

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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>0037051</u></p> <p>Facility Name: <u>Glen Brook</u></p> <p>Address: <u>801 N 1st St Box 698</u> <u>Vienna</u> <u>62995</u> <small>Number City Zip Code</small></p> <p>County: <u>Johnson</u></p> <p>Telephone Number: <u>(618)658-2005</u> Fax # <u>(618)833-4993</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/08/1995</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ashley Alley</u> Telephone Number: <u>(618)833-5070 x11</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>1/1/2014</u> to <u>12/31/2014</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Ashley Alley</u> (Title) <u>Asst. Comptroller</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> 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>Ashley Alley</u> (Title) <u>Asst. Comptroller</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ashley Alley</u> (Title) <u>Asst. Comptroller</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Glen Brook

0037051 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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 5840

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,882			4,882	13
14	TOTALS	4,882			4,882	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.60%

D. How many bed-hold days during this year were paid by the Department?

42 (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 7/23/1990

J. Was the facility purchased or leased after January 1, 1978?

YES Date 7/23/1990 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Glen Brook

0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	28,997	2,831	420	32,248		32,248	(708)	31,540		1
2	Food Purchase		46,206		46,206		46,206	(11,551)	34,655		2
3	Housekeeping		9,857	978	10,835		10,835	(2,384)	8,451		3
4	Laundry		1,418	10	1,428		1,428	(355)	1,073		4
5	Heat and Other Utilities			21,047	21,047		21,047	(5,070)	15,977		5
6	Maintenance		5,873	8,131	14,004		14,004	1,643	15,647		6
7	Other (specify):*										7
8	TOTAL General Services	28,997	66,185	30,586	125,768		125,768	(18,425)	107,343		8
	B. Health Care and Programs										
9	Medical Director			5,100	5,100		5,100	(2,475)	2,625		9
10	Nursing and Medical Records	320,007	2,735	18,123	340,865		340,865	(73,457)	267,408		10
10a	Therapy		729	6,260	6,989		6,989		6,989		10a
11	Activities			60	60		60		60		11
12	Social Services		95	2,288	2,383		2,383	(47)	2,336		12
13	CNA Training	16,088		2,940	19,028		19,028		19,028		13
14	Program Transportation		5,756	2,561	8,317		8,317	(762)	7,555		14
15	Other (specify):* DT Program			158,137	158,137		158,137	(158,137)			15
16	TOTAL Health Care and Programs	336,095	9,315	195,469	540,879		540,879	(234,878)	306,001		16
	C. General Administration										
17	Administrative	18,447			18,447		18,447	4,735	23,182		17
18	Directors Fees										18
19	Professional Services			27,470	27,470		27,470	(24,478)	2,992		19
20	Dues, Fees, Subscriptions & Promotions			3,972	3,972		3,972	(734)	3,238		20
21	Clerical & General Office Expenses	17,560	6,308	8,205	32,073		32,073	6,361	38,434		21
22	Employee Benefits & Payroll Taxes			57,280	57,280		57,280	(12,936)	44,344		22
23	Inservice Training & Education			243	243		243		243		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,019	4,019		4,019	(1,336)	2,683		26
27	Other (specify):* Late Fee/Fin. Charge			153	153		153	(153)			27
28	TOTAL General Administration	36,007	6,308	101,342	143,657		143,657	(28,541)	115,116		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	401,099	81,808	327,397	810,304		810,304	(281,844)	528,460		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.

