysis room construction		1996		7,439		10			7,439	23
24	Fireplace construction		1996		1,065		10			1,065	24
25	Mounted door alarm system and wiring		1996		2,505		10			2,505	25
26	PVC hand rail and wall bumper		1997		4,968		10			4,968	26
27	Window treatments		1997		2,226		10			2,226	27
28	Walls, cabinets and tub		1997		5,520		10			5,520	28
29	Cabinets, sink and lighting		1997		4,571		10			4,571	29
30	Walls, platform and ramp		1997		9,286		10			9,286	30
31	Window treatments		1997		2,394		10			2,394	31
32	Cabinets and cubicles		1997		9,631		10			9,631	32
33	Cabinets		1997		2,500		10			2,500	33
34	Base covers		1997		630		10			630	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

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

Report Period Beginning:

1/01/2011 Ending:

12/31/2011

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 <u>Doors</u>	1997	\$ 1,950	\$	10	\$	\$	\$ 1,950	37
38 <u>Sink</u>	1997	2,236		10			2,236	38
39 <u>Fire alarm equipment</u>	1997	1,975		10			1,975	39
40 <u>Walls and doors</u>	1997	2,480		10			2,480	40
41 <u>80 ton compressor</u>	1998	20,800		10			20,800	41
42 <u>Telephone system improvements</u>	1998	2,503		10			2,503	42
43 <u>Carpeting, window treatments, mini-blinds</u>	1998	20,703		10			20,703	43
44 <u>Handrail/bumper corner guard installation</u>	1998	4,200		10			4,200	44
45 <u>Cove base installation</u>	1998	2,508		10			2,508	45
46 <u>Handrail/bumper corner guard installation, accent rails</u>	1999	11,401		10			11,401	46
47 <u>Mini-blinds</u>	1999	3,963		10			3,963	47
48 <u>Carpeting, cove base installation</u>	1999	14,797		10			14,797	48
49 <u>Amtico, cove base installation</u>	1999	5,616		10			5,616	49
50 <u>Carpeting, cove base installation</u>	1999	1,634		10			1,634	50
51 <u>Wallpaper</u>	1999	10,900		10			10,900	51
52 <u>Handrail/bumper corner guard installation, accent rails</u>	1999	11,401		10			11,401	52
53 <u>Insurance claim: boiler</u>	1999	(19,000)		10			(19,000)	53
54 <u>Panel interior, interior mat installation</u>	1999	2,468		10			2,468	54
55 <u>Install alarms for ventilators</u>	1999	1,560		10			1,560	55
56 <u>Install handrails and bumper chair rails</u>	1999	4,600		10			4,600	56
57 <u>Carpeting</u>	1999	4,497		10			4,497	57
58 <u>Lighting improvements on the 5th floor</u>	1998	4,635		10			4,635	58
59 <u>Install new braille signs/slots</u>	1999	2,135		10			2,135	59
60 <u>Installation of mini-blinds</u>	1999	3,476		10			3,476	60
61 <u>Installation of handrails, bumpers, corner guards, chair rails</u>	1999	5,500		10			5,500	61
62 <u>Tube bundles for heat exchanger</u>	1999	3,382		10			3,382	62
63 <u>Install new tubes & door gaskets on boiler</u>	1999	7,400		10			7,400	63
64 <u>Install new motor, drain valve, drain hoses on washer</u>	1999	1,903		10			1,903	64
65 <u>Cove base installation, floor patches, vinyl tiles & powerbond</u>	1999	11,459		10			11,459	65
66 <u>Cove base installation</u>	2000	3,267		10			3,267	66
67 <u>Cove base installation</u>	2000	1,939		10			1,939	67
68 <u>Installation of fire dampers & exhaust fan</u>	2000	2,773		10			2,773	68
69								69
70 <u>TOTAL (lines 4 thru 69)</u>		\$ 7,717,449	\$		\$ 201,931	\$ 201,931	\$ 5,017,173	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

Report Period Beginning:

1/01/2011 Ending:

