

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: <u>0050112</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Brentwood North HC & Reh Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3705 Deerfield Rd</u> <u>Riverwoods</u> <u>60015</u>																									
Number City Zip Code																									
County: <u>Lake</u>																									
Telephone Number: <u>(847) 947-9000</u> Fax # <u>(847) 947-9005</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Sidney Glenner</u></td></tr><tr><td>(Title) <u>President</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago, IL 60606-4650</u></td></tr><tr><td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Sidney Glenner</u>	(Title) <u>President</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US 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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	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>																								
Date of Initial License for Current Owners: <u>09/01/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u>																									
Email Address: _____																									

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 <u>N/A</u>					
	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	<u>248</u>	Skilled (SNF)	<u>248</u>	<u>90,768</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>248</u>	TOTALS	<u>248</u>	<u>90,768</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,857</u>	<u>4,699</u>	<u>8,799</u>	<u>18,355</u>	8
9	SNF/PED					9
10	ICF	<u>14,571</u>	<u>10,963</u>	<u>0</u>	<u>25,534</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,428</u>	<u>15,662</u>	<u>8,799</u>	<u>43,889</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.35%

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 09/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/01/08 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 7,395

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: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Brentwood North HC & Reh Ctr** # **0050112** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	394,738	37,168	14,155	446,061		446,061		446,061			1
2	Food Purchase		384,093		384,093	(27,252)	356,841	(25,573)	331,268			2
3	Housekeeping		5,242	274,344	279,586		279,586		279,586			3
4	Laundry			183,436	183,436		183,436		183,436			4
5	Heat and Other Utilities			218,172	218,172		218,172	2,933	221,105			5
6	Maintenance	138,367	61,920	115,559	315,846		315,846	6,235	322,081			6
7	Other (specify):* Allocated Employee Benefits							331	331			7
8	TOTAL General Services	533,105	488,423	805,666	1,827,194	(27,252)	1,799,942	(16,074)	1,783,868			8
	B. Health Care and Programs											
9	Medical Director			145,606	145,606		145,606		145,606			9
10	Nursing and Medical Records	4,553,592	247,146	217,402	5,018,140		5,018,140	(15,368)	5,002,772			10
10a	Therapy		2,887	1,530,232	1,533,119		1,533,119	(262,241)	1,270,878			10a
11	Activities	135,691	10,740	612	147,043		147,043		147,043			11
12	Social Services	138,972		3,752	142,724		142,724		142,724			12
13	CNA Training											13
14	Program Transportation			13,402	13,402		13,402		13,402			14
15	Other (specify):* Allocated Employee Benefits							131,399	131,399			15
16	TOTAL Health Care and Programs	4,828,255	260,773	1,911,006	7,000,034		7,000,034	(146,210)	6,853,824			16
	C. General Administration											
17	Administrative	128,920		1,163,544	1,292,464		1,292,464	(1,146,141)	146,323			17
18	Directors Fees											18
19	Professional Services			207,578	207,578	(8,320)	199,258	22,747	222,005			19
20	Dues, Fees, Subscriptions & Promotions			89,815	89,815	1,890	91,705	(4,927)	86,778			20
21	Clerical & General Office Expenses	486,612	80,132	58,109	624,853	(1,890)	622,963	197,776	820,739			21
22	Employee Benefits & Payroll Taxes			738,325	738,325	27,252	765,577	(25,568)	740,009			22
23	Inservice Training & Education			2,690	2,690		2,690	3,493	6,183			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,392	10,392		10,392	(1,540)	8,852			25
26	Insurance-Prop.Liab.Malpractice			386,752	386,752		386,752	5,664	392,416			26
27	Other (specify):* Allocated Employee Benefits							71,997	71,997			27
28	TOTAL General Administration	615,532	80,132	2,657,205	3,352,869	18,932	3,371,801	(876,499)	2,495,302			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,976,892	829,328	5,373,877	12,180,097	(8,320)	12,171,777	(1,038,783)	11,132,994			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			112,219	112,219		112,219	557,812	670,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,828	206,828		206,828	(150,494)	56,334			32
33	Real Estate Taxes					8,320	8,320	104,232	112,552			33
34	Rent-Facility & Grounds			1,211,469	1,211,469		1,211,469	(1,211,469)				34
35	Rent-Equipment & Vehicles			56,303	56,303		56,303	8,669	64,972			35
36	Other (specify):*											36
37	TOTAL Ownership			1,586,819	1,586,819	8,320	1,595,139	(691,250)	903,889			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		417,356	45,291	462,647		462,647	(53,685)	408,962			39
40	Barber and Beauty Shops			39	39		39		39			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			351,923	351,923		351,923		351,923			42
43	Other (specify):* Non-Allowable			572,537	572,537		572,537	(572,537)				43
44	TOTAL Special Cost Centers		417,356	969,790	1,387,146		1,387,146	(626,222)	760,924			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,976,892	1,246,684	7,930,486	15,154,062		15,154,062	(2,356,255)	12,797,807			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(10,408)	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		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,721)	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	(37,925)	43		18
19	Entertainment				19
20	Contributions	(5,395)	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	(469,991)	43		24
25	Fund Raising, Advertising and Promotional	(55,057)	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:	(1,215,799)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,796,296)		\$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(559,959)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (559,959)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,356,255)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjust Mgt Co. medical supplies"A" to cost	\$ (2,162)	10	1
2	Adjust Mgt Co. medical supplies"other" to cost	(13,206)	10	2
3	Adjust Mgt Co. food to cost	(25,573)	2	3
4	Non-allowable patient clothing	(2,448)	43	4
5	Non-allowable professional fees	(112,137)	19	5
6	Non-allowable owner interest expense	(565,153)	32	6
7	Non-allowable owner interest expense	(190,680)	32	7
8	Non-allowable auto expense - marketing	(10,170)	25	8
9	Non-allowable Illinois Council on Long Term Care Dues	(8,041)	20	9
10	Adjust pharmacy expense to cost	(53,685)	39	10
11	Non-allowable marketing salaries	(206,976)	21	11
12	Non-allowable marketing employee benefits	(25,568)	22	12
13				13
14				14
15				15
16				16
17				17
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,215,799)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brentwood North HC & Reh Ctr# 0050112