Facility Name & ID Number Glen Brook

#0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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			43,792	43,792	43,792	(27,932)	15,860				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			600	600	600	(101)	499				32
33	Real Estate Taxes			9,787	9,787	9,787	(489)	9,298				33
34	Rent-Facility & Grounds			57,600	57,600	57,600	(75,718)	(18,118)				34
35	Rent-Equipment & Vehicles			90	90	90	102	192				35
36	Other (specify):* Officer Life Ins.			1,101	1,101	1,101	(1,101)					36
37	TOTAL Ownership			112,970	112,970	112,970	(105,239)	7,731				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,937	31,937	31,937		31,937				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			31,937	31,937	31,937		31,937				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	401,099	81,808	472,304	955,211	955,211	(387,083)	568,128				45

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

Facility Name & ID Number Glen Brook

0037051

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

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	\$ (158,137)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,157)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(28,666)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(101)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,020)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(153)	27		18
19	Entertainment				19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance	(1,101)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 Pg. 5A	(139,411)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (331,146)		\$	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	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)	(55,937)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (55,937)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (387,083)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Glen Brook

ID# 0037051

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PAC Dues	\$ (96)	20	1
2	Personal Items/Clothing/Gifts/Etc.	(47)	12	2
3	CILA Dietary Expenses	(708)	1	3
4	CILA Food Purchase Expenses	(11,551)	2	4
5	CILA Houskeeping Expenses	(2,464)	3	5
6	CILA Laundry Expenses	(355)	4	6
7	CILA Utilities Expenses	(5,262)	5	7
8	CILA Maintenance Expenses	(3,580)	6	8
9	CILA Physician Expense	(1,275)	9	9
10	CILA Nursing Expenses	(5,254)	10	10
11	CILA Transportation Expenses	(1,426)	14	11
12	CILA Office Expenses	(2,198)	21	12
13	CILA Emp. Insurance & PR Tax Expenses	(13,781)	22	13
14	CILA Bldg & Liab Ins. Expenses	(1,459)	26	14
15	CILA Real Estate Tax Expenses	(638)	33	15
16	CILA Lease Bldg Expenses	(18,600)	34	16
17	CILA Finders Fee	(300)	20	17
18	CILA Employee Wages	(68,407)	10	18
19	CILA Medical Director Fees	(1,200)	9	19
20	CILA Consultant/Nursing Fees	(810)	10	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(139,411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glen Brook# 0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	(708)	0	0	0	0	0	0	0	0	0	0	(708)	1
2	Food Purchase	(11,551)	0	0	0	0	0	0	0	0	0	0	(11,551)	2
3	Housekeeping	(2,464)	80	0	0	0	0	0	0	0	0	0	(2,384)	3
4	Laundry	(355)	0	0	0	0	0	0	0	0	0	0	(355)	4
5	Heat and Other Utilities	(5,262)	192	0	0	0	0	0	0	0	0	0	(5,070)	5
6	Maintenance	(3,580)	214	5,009	0	0	0	0	0	0	0	0	1,643	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(23,920)	486	5,009	0	(18,425)	8							
	B. Health Care and Programs													
9	Medical Director	(2,475)	0	0	0	0	0	0	0	0	0	0	(2,475)	9
10	Nursing and Medical Records	(74,471)	0	1,014	0	0	0	0	0	0	0	0	(73,457)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(47)	0	0	0	0	0	0	0	0	0	0	(47)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,426)	664	0	0	0	0	0	0	0	0	0	(762)	14
15	Other (specify):*	(158,137)	0	0	0	0	0	0	0	0	0	0	(158,137)	15
16	TOTAL Health Care and Programs	(236,556)	664	1,014	0	(234,878)	16							
	C. General Administration													
17	Administrative	0	0	4,735	0	0	0	0	0	0	0	0	4,735	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,020)	59	(23,517)	0	0	0	0	0	0	0	0	(24,478)	19
20	Fees, Subscriptions & Promotions	(796)	62	0	0	0	0	0	0	0	0	0	(734)	20
21	Clerical & General Office Expenses	(2,198)	867	7,692	0	0	0	0	0	0	0	0	6,361	21
22	Employee Benefits & Payroll Taxes	(15,938)	3,002	0	0	0	0	0	0	0	0	0	(12,936)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,459)	123	0	0	0	0	0	0	0	0	0	(1,336)	26
27	Other (specify):*	(153)	0	0	0	0	0	0	0	0	0	0	(153)	27
28	TOTAL General Administration	(21,564)	4,113	(11,090)	0	(28,541)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(282,040)	5,263	(5,067)	0	(281,844)	29							