12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,717,449	\$		\$ 201,931	\$ 201,931	\$ 5,017,173	1
2	2000	2,630		10			2,630	2
3	2000	3,975		10			3,975	3
4	2000	2,560		10			2,560	4
5	2000	4,120		10			4,120	5
6	2000	14,517		10			14,517	6
7	1999	2,969		10			2,969	7
8	2000	10,025		10			10,025	8
9	2000	33,284		10			33,284	9
10	2000	1,642		10			1,642	10
11	2000	3,324		10			3,324	11
12	2000	2,705		10			2,705	12
13	2000	11,500		10			11,500	13
14	2000	12,218		10			12,218	14
15	2001	6,750	337	10	337		6,750	15
16	2001	3,200	160	10	160		3,200	16
17	2001	26,841	1,343	10	1,343		26,841	17
18	2001	68,526	3,432	10	3,432		68,526	18
19	2000	4,320		10			4,320	19
20	2001	8,147	414	10	414		8,147	20
21	2001	24,145	1,212	10	1,212		24,145	21
22	2001	6,115	301	10	301		6,115	22
23	2001	3,006	156	10	156		3,006	23
24	2002	3,569	357	10	357		3,391	24
25	2002	3,616	362	10	362		3,439	25
26	2002	12,000	1,200	10	1,200		11,400	26
27	2002	5,467	547	10	547		5,196	27
28	2002	8,006	801	10	801		7,609	28
29	2003	10,846	1,085	10	1,085		9,222	29
30	2003	2,450	245	10	245		2,082	30
31	2003	3,962	396	10	396		3,366	31
32	2004	2,960	296	10	296		2,220	32
33								33
34		\$ 8,026,844	\$ 12,644		\$ 214,575	\$ 201,931	\$ 5,321,617	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

Report Period Beginning:

1/01/2011 Ending:

12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,026,844	\$ 12,644		\$ 214,575	\$ 201,931	\$ 5,321,617	1
2	2004	2,004	200	10	200		1,500	2
3	2004	2,339	234	10	234		1,755	3
4	2003	2,200	220	10	220		1,870	4
5	2005	5,565	557	10	557		3,620	5
6	2005	(15,497)	(1,550)	10	(1,550)		(10,075)	6
7	2005	7,803	780	10	780		5,070	7
8	2005	13,115	1,312	10	1,312		8,528	8
9	2005	1,983	198	10	198		1,287	9
10	2005	1,726	173	10	173		1,124	10
11	2005	1,594	159	10	159		1,034	11
12	2005	11,091	1,109	10	1,109		7,209	12
13	2005	21,100	2,110	10	2,110		13,715	13
14	2005	105,973	10,597	10	10,597		68,881	14
15	2005	17,729	1,773	10	1,773		11,524	15
16	2005	2,235	224	10	224		1,456	16
17	2005	1,393	139	10	139		904	17
18	2005	1,310	131	10	131		852	18
19	2006	3,175	318	10	318		1,749	19
20	2006	2,033	203	10	203		1,117	20
21	2006	5,258	526	10	526		2,893	21
22	2006	17,672	1,767	10	1,767		9,719	22
23	2006	99,654	9,965	10	9,965		54,808	23
24	2006	11,512	1,151	10	1,151		6,331	24
25	2006	3,450	345	10	345		1,898	25
26	2006	20,505	2,050	10	2,050		11,275	26
27	2006	14,960	1,496	10	1,496		8,228	27
28	2006	2,593	259	10	259		1,425	28
29	2006	3,742	374	10	374		2,057	29
30	2006	4,250	425	10	425		2,338	30
31	2006	2,946	295	10	295		1,622	31
32	2006	6,390	639	10	639		3,515	32
33	2006	16,266	1,627	10	1,627		8,948	33
34		\$ 8,424,913	\$ 52,450		\$ 254,381	\$ 201,931	\$ 5,559,794	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014

Report Period Beginning:

1/01/2011 Ending:

12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,424,913	\$ 52,450		\$ 254,381	\$ 201,931	\$ 5,559,794	1
2	2006	3,160	316	10	316		1,738	2
3	2006	2,995	300	10	300		1,649	3
4	2007	10,532	1,053	10	1,053		4,739	4
5	2008	3,000	300	10	300		1,050	5
6	2008	11,200	1,120	10	1,120		3,920	6
7	2008	4,308	430	10	430		1,505	7
8	2008	20,825	2,082	10	2,082		7,287	8
9	2008	3,901	390	10	390		1,365	9
10	2008	3,850	385	10	385		1,348	10
11	2008	4,494	449	10	449		1,572	11
12	2008	261,121	26,112	10	26,112		91,392	12
13	2008	5,600	560	10	560		1,960	13
14	2008	21,579	2,158	10	2,158		7,553	14
15	2008	6,550	655	10	655		2,293	15
16	2008	7,687	769	10	769		2,691	16
17	2009	3,333	333	10	333		833	17
18								18
19	2009	10,165	1,017	10	1,017		2,542	19
20								20
21	2009	5,700	570	10	570		1,425	21
22	2009	2,633	263	10	263		658	22
23	2009	6,800	680	10	680		1,700	23
24								24
25	2009	13,500	1,350	10	1,350		3,375	25
26	2009	77,071	7,707	10	7,707		19,268	26
27	2009	34,890	3,489	10	3,489		8,723	27
28	2009	3,526	353	10	353		882	28
29	2009	2,923	292	10	292		730	29
30	2009	(1,319)	(132)	10	(132)		(330)	30
31	2009	9,339	934	10	934		2,335	31
32	2009	2,690	269	10	269		673	32
33	2009	7,500	750	10	750		1,875	33
34		\$ 8,974,466	\$ 107,404		\$ 309,335	\$ 201,931	\$ 5,736,545	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,974,466	\$ 107,404		\$ 309,335	\$ 201,931	\$ 5,736,545	1
2	2009	(2,502)	(250)	10	(250)		(625)	2
3	2009	5,686	569	10	569		1,422	3
4	2009	29,734	2,973	10	2,973		7,433	4
5	2010	4,418	442	10	442		663	5
6	2010	2,900	290	10	290		435	6
7	2010	3,761	376	10	376		564	7
8	2010	265,344	26,534	10	26,534		39,801	8
9	2011	21,813	1,091	10	1,091		1,091	9
10								10
11								11
12								12
13								13
14	1998	17,112						14
15	1999	7,147						15
16	2000	856						16
17	2008	2,575			258	258	24,877	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		\$ 9,333,310	\$ 139,429		\$ 341,618	\$ 202,189	\$ 5,812,206	34

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	\$ 816,673	\$ 83,885	\$ 83,885	\$	10 years	\$ 449,772	71
72	Current Year Purchases	45,683	4,067	4,067		10 years	4,067	72
73	Fully Depreciated Assets	639,114	3,594	3,594		5, 10 years	639,114	73
74	Allocated from Therapy Masters, Mgt Co:	137,614		1,817	1,817		133,179	74
75	TOTALS	\$ 1,639,084	\$ 91,546	\$ 93,363	\$ 1,817		\$ 1,226,132	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:			\$ 25,382	\$	\$ 3,829	\$ 3,829		\$ 14,651	76
77										77
78										78
79										79
80	TOTALS			\$ 25,382	\$	\$ 3,829	\$ 3,829		\$ 14,651	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)	\$ 11,275,524	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 230,975	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 438,810	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 207,835	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,052,989	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: See Schedule VII, Page 6

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: \$ 24,745 Description: Postage meter \$568, Copy Machine \$18,235, Ice maker \$2,040, Allocated from Mgt Company: \$3,902

(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	Patient Care	2009 Toyota Sienna	\$ 575.00	\$ 450	17
18	Patient Care	2010 Acura MDX	725.00	1,450	18
19	Allocated from Management Company:			4,537	19
20					20
21	TOTAL		\$ #####	\$ 6,437	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.	<u>/2012</u>	\$ _____
13.	<u>/2013</u>	\$ _____
14.	<u>/2014</u>	\$ _____