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25,573)	0	0	0	0	0	0	0	0	0	0	(25,573)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,933	0	0	0	0	0	0	0	0	2,933	5
6	Maintenance	0	0	6,232	0	3	0	0	0	0	0	0	6,235	6
7	Other (specify):*	0	0	331	0	0	0	0	0	0	0	0	331	7
8	TOTAL General Services	(25,573)	0	9,496	0	3	0	0	0	0	0	0	(16,074)	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	(15,368)	0	0	0	0	0	0	0	0	0	0	(15,368)	10
10a	Therapy	0	0	0	0	(262,241)	0	0	0	0	0	0	(262,241)	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	131,399	0	0	0	0	0	0	131,399	15
16	TOTAL Health Care and Programs	(15,368)	0	0	0	(130,842)	0	0	0	0	0	0	(146,210)	16
	C. General Administration													
17	Administrative	0	0	(1,146,141)	0	0	0	0	0	0	0	0	(1,146,141)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(112,137)	0	14,575	61,278	59,031	0	0	0	0	0	0	22,747	19
20	Fees, Subscriptions & Promotions	(8,041)	0	1,428	0	1,686	0	0	0	0	0	0	(4,927)	20
21	Clerical & General Office Expenses	(217,384)	0	403,333	6,301	5,526	0	0	0	0	0	0	197,776	21
22	Employee Benefits & Payroll Taxes	(25,568)	0	0	0	0	0	0	0	0	0	0	(25,568)	22
23	Inservice Training & Education	0	0	975	0	2,518	0	0	0	0	0	0	3,493	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(10,170)	0	6,419	0	2,211	0	0	0	0	0	0	(1,540)	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,718	0	1,946	0	0	0	0	0	0	5,664	26
27	Other (specify):*	0	0	71,706	0	291	0	0	0	0	0	0	71,997	27
28	TOTAL General Administration	(373,300)	0	(643,987)	67,579	73,209	0	0	0	0	0	0	(876,499)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(414,241)	0	(634,491)	67,579	(57,630)	0	0	0	0	0	0	(1,038,783)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brentwood North HC & Reh Ctr # 0050112 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	6,993	550,819	0	0	0	0	0	0	0	557,812	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(755,833)	0	0	605,339	0	0	0	0	0	0	0	(150,494)	32
33	Real Estate Taxes	0	0	5,290	98,942	0	0	0	0	0	0	0	104,232	33
34	Rent-Facility & Grounds	0	0	0	(1,211,469)	0	0	0	0	0	0	0	(1,211,469)	34
35	Rent-Equipment & Vehicles	0	0	8,669	0	0	0	0	0	0	0	0	8,669	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(755,833)	0	20,952	43,631	0	0	0	0	0	0	0	(691,250)	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	(53,685)	0	0	0	0	0	0	0	0	0	0	(53,685)	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):*	(572,537)	0	0	0	0	0	0	0	0	0	0	(572,537)	43
44	TOTAL Special Cost Centers	(626,222)	0	0	0	0	0	0	0	0	0	0	(626,222)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,796,296)	0	(613,539)	111,210	(57,630)	0	0	0	0	0	0	(2,356,255)	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	99.00 %	See Attached Page 6-Supplemental		See Attached Schedule A		
Joshua Ray	1.00 %					

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		Total from Page 6A	\$ 1,163,544	Glen Health and Home Management, Inc.	A	\$ 550,005	\$ (613,539)	1
2	V								2
3	V		Total from Page 6B	1,211,469	Brentwood Healthcare Real Estate LLC.	B	1,322,679	111,210	3
4	V								4
5	V		Total from Page 6C	1,530,232	Therapy Masters, Inc.	C	1,472,602	(57,630)	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			\$ 3,905,245			\$ 3,345,286	\$ * (559,959)	14

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

Facility Name & ID Number

Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sidney Glenner	100.00 %	GlenBridge Nursing & Rehabilitation	Niles	See Attached Schedule A			1
2			Centre, Ltd.					2
3								3
4	Sidney Glenner	100.00 %	GlenCrest Nursing & Rehabilitation	Chicago				4
5			Centre, Ltd.					5
6								6
7	Sidney Glenner	100.00 %	Glen Elston Nursing & Rehabilitation	Chicago				7
8			Centre, Ltd.					8
9								9
10	Sidney Glenner	100.00 %	Glen Oaks Nursing & Rehabilitation	Northbrook				10
11			Centre, Ltd.					11
12								12
13	Sidney Glenner	100.00 %	GlenShire Nursing & Rehabilitation	Richton Park				13
14			Centre, Ltd.					14
15								15
16	Sidney Glenner	80.00 %	GlenLake Terrace Nursing & Rehabilitation	Waukegan				16
17	Joshua Ray	20.00 %	Centre, Ltd.					17
18								18
19	Sidney Glenner	50.00 %	Ballard Respiratory and Rehabilitation	Des Plaines				19
20	Joshua Ray	50.00 %	Center, LLC.					20
21								21
22	Sidney Glenner	50.00 %	Glen Saint Andrew Living Community LLC.	Niles				22
23	Joshua Ray	50.00 %						23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	\$ 1,163,544	Glen Health and Home Management, Inc.	A	\$	(1,163,544)	15
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	2,933	2,933	16
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	4,395	4,395	17
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	14,575	14,575	18
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,428	1,428	19
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	23,170	23,170	20
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	72,037	72,037	21
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	975	975	22
23	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	6,419	6,419	23
24	V	26	Insurance		Glen Health and Home Management, Inc.	A	3,718	3,718	24
25	V	30	Depreciation		Glen Health and Home Management, Inc.	A	6,993	6,993	25
26	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	5,290	5,290	26
27	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	8,669	8,669	27
28	V	6	Janitorial Salaries		Glen Health and Home Management, Inc.	A	1,837	1,837	28
29	V	17	Officer's Salaries		Glen Health and Home Management, Inc.	A	17,403	17,403	29
30	V	21	Administrative Salaries		Glen Health and Home Management, Inc.	A	380,163	380,163	30
31	V	22	Employee Benefits		Glen Health and Home Management, Inc.	A	(72,037)	(72,037)	31
32	V	7	Employee Benefits - Janitorial		Glen Health and Home Management, Inc.	A	331	331	32
33	V	27	Employee Benefits - Officer's		Glen Health and Home Management, Inc.	A	3,141	3,141	33
34	V	27	Employee Benefits - Admin		Glen Health and Home Management, Inc.	A	68,565	68,565	34
35	V								35
36	V								36
37	V				A - Ownership: Sidney Glenner - 100.00 % through attribution				37
38	V								38
39	Total			\$ 1,163,544			\$ 550,005	\$ * (613,539)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest Expense	\$	Brentwood Healthcare Real Estate LLC	B	\$ 603,925	\$ 603,925	15
16	V	30	Depreciation		Brentwood Healthcare Real Estate LLC	B	550,819	550,819	16
17	V	33	Real Estate Taxes		Brentwood Healthcare Real Estate LLC	B	98,942	98,942	17
18	V	34	Rental Income	1,211,469	Brentwood Healthcare Real Estate LLC	B		(1,211,469)	18
19	V	32	Interest Income		Brentwood Healthcare Real Estate LLC	B	(90)	(90)	19
20	V	19	Professional Fees		Brentwood Healthcare Real Estate LLC	B	61,278	61,278	20
21	V	32	Amortization of Mortgage Costs		Brentwood Healthcare Real Estate LLC	B	1,504	1,504	21
22	V	21	Office Expense		Brentwood Healthcare Real Estate LLC	B	6,301	6,301	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				B - Ownership:				32
33	V				Sidney Glenner - 70.00 %				33
34	V				Joshua Ray - 30.00 %				34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,211,469			\$ 1,322,679	\$ * 111,210	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Therapy	\$ 1,530,232	Therapy Masters, Inc.	C	\$ 1,267,991	\$ (262,241)	15
16	V	19	Professional Fees		Therapy Masters, Inc.	C	59,031	59,031	16
17	V	20	Licenses, Permits, and Inspection		Therapy Masters, Inc.	C	1,686	1,686	17
18	V	6	Repairs and Maintenance		Therapy Masters, Inc.	C	3	3	18
19	V	21	Clerical		Therapy Masters, Inc.	C	2,813	2,813	19
20	V	22	Employee Benefits and Payroll		Therapy Masters, Inc.	C	131,690	131,690	20
21	V	23	Training and Education		Therapy Masters, Inc.	C	2,518	2,518	21
22	V	25	Auto Expenses		Therapy Masters, Inc.	C	2,211	2,211	22
23	V	21	Clerical Salaries		Therapy Masters, Inc.	C	2,713	2,713	23
24	V	22	Employee Benefits		Therapy Masters, Inc.	C	(131,690)	(131,690)	24
25	V	15	Employee Benefits - Therapy		Therapy Masters, Inc.	C	131,399	131,399	25
26	V	27	Employee Benefits - Clerical		Therapy Masters, Inc.	C	291	291	26
27	V	26	Liability Insurance		Therapy Masters, Inc.	C	1,946	1,946	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V				C - Ownership: 100.00 % Sidney Glenner				33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,530,232			\$ 1,472,602	\$ * (57,630)	39