STATE OF ILLINOIS

Facility Name & ID Number Glen Brook# 0037051

Report Period Beginning:

1/1/2014

Ending:

Summary B

12/31/2014

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	(28,666)	734	0	0	0	0	0	0	0	0	0	(27,932)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(101)	0	0	0	0	0	0	0	0	0	0	(101)	32
33	Real Estate Taxes	(638)	149	0	0	0	0	0	0	0	0	0	(489)	33
34	Rent-Facility & Grounds	(18,600)	482	(57,600)	0	0	0	0	0	0	0	0	(75,718)	34
35	Rent-Equipment & Vehicles	0	102	0	0	0	0	0	0	0	0	0	102	35
36	Other (specify):*	(1,101)	0	0	0	0	0	0	0	0	0	0	(1,101)	36
37	TOTAL Ownership	(49,106)	1,467	(57,600)	0	(105,239)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(331,146)	6,730	(62,667)	0	0	0	0	0	0	0	0	(387,083)	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
James A. Keller	50	Mulberry Manor	Anna	kel-Tech Mgmt. Co	Anna	Mgmt Co.
Norine Keller	50			JR's Center	Anna	Workshop
				ILS	Anna & Metropolis	CILA's
				Krypton	Metropolis	CILA's
				Lincoln Square	Jonesboro & Dongola	CILA's
				Pilot House of Cairo	Cairo	CILA's
				CIL	Anna	CILA's

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	3 Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 80	\$	80	1
2	V	5 Heat & Other Utilities		kel-Tech Management Co.	25.00%	192		192	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	214		214	3
4	V	14 Program Transportation		kel-Tech Management Co.	25.00%	664		664	4
5	V	19 Professional Services		kel-Tech Management Co.	25.00%	59		59	5
6	V	20 Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	62		62	6
7	V	21 Clerical & General		kel-Tech Management Co.	25.00%	867		867	7
8	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	3,002		3,002	8
9	V	26 Insurance		kel-Tech Management Co.	25.00%	123		123	9
10	V	30 Depreciation		kel-Tech Management Co.	25.00%	734		734	10
11	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	149		149	11
12	V	34 Rent- Facility		kel-Tech Management Co.	25.00%	482		482	12
13	V	35 Rent - Equipment		kel-Tech Management Co.	25.00%	102		102	13
14	Total		\$			\$ 6,730	\$ *	6,730	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing	\$	kel-Tech Management Co.	25.00%	\$ 1,014	\$ 1,014
16	V	17 Administration		kel-Tech Management Co.	25.00%	4,735	4,735
17	V	21 Clerical		kel-Tech Management Co.	25.00%	7,692	7,692
18	V	6 Maintenance		kel-Tech Management Co.	25.00%	5,009	5,009
19	V						
20	V						
21	V	19 Professional Services	23,517	kel-Tech Management Co.	25.00%		(23,517)
22	V	34 Building Lease	57,600	Glen Brook Land Trust	100.00%		(57,600)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 81,117			\$ 18,450	\$ * (62,667)