* 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	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
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	2		3	4		5	6	7	8
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
					Units	Cost					
1	Licensed Occupational Therapist	Ln10a, Col 1,2&3	2,355	hrs	\$ 54,222	13,261	\$ 769,478	\$ 1,331	15,616	\$ 825,031	1
2	Licensed Speech and Language Development Therapist	Ln10a, Col 2&3		hrs		3,473	209,591	1,431	3,473	211,022	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	Ln10a, Col 2&3		hrs		12,177	803,875	380	12,177	804,255	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				532,258		532,258	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	15,261	hours	376,619		205,602		15,261	376,619	13
14	TOTAL				\$ 430,841	28,911	\$ 1,988,546	\$ 535,400	46,527	\$ 2,954,787	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 GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014Report Period Beginning: 1/01/2011Ending: 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	\$ 376,597	\$ 1,333,055	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>297,990</u>)	8,370,346	8,370,346	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,051	237,415	6
7	Other Prepaid Expenses	82,151	82,151	7
8	Accounts Receivable (owners or related parties)	(1,001,576)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,039,569	\$ 10,022,967	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		277,748	13
14	Buildings, at Historical Cost		7,014,066	14
15	Leasehold Improvements, at Historical Cost	2,196,066	2,319,244	15
16	Equipment, at Historical Cost	1,501,470	1,664,466	16
17	Accumulated Depreciation (book methods)	(2,470,992)	(7,052,989)	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 (spe Escrows)		974,637	22
23	Other(specify): <u>Mortgage Costs (Net)</u>		100,770	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,226,544	\$ 5,297,942	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,266,113	\$ 15,320,909	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 573,600	\$ 573,600	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,841	13,841	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	380,423	380,423	30
31	Accrued Taxes Payable (excluding real estate taxes)	(23,995)	(23,995)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		633,000	32
33	Accrued Interest Payable		84,322	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule E:</u>	1,878,935	1,878,935	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,822,804	\$ 3,540,126	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,237,255	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Loans Payable Stockholders:</u>	11,635,025	11,635,025	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,635,025	\$ 31,872,280	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,457,829	\$ 35,412,406	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,191,716)	\$ (20,091,497)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,266,113	\$ 15,320,909	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,967,191)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,967,191)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,224,525)	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)	\$ (1,224,525)	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)	\$ (5,191,716)	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	\$ 15,590,671	1
2	Discounts and Allowances for all Levels	(3,292,026)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,298,645	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,127,989	6
7	Oxygen	439,110	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,567,099	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,360	15
16	Rental of Facility Space		16
17	Sale of Drugs	728,131	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,331	19
20	Radiology and X-Ray	11,460	20
21	Other Medical Services	849,345	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,632,627	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,797	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	69	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 69	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,506,237	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,350,243	31
32	Health Care	8,497,586	32
33	General Administration	4,478,749	33
B. Capital Expense			
34	Ownership	3,149,614	34
C. Ancillary Expense			
35	Special Cost Centers	1,089,222	35
36	Provider Participation Fee	165,348	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,730,762	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,224,525)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,224,525)	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 **GlenBridge Nursing and Rehabilitation Centre, Ltd.**

0035014

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	1,929	2,110	\$ 98,247	\$ 46.56	1
2	Assistant Director of Nursing	49	84	3,638	43.31	2
3	Registered Nurses	59,917	63,516	1,775,935	27.96	3
4	Licensed Practical Nurses	21,570	22,888	531,505	23.22	4
5	CNAs & Orderlies	133,872	145,659	1,721,054	11.82	5
6	CNA Trainees					6
7	Licensed Therapist	16,768	17,616	430,841	24.46	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,009	2,246	52,939	23.57	9
10	Activity Assistants	11,859	13,077	132,605	10.14	10
11	Social Service Workers	9,716	10,601	225,698	21.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,615	14,785	181,814	12.30	14
15	Cook Helpers/Assistants	24,573	26,846	305,481	11.38	15
16	Dishwashers					16
17	Maintenance Workers	6,136	6,609	97,515	14.75	17
18	Housekeepers	27,278	29,411	292,366	9.94	18
19	Laundry	11,006	12,317	136,486	11.08	19
20	Administrator	2,081	2,265	102,018	45.04	20
21	Assistant Administrator	1,574	1,670	66,761	39.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,097	13,222	305,728	23.12	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	1,777	2,126	50,002	23.52	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerks</u>	16,638	17,820	245,484	13.78	33
34	TOTAL (lines 1 - 33)	374,464	404,868	\$ 6,756,117 *	\$ 16.69	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	\$ 52,562	Ln 1, Col 3	35
36	Medical Director	Monthly	145,200	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	17,155	Ln 10, 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	48	2,400	Ln 11, Col 3	44
45	Social Service Consultant	74	4,158	Ln 12, Col 3	45
46	Other(specify)				46
47	<u>Religious Consultant</u>	Monthly	4,900	Ln 12, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	122	\$ 226,375		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9,408	\$ 258,720	Ln 10, Col 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,408	\$ 258,720		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GlenBridge Nursing and Rehabilitation Centre, Ltd.