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

Facility Name & ID Number Brentwood North HC & Reh Ctr # 0050112 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Chairman of Board	Administrative	99.00 %	214,018	5	7.97%	Salary	\$ 17,403	Ln 17, Col 7	1
2	Jonathan Glenner	Clerical	Clerical	0.00 %	49,778	3	7.97%	Salary	4,048	Ln 21, Col 7	2
3	Daniel Glenner	President	Administrative	0.00 %	179,104	1	1.00%	Salary	14,564	Ln 21, Col 7	3
4	Elliot Glenner	Dir of Purchasing	Administrative	0.00 %	84,588	3	7.97%	Salary	6,878	Ln 21, Col 7	4
5											5
6											6
7											7
8											8
9											9
10		See Schedule B									10
11											11
12											12
13								TOTAL	\$ 42,893		13

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

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

Facility Name & ID Number Brentwood North HC & Reh Ctr# 0050112

Report Period Beginning:

01/01/2016Ending: 2/31/2016

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Resident Days	583,629	9	\$ 39,007	\$ 43,889	\$ 2,933	1
2	6	Repairs and Maintenance	Resident Days	583,629	9	58,439	43,889	4,395	2
3	19	Professional Fees	Resident Days	583,629	9	193,812	43,889	14,575	3
4	20	Licenses, Permits and Inspection	Resident Days	583,629	9	18,995	43,889	1,428	4
5	21	Clerical	Resident Days	583,629	9	308,114	43,889	23,170	5
6	22	Employee Benefits and Payroll	Resident Days	583,629	9	957,941	43,889	72,037	6
7	23	Training and Education	Resident Days	583,629	9	12,962	43,889	975	7
8	25	Auto Expenses	Resident Days	583,629	9	85,358	43,889	6,419	8
9	26	Insurance	Resident Days	583,629	9	49,447	43,889	3,718	9
10	30	Depreciation	Resident Days	583,629	9	92,988	43,889	6,993	10
11	33	Real Estate Taxes	Resident Days	583,629	9	70,340	43,889	5,290	11
12	35	Equipment and Vehicle Rental	Resident Days	583,629	9	115,277	43,889	8,669	12
13	6	Janitorial Salaries	Resident Days	583,629	9	24,431	24,431	1,837	13
14	17	Officer's Salaries	Resident Days	583,629	9	231,420	231,420	17,403	14
15	21	Administrative Salaries	Resident Days	583,629	9	5,055,342	5,055,342	380,163	15
16	22	Employee Benefits	Payroll					(72,037)	16
17	7	Employee Benefits - Janitorial	Payroll					331	17
18	27	Employee Benefits - Officer's	Payroll					3,141	18
19	27	Employee Benefits - Admin	Payroll					68,565	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,313,873	\$ 5,311,193	\$ 550,005	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE													
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)													
	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	SLG Limited Partnership	X		Mortgage	\$86,367.26	8/28/2008	\$ 15,180,000	\$ 4,012,850	9/01/2033	0.0525	\$ 565,153	1	
2	MB Financial Bank		X	Construction Loan		5/26/2016	3,000,000		12/30/2016	0.0338	38,772	2	
3	MB Financial Bank		X	Working Capital		12/1/2015	1,094,337	1,094,337	11/15/17	0.2673	16,148	3	
4	Popular Bank		X	Mortgage	\$48,333.33	12/30/16	14,500,000	14,500,000	12/31/2019	0.0477		4	
5	Popular Bank		X	Amortization of Mortgage Costs							1,504	5	
	Working Capital												
6	Sidney Glenner	X		Working Capital		Various	57,711	57,711		0.0525	1,294	6	
7	AMJED GST Trust	X		Working Capital		Various	6,926,050	6,926,050		0.0525	176,261	7	
8	Joshua Ray	X		Working Capital		Various	1,075,291	1,075,291		0.0525	13,125	8	
9	TOTAL Facility Related				\$134,700.59		\$ 41,833,389	\$ 27,666,239			\$ 812,257	9	
	B. Non-Facility Related*												
10								Non-Allowable owner interest expense:		(565,153)	10		
11								Non-Allowable owner interest expense:		(190,680)	11		
12								Interest Income Offset:		(90)	12		
13											13		
14	TOTAL Non-Facility Related						\$	\$			\$ (755,923)	14	
15	TOTALS (line 9+line14)						\$ 41,833,389	\$ 27,666,239			\$ 56,334	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.)