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

Facility Name & ID Number

Glen Brook

0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	JoAnn Keller	50	Mulberry Manor	Anna				1
2	James K. Keller Family Trust	50	Mulberry Manor	Anna				2
3	Don Pippins	50			CIL	Anna	CILA's	3
4	Denise Pippins	50			CIL	Anna	CILA's	4
5	Don Pippins	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	5
6	Jacob L. Alley	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	6
7	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	7
8	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	8
9	Jacob L. Alley	33			ILS	Anna & Metropolis	CILA's	9
10	James A. Keller	33			ILS	Anna & Metropolis	CILA's	10
11	James K. Keller Family Trust	33			ILS	Anna & Metropolis	CILA's	11
12	JoAnn Keller	33			ILS	Anna & Metropolis	CILA's	12
13	JoAnn Keller	33			ILS Land Trust	Anna	Land Trust	13
14	Jacob L. Alley	33			ILS Land Trust	Anna	Land Trust	14
15	James A. Keller	33			ILS Land Trust	Anna	CILA's	15
16	James K. Keller Family Trust	33			ILS Land Trust	Anna	CILA's	16
17	Josh Alley	20			Krypton	Metropolis	CILA's	17
18	Jacob L. Alley	30			Krypton	Metropolis	CILA's	18
19	Diana Alley	30			Krypton	Metropolis	CILA's	19
20	Jacob L. Alley, II	20			Krypton	Metropolis	CILA's	20
21	Josh Alley	20			Lincoln Square	Jonesboro & Dongola	CILA's	21
22	Jacob L. Alley	30			Lincoln Square	Jonesboro & Dongola	CILA's	22
23	Diana Alley	30			Lincoln Square	Jonesboro & Dongola	CILA's	23
24	Jacob L. Alley, II	20			Lincoln Square	Jonesboro & Dongola	CILA's	24
25	JoAnn Keller	50			Pilot House of Cairo	Cairo	CILA's	25
26	James K. Keller Family Trust	50			Pilot House of Cairo	Cairo	CILA's	26
27	Denise Pippins	16			JR's Centre	Anna	Workshop	27
28	Don Pippins	16			JR's Centre	Anna	Workshop	28
29	JoAnn Keller	16			JR's Centre	Anna	Workshop	29
30								30

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James A. Keller	Owner/Admin.	Administrator	50.00		10.00	Admin.	\$ 18,447	17-1	1
2	Norine Keller	Officer	Director	50.00			Admin.	7,809	21-1	2
3										3
4	James M. Keller	RSD/QIDP	RSD/QIDP	0.00		10.00	RSD/QIDP	11,442	10-1	4
5										5
6										6
7	kel-Tech Allocation									7
8	Diana Alley						Nursing	1,014	19-3	8
9	Jacob Alley						Maintenance	3,857	19-3	9
10	James A. Keller						Administration	4,735	19-3	10
11										11
12										12
13							TOTAL	\$ 47,304		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 Glen Brook

0037051

Report Period Beginning:

1/1/2014

Ending: 2/31/2014

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

Name of Related Organization kel-Tech Management Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Houskeeping	Mgmt Fee Contribution	351,160	9	\$ 1,199	\$ 23,517	\$ 80	1
2	5	Utilities Elec/Gas	Mgmt Fee Contribution	351,160	9	2,476	23,517	166	2
3	5	Utilities Water	Mgmt Fee Contribution	351,160	9	395	23,517	26	3
4	6	Maint. Building	Mgmt Fee Contribution	351,160	9	385	23,517	26	4
5	6	Maint. Supplies	Mgmt Fee Contribution	351,160	9	687	23,517	46	5
6	6	Grounds Maint.	Mgmt Fee Contribution	351,160	9	618	23,517	41	6
7	6	Preventative Maint.	Mgmt Fee Contribution	351,160	9	180	23,517	12	7
8	14	Repairs Vehicle	Mgmt Fee Contribution	351,160	9	751	23,517	50	8
9	14	Transportation	Mgmt Fee Contribution	351,160	9	6,337	23,517	424	9
10	14	Insurance Vehicles	Mgmt Fee Contribution	351,160	9	2,011	23,517	135	10
11	14	Maint. Vehicle	Mgmt Fee Contribution	351,160	9	811	23,517	54	11
12	19	Legal & Accounting	Mgmt Fee Contribution	351,160	9	885	23,517	59	12
13	20	Dues Fees Subscriptions	Mgmt Fee Contribution	351,160	9	682	23,517	46	13
14	21	G & A Supplies	Mgmt Fee Contribution	351,160	9	6,028	23,517	404	14
15	21	Postage	Mgmt Fee Contribution	351,160	9	2,376	23,517	159	15
16	21	Bank Charges	Mgmt Fee Contribution	351,160	9	188	23,517	13	16
17	21	IT Services	Mgmt Fee Contribution	351,160	9	1,319	23,517	88	17
18	21	Copier Expense Service Calls	Mgmt Fee Contribution	351,160	9	103	23,517	7	18
19	21	G&A Misc.	Mgmt Fee Contribution	351,160	9	461	23,517	31	19
20	21	Software Expense	Mgmt Fee Contribution	351,160	9	1,149	23,517	77	20
21	21	Telephone	Mgmt Fee Contribution	351,160	9	1,283	23,517	86	21
22	21	Cell Phone Expense	Mgmt Fee Contribution	351,160	9	1,102	23,517	74	22
23	21	Utilities - Internet	Mgmt Fee Contribution	351,160	9	252	23,517	17	23
24	22	Ins. Emp. Group	Mgmt Fee Contribution	351,160	9	20,267	23,517	1,357	24
25	TOTALS					\$ 51,945	\$	\$ 3,478	25