0035014

Report Period Beginning: 1/01/2011

Ending: 12/31/2011

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 GlenBridge Nursing and Rehabilitation Centre, Ltd.# 0035014Report 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 \$22,478
- (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. \$ 42,241 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. \$ 165,348
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. \$ 31,128 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? No
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

GlenBridge Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0035014
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
GlenBridge Real Estate & Development 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.	Brentwood North Healthcare & Rehabilitation	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenShire Nursing & Rehab. Centre, Ltd.	GlenLake Terrace Nursing & Rehab. Centre, Ltd.	
Sidney Glenner	39,247	37,312	16,233	15,036	30,168	32,114	170,110
Jonathan Glenner	10,225	9,721	4,229	3,917	7,860	8,367	44,319
Daniel Glenner	5,652	5,373	2,338	2,165	4,345	4,625	24,498
Elliot Glenner	4,936	4,692	2,040	1,891	3,794	4,039	21,392
David Weinschneider	10,172	9,671	4,208	3,897	7,819	8,324	44,091
Joshua Ray	39,247	37,312	16,233	15,036	30,168	32,114	170,110
Total compensation received from other Nursing Homes	109,479	104,081	45,281	41,942	84,154	89,583	474,520

See Accountants' Compilation Report

SCHEDULE C

XIX. SUPPORT SCHEDULES

C. Professional Services
 Page 21

Vendor/Payee	Type	AMOUNT
Health Data Systems, Inc.	Computers	6,898
Point ClickCare	Computers	54,004
E Health Data Solutions	Computer System Consulting	5,160
RSM McGladrey	Accounting	50,104
Frost, Rутtenberg & Rothblatt	Accounting	375
Myers, Miller & Krauskopf LLC	Legal	4,988
Myers, Carden & Sax LLP	Legal	1,573
Ira I. Silverstein	Legal	400
Much Shelist	Legal	12,964
Korey Law LLC	Legal	500
Skidelsky & Associates	Real Estate Tax Reduction	185
Divinity Marketing	Consulting Fees	3,750
First Real Estate Services Ltd	Real Estate Appraisal	750
Personnel Planners, Inc.	Unemployment Consulting	1,020
Commitment Consulting	A/R Collections	37,412
Cindy Stachura	Consultant	1,200
Total Schedule V, Line 19, Col. 3		<u>181,283</u>
Allocated from Management Co:		
Health Data Systems, Inc. - Computer Services		843
Point ClickCare - Computer Services		5,812
RSM McGladrey - Accounting Services		26,478
Clinical Reimbursement Solutions - Accounting Services		1,112
Frost, Rутtenberg & Rothblatt - Accounting Services		1,851
Harold Geiser - Accounting		1,640
Much Shelist - Legal		169
Total allocated from Management Co.		<u>37,905</u>
Total allocated from Therapy Masters:		8,717
GlenBridge Real Estate LLC:		
Much Shelist	Legal	250
Skidelsky & Associates	Real Estate Reduction	59,055
Total from GlenBridge Real Estate LLC:		<u>59,305</u>
Reclass Skidelsky & Associates invoice to Line 33		-185
Reclass Skidelsky & Associates invoice to Line 33		-59,055
Reclass First Real Estate Services Ltd invoice to Line 33		-750
Non-Allowable Expenses:		
Commitment Consulting - A/R Collections		-37,412
Divinity Marketing - Consulting Fees		-3,750
RSM McGladrey - Accounting Services		-49,575
Ira I. Silverstein - A/R collections		-400
Myers, Miller & Krauskopf LLC - Legal - out of period		-4,988
Myers, Carden & Sax LLP - Legal - out of period		-1,573
Total Non-Allowable Expenses:		<u>-97,698</u>
Total adjustments page 21, Sch C.		<u>-51,761</u>
Total Schedule V, line 19, column 8		<u>129,522</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	35,553
FUTA	433
SUTA	1,174
401K Match	2,595
Insurance - Hospital	33,810
Employee Benefits	3,762
Other Employee Benefits	636
Workers Compensation Insurance	968
Total allocated from Management Co.	<u>78,931</u>
Employee Benefits reclassified to Lines 7, 27	-78,931
Allocated from Therapy Masters, Inc.:	
FICA taxes	97,779
FUTA	1,342
SUTA	1,945
401K Match	0
Insurance - Hospital	36,996
Workers Compensation Insurance	3,100
Other Employee Benefits	404
Uniform Allowance	9,727
Total allocated from Therapy Masters, Inc. Co.	<u>151,293</u>
Employee Benefits reclassified to Lines 15,27	-151,293
Total allocated to Page 21	<u>0</u>