** 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 2015 report.			\$	186,000	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.)			\$	138,942	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(47,058)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	146,000	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.)			\$	8,320	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.			\$	107,262	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	160,692	8	
		2012	168,134	9	
		2013	174,219	10	
		2014	176,668	11	
		2015	138,942	12	
See Attached Schedule G For Calculation Of 2016 Real Estate Tax Accrual.		13	FROM R. E. TAX STATEMENT FOR 2015 \$		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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brentwood North HC & Reh Ctr COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0050112

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 2015 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 2015.

(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>2,656.47</u>	\$ <u>2,656.47</u>
2. <u>15-35-200-001</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>128,712.02</u>	\$ <u>128,712.02</u>
3. <u>15-35-200-016</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>2,441.64</u>	\$ <u>2,441.64</u>
4. <u>15-35-200-002</u>	<u>3705 Deerfield Rd, Riverwoods, IL</u>	\$ <u>5,132.11</u>	\$ <u>5,132.11</u>
5. <u>Allocated from Management Co:</u>	<u></u>	\$ <u>74,688.61</u>	\$ <u>5,290.00</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>213,630.85</u></u>	\$ <u><u>144,232.24</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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).

[illegible]

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care			\$ 2,373,245	1
2	Allocated from Management Company:			6,388	2
3	TOTALS			\$ 2,379,633	3

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	\$	\$ 2,860,479
5										
6	See Attached				138,376			4,497	4,497	
7	Schedule J									
8										
	Improvement Type**									
9	Rooftop condenser unit		2008		7,920	792	10	792		6,732
10	Ceramic tile installation		2010		3,679	368	10	368		2,392
11	Elevator hydraulic jack assembly		2010		21,500	2,150	10	2,150		13,975
12	Installation of roof drains and patch roof		2010		11,400	1,140	10	1,140		7,410
13	Install aluminum paneling for exterior substructure		2011		3,135	314	10	314		1,727
14	Furnish and install air-conditioning unit		2011		3,015	302	10	302		1,661
15	Sidewalk and curb concrete project		2011		4,000	400	10	400		2,200
16	Remove wallpaper, plaster and paint medical room and back entrance		2011		5,255	526	10	526		2,893
17	Remove wallpaper, plaster & paint, install laminated floor in media room		2011		6,840	684	10	684		3,762
18	back entrance and therapy area									
19	Remove and install carpet, vinyl tile & cove base in beauty salon and		2011		30,510	3,051	10	3,051		16,781
20	resident rooms									
21	Remove and install wallpaper, painting project in lobby		2011		11,861	1,186	10	1,186		6,523
22	Remove and install wallpaper, paint resident rooms		2011		5,100	510	10	510		2,805
23	Two Carrier rooftop heating/cooling units		2011		24,569	2,457	10	2,457		13,513
24	Remove wallpaper, plaster & painting project in main bathroom and		2011		3,425	343	10	343		1,886
25	resident rooms									
26	Remove carpet and install vinyl tile flooring in dining room		2011		4,800	480	10	480		2,640
27	Purchase Rheem 120 gallon hot water storage tank		2011		3,135	314	10	314		1,727
28	Remove wallpaper, paint, furnish and install cove base in resident room		2012		4,100	410	10	410		1,845
29	Furnish and install ceramic floor and wall tile, grab bars, paint in showers		2012		34,080	3,408	10	3,408		15,336
30	and tub rooms									
31	Remove and install wallpaper, paint, cove base in resident rooms,		2012		7,350	735	10	735		3,308
32	nurses station and staff bathrooms									
33	Bohn evaporator and condenser		2012		13,660	1,366	10	1,366		6,147
34	Furnish and install fire rated door		2013		6,400	640	10	640		2,240
35	Furnish AO Smith 275,000 BTU water heater		2013		7,283	728	10	728		2,548
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

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof restoration project	2013	\$ 11,480	\$ 1,148	10	\$ 1,148		\$ 4,018	37
38	Roof restoration project	2013	5,700	570	10	570		1,995	38
39	Furnish AO Smith 250,000 BTU water heater	2013	6,885	689	10	689		2,411	39
40	Parking lot paving	2014	16,514	1,651	10	1,651		4,128	40
41	Replace evaporator coil, temp control & valves in walk-in cooler	2014	4,024	402	10	402		1,005	41
42	Telephone wiring project	2014	4,914	491	10	491		1,228	42
43	Hot water heater - AO Smith 100 gallon	2014	7,104	710	10	710		1,775	43
44	Install vinyl tile & cove base in resident rooms 208-215	2014	26,429	2,643	10	2,643		6,607	44
45	Corridor Bathrooms: furnish and install new toilets, ceramic tile	2015	457,651	45,765	10	45,765		68,648	45
46	on floors and walls, wallcovering								46
47	Main Dining Room and Lounge: vinyl plankwood, carpeting,								47
48	wallcovering, electrical work								48
49	Far West Wing Resident Rooms: remove and install vinyl tile								49
50	and cove base, lighting, bumper guards								50
51	Resident Toom Bathrooms: install new ceramic floor tile and								51
52	walls, wallcovering, relocate power, vanity sinks, grab bars								52
53	Furnish and install outlets, relocate outlets and call light	2015	9,900	990	10	990		1,485	53
54	Break out and pour concrete floor in main dining room; new	2015	9,141	914	10	914		1,371	54
55	ceramic wall and floor tile, wallpaper in resident room bathrooms								55
56	Furnish and install outlets, relocate outlets and call light	2015	11,750	1,175	10	1,175		1,763	56
57	Furnish and install outlets, relocate outlets and call light	2015	14,300	1,430	10	1,430		2,145	57
58	Multizone split inverter coil system fan and install 25 feet of	2015	4,574	457	10	457		686	58
59	insulated tubing								59
60	Backflow preventer replacement	2015	4,840	484	10	484		726	60
61	Installation of light fixture units in resident rooms	2015	4,800	480	10	480		720	61
62	Purchase of glass mosiac tile in bathrooms, grab bars, light	2015	5,827	582	10	582		873	62
63	fixtures and sinks								63
64	Installation of light fixture units in resident rooms	2015	4,800	480	10	480		720	64
65	Dementia Coordinators Office: remove cove base, purchase	2015	33,844	3,384	10	3,384		5,076	65
66	vinyl tile and cove base, remove wallpaper and paint walls								66
67	East Wing Corridor: vinyl plankwood, floor border, wallcovering								67
68	East Wing Resident Rooms: vinyl tile, wallcovering, cove base								68
69	Resident Room Bathrooms: ceramic tile								69
70	TOTAL (lines 4 thru 69)		\$ 10,176,197	\$ 423,276		\$ 427,773	\$ 4,497	\$ 3,087,910	70