Facility Name & ID Number Glen Brook

0037051

Report Period Beginning:

1/1/2014

Ending: 2/31/2014

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

Name of Related Organization kel-Tech Management Co.
 Street Address 158 E. Vienna St.
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	22	Ins. W/C	Mgmt Fee Contribution	351,160	9	\$ 3,263	\$ 23,517	\$ 219	1	
2	22	Payroll Tax Expense	Mgmt Fee Contribution	351,160	9	21,243	23,517	1,423	2	
3	22	Misc. Emp Benefits	Mgmt Fee Contribution	351,160	9	60	23,517	4	3	
4	26	Insurance Bldg & Liab	Mgmt Fee Contribution	351,160	9	1,833	23,517	123	4	
5	30	Depreciation	Mgmt Fee Contribution	351,160	9	10,959	23,517	734	5	
6	33	Real Estate Taxes	Mgmt Fee Contribution	351,160	9	2,226	23,517	149	6	
7	34	Lease Bldg	Mgmt Fee Contribution	351,160	9	7,200	23,517	482	7	
8	35	Lease Equip	Mgmt Fee Contribution	351,160	9	1,518	23,517	102	8	
9	10	Nursing	Mgmt Fee Contribution	351,160	9	15,139	15,139	23,517	1,014	9
10	17	Administration	Mgmt Fee Contribution	351,160	9	70,674	70,674	23,517	4,733	10
11	21	Clerical	Mgmt Fee Contribution	351,160	9	114,813	114,813	23,517	7,689	11
12	6	Maintenance	Mgmt Fee Contribution	351,160	9	74,755	74,755	23,517	5,006	12
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 323,683	\$ 275,381	\$ 21,678	25	

Facility Name & ID Number

Glen Brook

0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Old National Bank		X	Auto Loan - '12 Chevy E-350	\$675.00	6/11/2014	\$ 30,419	\$ 26,824	6/11/2018	3.1000	\$ 456	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Capaha Bank		X	Line of Credit		6/4/14			6/4/15	5.5000	43	6						
7												7						
8												8						
9	TOTAL Facility Related				\$675.00		\$ 30,419	\$ 26,824			\$ 499	9						
	B. Non-Facility Related*																	
10	US Bank		X	Auto Loan - '14 Ford Transit	\$425.00	11/20/2014	23,774	23,025	11/20/2018	2.8000	101	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related				\$425.00		\$ 23,774	\$ 23,025			\$ 101	14						
15	TOTALS (line 9+line14)						\$ 54,193	\$ 49,849			\$ 600	15						