See Accountants' Compilation Report

GlenBridge Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0035014
12/31/2011

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Due to Third Party	915,160
Accrued Management Fees	924,214
Accrued 401K	99
Accrued Union Dues	8,560
Credit Union	(3,901)
Accrued Profit Sharing	805
Accrued Wage Assignment	31,666
Workshop	2,332
Sundry Payable	0
Total, Page 17, Line36	<u><u>1,878,935</u></u>

See Accountants' Compilation Report

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

<u>DESCRIPTION</u>	<u>AMOUNT</u>	<u>REFERENCE</u>
Non-allowable IL Council on Long Term Care fee	-7,420	20
Non-allowable professional fees	-97,698	19
Non-allowable bank charges	-15	43
Non-allowable clerical expense	-270	43
Non-allowable loss on early extinguishment of debt	-340,597	43
Adjust mgt co. med supplies - med'A' to cost	-97,581	10
Adjust mgt co. med supplies - 'other' to cost	-202,044	10
Adjust mgt co. food to cost	-74,638	2
Non-allowable related party interest expense	-24,350	32
Non-allowable auto expense - marketing	-845	25
Total	<u>-845,458</u>	

See Accountants' Compilation Report

GlenBridge Real Estate and Development, LLC.
Accrued Real Estate Taxes
12/31/2011

SCHEDULE G

	Accrued 1/01/11	Payments	Expense	Accrued 12/31/11
Balance @ 1/01/11	-573,000.00		-573,000.00	
2010 real estate taxes paid		608,642.49	608,642.49	
Estimated 2011 real estate taxes:				
2010 taxes	608,642.49			
Estimated increase	4.00%			
Estimated 2011 taxes	<u>632,988.19</u>			
USE	<u>633,000.00</u>		633,000.00	-633,000.00
Totals	<u>-573,000.00</u>	<u>608,642.49</u>	<u>668,642.49</u>	<u>-633,000.00</u>

Real estate tax history:

Year	Amount	\$	Increase %
1991	344,588.08		
1992	355,177.77	10,589.69	3.07%
1993	393,112.43	37,934.66	10.68%
1994	402,034.81	8,922.38	2.27%
1995	397,141.59	-4,893.22	-1.22%
1996	393,772.20	-3,369.39	-0.85%
1997	404,786.31	11,014.11	2.80%
1998	439,085.19	34,298.88	8.47%
1999	444,302.54	5,217.35	1.19%
2000	449,207.00	4,904.46	1.10%
2001	444,964.23	-4,242.77	-0.94%
2002	451,039.70	6,075.47	1.37%
2003	450,122.47	-917.23	-0.20%
2004	517,833.15	67,710.68	15.04%
2005	532,056.62	14,223.47	2.75%
2006	535,626.03	3,569.41	0.67%
2007	680,599.97	144,973.94	27.07%
2008	692,818.24	12,218.27	1.80%
2009	558,272.04	-134,546.20	-19.42%
2010	608,642.49	50,370.45	9.02%

See Accountants' Compilation Report

Provider Name: GlenBridge Nursing & Rehab Ctr.