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

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,176,197	\$ 423,276		\$ 427,773	\$ 4,497	\$ 3,087,910	1
2	Main Dining Room: remove cove base, custom carpet installation	2015	110,278	11,028	10	11,028		16,542	2
3	vinyl tile, frame out walls, drywall								3
4	Far East Corridor: wallcovering								4
5	Far East Dining Room: remove cove base and vinyl, install vinyl								5
6	tile and cove base, wallcovering, frame out walls and drywall								6
7	Lobby Bathroom: ceramic wall/floor tile and wallcovering,	2015	50,171	5,017	10	5,017		7,526	7
8	Far East Corridor: replace ceiling tiles and ceiling lights,								8
9	Far East Lounge: wallcovering								9
10	Far East Corridor: remove wood base and install vinyl tile	2015	218,042	21,804	10	21,804		32,706	10
11	Far East Nourishment Room:replace ceiling tile, custom millwork								11
12	with laminate tops including sinks and faucets								12
13	Far East Med Rooms: remove cove base and install vinyl tile								13
14	flooring and cove base, replace ceiling tiles								14
15	Far East Resident Rooms: remove cove base and carpet, install								15
16	vinyl tile and cove base, wallcovering, bumper guards								16
17									17
18	Lobby Bathrooms, Corridor bathrooms, far east corridor	2016	204,976	10,249	10	10,249		10,249	18
19	and nurses station, far east dinning room/activity room,								19
20	east pod dining, 63 resident rooms, main dining room,								20
21	beauty parlor, ice cream parlor: remove wallcovers, prep walls and install								21
22	new wallcovers								22
23	Lobby Bathroom: replace existing plumbing fixtures, hardware,								23
24	floor and wall tile, drywall. Provide wall support, prep and paint								24
25	East Wing Corridor: remove flooring and install vinyl tile,								25
26	vinyl plankwood								26
27	Far East Ice Cream Parlor: disconnect sink and faucet, remove								27
28	cabinets and counter tops, repair walls								28
29	East Wing Corridor: flooring (vinyl plankwood)	2016	11,835	592	10	592		592	29
30	Far East Corridor: Remove, prep and install new flooring								30
31	Far East Nurses Station: revised textured panels and granite top								31
32	Far East Shower Room: Wall tile, floor tile, wallcovering,	2016	15,112	756	10	756		756	32
33	grab bars								33
34	TOTAL (lines 1 thru 33)		\$ 10,786,611	\$ 472,722		\$ 477,219	\$ 4,497	\$ 3,156,281	34

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

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,786,611	\$ 472,722		\$ 477,219	\$ 4,497	\$ 3,156,281	1
2	East Dining Room: remove flooring, install pure vinyl tile	2016	16,228	811		811		811	2
3	Far West Corridor, Far east corridor, far west resident rooms,								3
4	far east resident rooms, far east nurses station, lobby bathrooms,								4
5	corridor bathrooms, beauty salon and main dining: Cornerguards								5
6	Far East Shower Room: glass mosaic tile	2016	104,799	5,240		5,240		5,240	6
7	Far East Nurses Station: demo nurses station, install ceiling tile,								7
8	remove walls and plumbing, and run power								8
9	East Dining Room: Installation of lighting								9
10	Far West Wing Resident Rooms: remove existing cubicle,								10
11	repair ceiling, install new cubicle track - credit for cubicle track								11
12	63 Resident Room Bathrooms: remove plumbing, floor tile, wall tile,								12
13	drywall. Install new ceramic tile to floor and walls, prep and paint								13
14	walls and wallcoverings, and electric work								14
15	Resident Rooms - B wing: plumbing	2016	7,798	390		390		390	15
16	Resident Rooms - B,C,D,&E: plumbing								16
17	Far East Shower Room: Grout, mortar, waterproofing and								17
18	schluter								18
19	Far East Lounge: build full height wall, drywall								19
20	Far East Nourishment Room: soffit, drywall and new ceiling grid								20
21	Far East Med Rooms: plumbing and drywall								21
22	Far East Wing Resident Rooms: electric work, lighting,								22
23	new studs and drywall								23
24	Far East Beauty Salon: wallcovering	2016	35,433	1,772		1,772		1,772	24
25	Far East Wing Resident Rooms: vinyl and cove base installation,								25
26	floor prep, sloan valve. Far East Lounge: Gazebo installation								26
27	Far East Dining Room: custom kitchenette								27
28	Corridors: Installation of signage with logo								28
29	Re-face one side and re-varnish left and right edges of 340 doors	2016	57,800	2,890		2,890		2,890	29
30	on main floor								30
31	East Shower Room: demo wall and flooring, install 2 new mixing	2016	14,000	700		700		700	31
32	valves, install flooring, wall tile, wallpaper, install light fixture,								32
33	and reinstall toilet								33
34	TOTAL (lines 1 thru 33)		\$ 11,022,669	\$ 484,525		\$ 489,022	\$ 4,497	\$ 3,168,084	34