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

* 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 2013 report.		\$	<u>10,558</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>8,798</u>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,760)</u>	3															
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>11,547</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.)		\$		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>9,787</u>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>8,686</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>8,865</u>	9																
	2011	<u>8,935</u>	10																
	2012	<u>9,014</u>	11																
	2013	<u>8,798</u>	12																
<u>Sch IX</u>		<u>9,787</u>																	
<u>kel-Tech Allocation</u>		<u>149</u>																	
<u>Non-Allowable CILA</u>		<u>-638</u>																	
<u>Sch V Line 33, Col. 8</u>		<u>9,298</u>																	

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glen Brook COUNTY Johnson
 FACILITY IDPH LICENSE NUMBER 0037051
 CONTACT PERSON REGARDING THIS REPORT Ashley Alley
 TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>08-05-238-008</u>	<u>Woodcrest Hills Lot 24 & 25</u>	\$ <u>8,160.44</u>	\$ <u>8,160.44</u>
2.	<u>06-32-214-001</u>	<u>PT NE QTR</u>	\$ <u>637.90</u>	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>8,798.34</u></u>	\$ <u><u>8,160.44</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? X YES 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Glen Brook

0037051 Report Period Beginning:

1/1/2014 Ending:

12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Brick/Vinyl Frame Wood Number of Stories 1

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>HealthCare</u>	<u>85,000</u>	<u>1989</u>	<u>\$ 18,000</u>	1
2					2
3	TOTALS	85,000		\$ 18,000	3

Facility Name & ID Number Glen Brook

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	16	1990	1990	\$ 220,501	\$	40	\$ 5,513	\$ 5,513	\$ 135,067
5									
6									
7									
8									
	Improvement Type**								
9	Improvements/Landscape	1990		2,156		20			2,156
10	Sidewalk/Driveway	1990		6,200		20			6,097
11	Driveway & Parking Lot	2004		12,802	378	15	854	476	8,966
12	Landscaping	2005		3,934	232	15	262	30	2,489
13	Tile Floor - Living Room	2006		2,784	165	15	186	21	1,511
14	Sprinkler Sys - Pendants	2006		6,450	381	15	430	49	3,494
15	Tubcut Improvement in Bathrooms	2014		3,084	1,677	15	180	(1,497)	180
16	Office Remodel	2014		1,453	736	15	12	(724)	12
17	Front Porch	2013		771	37	15		(37)	77
18	Tub Cut Improvement in Bathroom	2014		1,000	531	15		(531)	42
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Glen Brook

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	261,135	\$	4,137	\$	7,437	\$	3,300	\$	160,091	70

**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	\$ 33,071	\$ 208	\$ 2,349	\$ 2,141		\$ 10,648	71
72	Current Year Purchases	9,713	5,881	1,024	(4,857)		1,024	72
73	Fully Depreciated Assets	4,662					21,926	73
74	Non-Care Assets	18,664	4,006		(4,006)		3,754	74
75	TOTALS	\$ 66,110	\$ 10,095	\$ 3,373	\$ (6,722)		\$ 37,352	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	Healthcare	1999 Ford Van	1998	\$ 26,717	\$	\$	\$	5	\$ 26,717	76
77	Healthcare	2012 3500 Chevy Van	2014	27,326	17,079	3,416	(13,663)	5	3,416	77
78	Healthcare	2007 Kia Spectra	2012	4,500		900	900	5	2,550	78
79	See Pg 24			39,642	12,481		(12,481)		16,462	79
80	TOTALS			\$ 98,185	\$ 29,560	\$ 4,316	\$ (25,244)		\$ 49,145	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)	\$ 443,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,792	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,126	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (28,666)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 246,588	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	CILA Furniture/Fixtures/Equip.	\$ 18,664	\$ 4,006	\$ 3,754	86
87	2014 Ford Transit - CILA	23,774	12,481	594	87
88	Improvements	1,771	568	119	88
89	2006 Chevy Trailblazer	15,868		15,868	89
90					90
91	TOTALS	\$ 60,077	\$ 17,055	\$ 20,335	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: Related Party

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 90

Description: Water Cooler Lease

(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	488	1,746		2,234
4	Clinical Wages (b)	952	3,405		4,357
5	In-House Trainer Wages (c)	2,074	7,423		9,497
6	Transportation				
7	Contractual Payments	980	1,960		2,940
8	CNA Competency Tests				
9	TOTALS	\$ 4,494	\$ 14,534	\$	\$ 19,028
10	SUM OF line 9, col. 1 and 2 (e)	\$ 19,028			

- (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.