Provider I.D. #: 0035014

Year Ended: December 31, 2011

SCHEDULE H

Training & Education

Person(s) Attending	Date Attended	Location	Title Sponsor	Total Cost
Patricia Davis, John Marc Sianghio	6/8-6/9/2011	Peoria, IL	Illinois Nursing Home Administrator's Assoc Illinois Administrator's Conference	290
Elouisa Ang	4/1, 4/8, 4/15, 4/19 5/6, 5/13, 5/20, 5/27	Westmont, IL	Pathway Health Services Restorative Nurse Certification Training	375
John Marc Sianghio, Rudolf Sternschein	6/15/2011	Skokie, IL	Illinois Council on Long Term Care Writing Winning IDRs and Other Hot Topic Frontline Legal Issues	210
John Marc Sianghio, Rudolf Sternschein Manny Pedre, Joshua Ray, Jackie Macenas	3/15-3/16/2011	Springfield, IL	Illinois Nursing Home Administrator's Assoc Illinois Administrator's Conference	380
Rudolf Sternschein	6/2/2011	Grayslake, IL	LC Pioneer Coalition 2011 Lake County Pioneer Coalition Annual Seminar	50
Social Work and Nursing Staff	6/22/2011	Niles, IL	Dr. George Savarese Clinical Intervention Strategies in Geriatric Practice	259
Rudolf Sternschein, John Marc Sianghio	6/15/2011 6/16/2011	Oak Lawn, IL Skokie, IL	Illinois Council on Long Term Care Writing Winning IDRs and Other Hot Topic Frontline Legal Issues	210
Rudolf Sternschein John Marc Sianghio	7/6/2011 7/6/2011	Skokie, IL Oak Lawn, IL	Illinois Council on Long Term Care The New Medicaid Integrated Care Program	210
Marlene Chan	9/16/2011	Chicago, IL	Cynthia Chow & Associates Redefining the Future	110
Rudolf Sternschein	10/3/2011	Skokie, IL	Illinois Council on Long Term Care Consistent Staff-The Key to Quality	60
Nursing Staff	10/28/2011	Niles, IL	Omnicare Edu-Nurse IV Training	250
			Allocated From Management Company	1,022
			Allocated From Therapy Masters	5,426
			Total	<u>8,852</u>

SEE ACCOUNTANTS' COMPILATION REPORT

GlenBridge Nursing and Rehabilitation Centre, LTD.
Provider I.D. #0035014
12/31/2011

SCHEDULE I

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

	Gasoline Allowance	Licenses/ Stickers	Employee Reimbursement: Parking, Tolls, Mileage	Repairs	Total
Direct Expense	5,430	99	3,925	1,216	10,670
Non-allowable auto expense - marketing					-845
Allocated from Management Company					4,147
Allocated from Therapy Masters					2,096
TOTAL	5,430	99	3,925	1,216	16,068

SEE ACCOUNTANTS' COMPILATION REPORT

SCHEDULE K

XIX. SUPPORT SCHEDULES

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F. Dues, Fees, Subscriptions and Promotions

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Illinois Council on Long Term Care Dues	29,898
Employment Fees	46,400
Registered Nurse License Renewal Fee	82
Village of Niles Annual Business License, Fee	4,952
Secretary of State Annual Report Fee	225
State Fire Marshall Boiler Inspection	200
Thompson Elevator Inspection Fee	120
Cook County Department of Environmental Control Equipment Inspection	347
Non-allowable Illinois Council on Long Term Care Fee	<u>-7,420</u>
Total allocated to Page 21	<u><u>74,804</u></u>

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