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

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,022,669	\$ 484,525		\$ 489,022	\$ 4,497	\$ 3,168,084	1
2	Far West Resident Rooms: electric work, new outlets	2016	3,000	150		150		150	2
3	Nurses Station: electric work, install and relocate lights,	2016	3,200	160		160		160	3
4	install a call light								4
5									5
6	Demo ceiling and closet, install new can lights and ceiling tile	2016	7,502	375	10	375		375	6
7	in shower								7
8	Furnish and install conduit, paint in 32 resident rooms	2016	30,500	1,525	10	1,525		1,525	8
9	Furnish and install 94 double plug USB wall sockets	2016	7,850	393	10	393		393	9
10	Reface and revarnish one side of 27 doors	2016	4,950	248	10	248		248	10
11	Purchase of outdoor air-conditioning system	2016	6,303	315	10	315		315	11
12									12
13	Remove existing cove base, custom installation of vinyl tile in the								13
14	east wing resident rooms, light fixtures.								14
15	Demo and remove cabinets, ceiling, walls , doors, frames and	2016	565,784	28,289	10	28,289		28,289	15
16	bathroom fixtures in Physical Therapy room. Provide new conduit								16
17	and wiring to new switches, conduit boxes to smoke detectors.								17
18	Install counter tops and tiles in the bathrooms. Remove cove base,								18
19	install carpet tile in two offices. Furnish new acoustical ceiling								19
20	and lighting.								20
21									21
22									22
23									23
24									24
25									25
26									26
27	See Attached Schedule L:								27
28	Leasehold Improvements Allocated from Management Company:	1998	7,621						28
29	Leasehold Improvements Allocated from Management Company:	1999	3,182						29
30	Leasehold Improvements Allocated from Management Company:	2000	381						30
31	Leasehold Improvements Allocated from Management Company:	2008	1,147						31
32	Leasehold Improvements Allocated from Management Company:	2016	11,369			1,495	1,495	16,571	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,675,458	\$ 515,980		\$ 521,972	\$ 5,992	\$ 3,216,110	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 984,652	\$ 126,142	\$ 126,142	\$	5, 10 years	\$ 229,605	71
72	Current Year Purchases	190,388	18,482	18,482		10 years	18,482	72
73	Fully Depreciated Assets	2,526,410	2,434	2,434		5, 7 years	2,526,410	73
74	Allocated from Therapy Masters, Mgt Co:	61,348		694	694		52,382	74
75	TOTALS	\$ 3,762,798	\$ 147,058	\$ 147,752	\$ 694		\$ 2,826,879	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:			\$ 12,862	\$	\$ 307	\$ 307	5 years	\$ 12,706	76
77										77
78										78
79										79
80	TOTALS			\$ 12,862	\$	\$ 307	\$ 307		\$ 12,706	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)	\$ 17,830,751	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 663,038	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 670,031	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,993	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,055,695	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A.
- N/A

9. Option to Buy: ☐ YES ☒ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 59,167 Description: See Attached Schedule M
(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	Allocated from Management Company:		\$	\$ 5,805	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,805	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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

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.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Units	Cost				
1	Licensed Occupational Therapist	Ln10a,Col 3	hrs	\$	9,568	\$ 538,871	\$	9,568	\$ 538,871	1
2	Licensed Speech and Language Development Therapist	Ln10a,Col 3	hrs		1,996	118,860		1,996	118,860	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		15,405	872,501	2,887	15,405	875,388	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				417,356		417,356	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):	Ln 39, Col 3				45,291			45,291	13
14	TOTAL			\$	26,969	\$ 1,575,523	\$ 420,243	26,969	\$ 1,995,766	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.

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	\$ (1,485,350)	\$ 1,289,879	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,544,613	6,544,613	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	259,007	259,007	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Receivable from Insurance</u>	1,641,000	1,641,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,959,270	\$ 9,734,499	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,379,633	13
14	Buildings, at Historical Cost		9,308,703	14
15	Leasehold Improvements, at Historical Cost	514,146	2,366,755	15
16	Equipment, at Historical Cost	586,398	3,775,660	16
17	Accumulated Depreciation (book methods)	(389,788)	(6,055,695)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Mortgage Costs(net)</u>		449,571	22
23	Other(specify): <u>Due from Related Parties:</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 710,756	\$ 12,224,627	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,670,026	\$ 21,959,126	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,976,262	\$ 3,976,262	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	615,571	615,571	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	(47,944)	(47,944)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		146,000	32
33	Accrued Interest Payable	691,762	691,762	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule E:</u>	3,839,206	3,839,206	36
37	<u>Due to Related Parties:</u>	1,043,253	1,114,196	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,118,110	\$ 10,335,053	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,094,337	5,107,187	39
40	Mortgage Payable		14,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Stockholders:</u>	8,059,052	8,059,052	43
44	<u>Loan Payable - Line of Credit:</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,153,389	\$ 27,666,239	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,271,499	\$ 38,001,292	46
47	TOTAL EQUITY(page 18, line 24)	\$ (11,601,473)	\$ (16,042,166)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,670,026	\$ 21,959,126	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,655,281)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,655,281)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,946,192)	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)	\$ (2,946,192)	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)	\$ (11,601,473)	24

Operating Entity Only

* This must agree with page 17, line 47.

Facility Name & ID Number Brentwood North HC & Reh Ctr

0050112

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,866,256	1
2	Discounts and Allowances for all Levels	(1,617,526)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,248,730	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,203,623	6
7	Oxygen	51,139	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,254,762	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	7,607	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	391,101	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	84,600	19
20	Radiology and X-Ray	11,945	20
21	Other Medical Services	208,992	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 704,245	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	133	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 133	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,207,870	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,827,194	31
32	Health Care	7,000,034	32
33	General Administration	3,352,869	33
	B. Capital Expense		
34	Ownership	1,586,819	34
	C. Ancillary Expense		
35	Special Cost Centers	1,035,223	35
36	Provider Participation Fee	351,923	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,154,062	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,946,192)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,946,192)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,061,394	44
45	Private Pay - Net Inpatient Revenue	3,390,899	45
46	Medicare - Net Inpatient Revenue	4,264,740	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	517,920	47
48	Other-(specify)	13,777	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,248,730	49

* 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.

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

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	1,886	2,099	\$ 115,004	\$ 54.79	1
2	Assistant Director of Nursing	1,854	2,059	86,941	42.22	2
3	Registered Nurses	66,649	72,029	1,845,114	25.62	3
4	Licensed Practical Nurses	17,144	18,478	446,988	24.19	4
5	CNAs & Orderlies	121,727	132,255	1,932,658	14.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,870	2,059	30,185	14.66	9
10	Activity Assistants	7,334	8,330	105,506	12.67	10
11	Social Service Workers	5,746	6,296	138,972	22.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,029	9,082	141,316	15.56	14
15	Cook Helpers/Assistants	19,673	21,924	253,422	11.56	15
16	Dishwashers					16
17	Maintenance Workers	5,637	6,409	138,367	21.59	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,905	2,111	128,920	61.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,605	21,662	486,612	22.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,545	5,067	103,209	20.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerks</u>	1,149	1,245	23,678	19.02	33
34	TOTAL (lines 1 - 33)	284,753	311,105	\$ 5,976,892 *	\$ 19.21	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	\$ 14,155	Ln 1, Col 3	35
36	Medical Director	Monthly	145,606	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,150	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	12	612	Ln11, Col 3	44
45	Social Service Consultant	62	3,752	Ln12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	74	\$ 174,275		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,500	\$ 202,492	Ln10, Col 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,500	\$ 202,492		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Brentwood North HC & Reh Ctr

0050112

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Christopher Kropp	Administrator	0.00%	\$ 97,248	Workers' Compensation Insurance	\$ 69,385	IDPH License Fee	\$				
Philip Thompson	Administrator	0.00 %	31,672	Unemployment Compensation Insurance	29,406	Advertising: Employee Recruitment					699
				FICA Taxes	443,334	Health Care Worker Background Check					
				Employee Health Insurance	180,373	(Indicate # of checks performed 34)					340
				Employee Meals	27,252	Patient Background Checks	155				1,550
				Illinois Municipal Retirement Fund (IMRF)*							
				401K Match	11,918	See Attached Schedule K:					81,075
				Other Employee Benefits	3,909	Allocated from Therapy Masters, Inc.:					1,686
						Allocated from Management Company:					1,428
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	(				
(List each licensed administrator separately.)			\$ 128,920			Non-allowable advertising	(				
B. Administrative - Other						Yellow page advertising	(				
Description			Amount	Non-Allowable Marketing Employee Benefits:	(25,568)						
Management Fees (eliminated in Column 7)			\$ 1,163,544	See Attached Schedule D:	0						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,163,544	TOTAL (agree to Schedule V,	\$ 740,009						
(Attach a copy of any management service agreement)				line 22, col.8)							
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
			\$			\$	Out-of-State Travel	\$			
See Attached Schedule C:			222,005				In-State Travel				
							Seminar Expense				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				Entertainment Expense	(		
(For legal fee disclosure, see page 39 of instructions)			\$ 222,005			\$	(agree to Sch. V,				
							line 24, col. 8)	\$			
							TOTAL				

* Attach copy of IMRF notifications

**See instructions.

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 \$16,325

(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. \$ 53,950 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. \$ 351,923
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 benefit on Schedule V. \$ 27,252 Has any meal income been offset against related costs? No Indicate the amount. \$ No

(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? N/A
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2016

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
Brentwood Healthcare Real Estate LLC.	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Co.
Therapy Masters	Skokie	Therapy company

SCHEDULE B

SCHEDULE VII RELATED PARTIES

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

Name	Compensation Received From Other Nursing Homes								Total
	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Bridge Nursing & Rehab. Centre, Ltd.	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenShire Nursing & Rehab. Centre, Ltd.	Glen Lake Terrace Nursing & Rehab	Ballard Respiratory & Rehab	Glen Saint Andrew Living Comm	
Sidney Glenner	34,326	35,426	34,327	13,643	23,658	28,487	18,488	25,663	214,018
Jonathan Glenner	7,984	8,240	7,984	3,173	5,502	6,626	4,300	5,969	49,778
Daniel Glenner	28,726	29,647	28,727	11,417	19,798	23,840	15,472	21,477	179,104
Elliot Glenner	13,567	14,002	13,568	5,392	9,350	11,259	7,307	10,143	84,588
Total compensation received from other Nursing Homes	84,603	87,315	84,606	33,625	58,308	70,212	45,567	63,252	527,488

SCHEDULE C

XIX. SUPPORT SCHEDULES

C. Professional Services

Page 21

Vendor/Payee	Type	AMOUNT
Health Data Systems, Inc.	Computers	7,132
Point ClickCare	Computers	43,764
EHealth Data Solutions	Computers	4,170
Net Health	Computers	10,929
Kronos	Computers	16,322
Comcast Business	Computers	1,552
Microsoft Corporation	Computers	6,901
RSM US LLP	Accounting	29,556
Marcum	Accounting	350
Much Shelist	Legal	4,161
Marilyn P. Dunn	Legal	60
Meyers & Flowers LLC	Legal	282
Polsinelli	Legal	46,254
O'Hagan LLC	Legal	11,686
Vanek, Larson & Kolb LLC	Legal	180
Clark Hill PLC	Legal	1,219
Company Nurse	Workers Injury Consultation	1,520
Prospect Resources	Maintenance Consulting	1,500
2401 Incorporated	Construction Management	10,710
Personnel Planners, Inc.	Unemployment Consulting	885
Creative Technology Solutions	IT Consulting	1,402
Platinum Billing Solutions	A/R Collections	7,043
Total Schedule V, Line 19, Col. 3		207,578
Allocated from Management Co:		
Point ClickCare - Computer Services		1,317
Lexis Nexis - Computer Services		2
Health Data Systems, Inc. - Computer Services		89
Microsoft - Computer Services		519
Rosie Connectivity Solutions - Computer Services		38
Creative Technology Solutions - Computer Services		588
MB Financial - Legal		2,536
Marcum - Accounting		576
Govig - Recruiting		6,767
Perfect Staffing - Recruiting		1,184
Personnel Planners - Financial Consulting		17
Marilyn Dunn - Legal		15
Polsinelli - Legal		597
Much Shelist - Legal		330
Total allocated from Management Co.		14,575
Allocated from Therapy Masters, Inc.:		
Casamba - Computer Services		6,323
Health Data Services - Computer Services		201
VIRTU SENES - Computer Services		745
RSM US LLP- Accounting Services		257
O'Hagan LLC - Legal Services		1,378
Theracore - Business Consulting		44,104
Personnel Planners - Financial Consulting		110
Career Tree Network - Therapist Recruitment		5,913
Total allocated from Therapy Masters:		59,031
Allocated from Brentwood Healthcare Real Estate LLC:		
Marilyn Dunn - Legal		600
Skidelsky & Associates - Real Estate Tax Appraisal		8,320
Construction Loan Professional Fees		52,358
Total allocated from Brentwood Healthcare Real Estate LLC:		61,278
Reclass Skidelsky & Associates - Real Estate Tax Appraisal to Line 33		-8,320
Non-Allowable Expenses:		
RSM US LLP - Accounting Fees		-24,353
Platinum Billing Solutions - A/R Collections		-7,043
Marilyn Dunn - Legal - Construction Loan Professional Fees- Brentwood HC RE LLC		-600
Construction Loan Professional Fees - Brentwood HC RE LLC		-52,358
Much Shelist - Legal - A/R Collections		-3,933
Meyers & Flowers LLC - Legal - A/R Collections		-282
Polsinelli Shughart - Legal - Out of Period		-13,185
O'Hagan LLC - Legal - Out of Period		-8,984
Vaenk, Larson & Kolb LLC - Legal A/R Collections		-180
Clark Hill PLC - Legal Out of Period		-1,219
Total Non-Allowable Expenses:		-112,137
Total adjustments page 21, Sch C		14,427
Total Schedule V, line 19, column f		222,005

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

DESCRIPTION	AMOUNT
Allocated from Management Co:	
FICA taxes	27,041
FUTA	225
SUTA	1,376
401K Match	2,161
Insurance - Hospital	37,731
Workers Compensation Insurance	3,503
Total allocated from Management Co.	<u>72,037</u>
Employee Benefits reclassified to Lines 7, 27	-72,037
Allocated from Therapy Masters, Inc.:	
FICA taxes	90,848
FUTA	942
SUTA	1,559
401K Match	8,418
Insurance - Hospital	24,120
Workers Compensation Insurance	5,803
Total allocated from Therapy Masters, Inc. Co.	<u>131,690</u>
Employee Benefits reclassified to Lines 15,27	-131,690
Total allocated to Page 21	<u>0</u>

Brentwood North Healthcare and Rehabilitation Centre, Inc.
Provider I.D. # 50112
12/31/2016

SCHEDULE E

SUPPORT SCHEDULES

Page 17, Line 36

DESCRIPTION	AMOUNT
Accrued Expenses	0
Insurance Payable	163,988
Accrued 401K	1,182
Accrued Profit Sharing	231
Accrued Management Fees	1,956,612
Accrued Provider Participation Fee - Tax	75,899
Accrued Wage Assignment	30
Due Con Mutual	64
Credit Union	200
Advance from HFS	0
Professional Liability Claims	1,641,000
Total, Page 17, Line 36	3,839,206

SCHEDULE F

SCHEDULE VI. ADJUSTMENT DETAIL

Schedule A. Nonallowable Expenses

Page 5

DESCRIPTION	AMOUNT	REFERENCE
Patient clothing	-2,448	43
Non-allowable owner interest expense	-565,153	32
Non-allowable owner interest expense	-190,680	32
Non-allowable professional fees	-112,137	19
Non-allowable auto expense - marketing	-10,170	25
Non-allowable Illinois Council on Long Term Care PAC Fees	-8,041	20
Non-allowable marketing salaries	-206,976	21
Non-allowable marketing employee benefits	-25,568	22
Adjust mgt co. med supplies - med'A' to cost	-2,162	10
Adjust mgt co. med supplies - med'other' to cost	-13,206	10
Adjust mgt co. food to cost	-25,573	2
Adjust pharmacy expense to cost	-53,685	39
Total	-1,215,799	

Brentwood Healthcare Real Estate LLC
Accrued Real Estate Taxes
12/31/2016

SCHEDULE G

	Accrued 1/01/16	Payments	Expense	Accrued 12/31/16
Balance @ 1/01/16 - G/L# 230	(186,000.00)		(186,000.00)	
2015 Real Estate Taxes Paid		138,942.24	138,942.24	
Estimated 2016 real estate taxes:				
2015 taxes	138,942.24			
Estimated increase	5.00%			
Estimated 2016 taxes	145,889.35			
USE	146,000.00		146,000.00	(146,000.00)
Totals	(186,000.00)	138,942.24	98,942.24	(146,000.00)

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%
2011	160,692.09	10,960.61	7.32%
2012	168,134.10	7,442.01	4.63%
2013	174,219.12	6,085.02	3.62%
2014	176,667.78	2,448.66	1.41%
2015	138,942.24	(37,725.54)	-21.35%

Provider Name: Brentwood North HC Rehabilitation
Provider I.D. #: 50112
Year Ended: December 31, 2016

SCHEDULE H

Training & Education

Person(s) Attending	Date Attended	Location	Title Sponsor	Total Cost
Erika Streit	2/16/16, 2/17/16	Arlington Heights, IL	Illinois Activity Professsionals Association Dementia Seminar	285
Sarah Pappé	3/28/2016	Skokie, IL	Illinois Council on Long Term Care: What do you know about Sepsis?	125
Dietary Staff	6/6/2016	Lake Zurich, IL	Food Safety and Enviromental Solutions, LLC. Food Service Sanitation Manager Certification	500
Pamela May Valbuena	9/15/2016	Skokie, IL	Illinois Council on Long Term Care: October 1 Changes to Section S	80
MDS Department	10/5/2016	Riverwoods, IL	Pathway Health- MDS Training	550
Erika Streit	11/02/16	Park Ridge, IL	Advocate Lutheran General Hospital: Teepa 2016 Alzheimer/Dementia Conference	240
Alvin Almaria	10/13/2016	Oak Lawn, IL	Advocate Christ Hospital - ACMC Wound Conference	80
Cecillia Serrano	10/7/2016	Oak Lawn, IL	Ventricular Assist Device (VAD) Symposium	80
Nursing Staff	12/31/2016	Riverwoods, IL	RosieConnect 2.0 Training	750
			Allocated From Management Company	975
			Allocated From Therapy Masters	2,518
			Total	6,183

SCHEDULE I

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

	Gasoline Allowance	Employee Reimbursement: Mileage, Tolls, Parking	Total
Direct Expense	9,600	792	10,392
Non-allowable auto expense - marketing			-10,170
Allocated from Management Company			6,419
Allocated from Therapy Masters			2,211
TOTAL	9,600	792	8,852

SCHEDULE K

XIX. SUPPORT SCHEDULES

Page 21
F. Dues, Fees, Subscriptions and Promotions

DESCRIPTION	AMOUNT
Illinois Council on Long Term Care Dues	24,366
Employment Fees	60,000
Joint Commission Annual Certification, Program Fee	3,000
Secretary of State Annual Report Fee	125
State Fire Marshall Inspection Fee	100
Suburban Elevator Company Inspection Fee	299
Village of Riverwoods Inspection Fee	120
CLIA Laboratory User Fees	150
AANAC Dues	119
Lake County Health Dept & Comm Fees	837
Non-allowable Illinois Council on Long Term Care Dues	-8,041
Total allocated to Page 21	81,075

SCHEDULE M

Page14, Line 16
Rental Amount for Movable Equipment

	Copy Machine	Dish Machine	Postage	Ice- Maker	Therapy Equipment	Maintenance Equipment	Telephone System	Total
Direct Expense	3,920	1,319	555	1,200	22,257	824	26,229	56,304
Allocated from Management Company								2,863
Allocated from Therapy Masters								0
TOTAL	3,920	1,319	555	1,200	22,257	824	26,229	59,167