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	<u>5</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>4</u>
2. From other facilities (f)	
TOTAL TRAINED	9

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			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		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Glen Brook# 0037051Report Period Beginning: 1/1/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 34,420	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	124,830		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	32,625		8
9	Other(specify): <u>DSP Trn'g Reimb.</u>	1,890		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 193,765	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	32,279		15
16	Equipment, at Historical Cost	164,295		16
17	Accumulated Depreciation (book methods)	(157,934)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 38,640	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 232,405	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,470	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,908		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,770		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,910		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Credit Card Payable</u>	4,872		36
37	<u>Payroll Liabilities</u>	(845)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 50,085	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Auto Loans - Notes Payable</u>	49,849		43
44	<u>N/P - kel-Tech Management Co.</u>	15,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 64,849	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 114,934	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 117,471	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 232,405	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 158,971	1
2	Restatements (describe):		2
3	Adjustment made on previous Y/E	(637)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 158,334	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(27,863)	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	(13,000)	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)	\$ (40,863)	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)	\$ 117,471	24 *

* This must agree with page 17, line 47.

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	\$ 754,681	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 754,681	3
B. Ancillary Revenue			
4	Day Care	158,137	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 158,137	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	13,230	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,230	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain/Loss on Sale of Assets	1,300	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,300	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 927,348	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	125,768	31
32	Health Care	540,879	32
33	General Administration	143,657	33
B. Capital Expense			
34	Ownership	112,970	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	31,937	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 955,211	40
41	Income before Income Taxes (line 30 minus line 40)**	(27,863)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (27,863)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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.

Facility Name & ID Number Glen Brook

0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,996	2,145	20,331	9.48
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician	1,981	2,117	28,994	13.70
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	312	312	26,256	84.15
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,124	1,124	9,749	8.67
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,154	1,154	23,280	20.17
29	Resident Services Coordinator	1,732	1,764	34,461	19.54
30	Habilitation Aides (DD Homes)	25,001	25,523	258,028	10.11
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>See Pg. 24</u>				33
34	TOTAL (lines 1 - 33)	33,300	34,139	\$ 401,099 *	\$ 11.75

* 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	10	\$ 420	1-3
36	Medical Director	26	5,100	9-3
37	Medical Records Consultant			
38	Nurse Consultant	420	15,750	10-3
39	Pharmacist Consultant	15	505	10-3
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant	13	975	10a-3
44	Activity Consultant			
45	Social Service Consultant	44	2,200	12-3
46	Other(specify) <u>Behavioral Cons.</u>		3,750	10a-3
47	<u>Psychologist Consultant</u>	31	1,250	10a-3
48	<u>QMRP Consultant</u>	4	88	10a-3
49	TOTAL (lines 35 - 48)	563	\$ 30,038	

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
James A. Keller	Administrator	50	\$ 18,447	Workers' Compensation Insurance	\$ 15,631	IDPH License Fee	\$		
				Unemployment Compensation Insurance	6,907	Advertising: Employee Recruitment			
				FICA Taxes	30,393	Health Care Worker Background Check			
				Employee Health Insurance	875	(Indicate # of checks performed <u>2</u>)	80		
				Employee Meals	2,157	Patient Background Checks <u>5</u>	86		
				Illinois Municipal Retirement Fund (IMRF)*		See Pg. 24	3,010		
				Misc. Employee Benefits	1,317				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						kel-Tech Allocation	62		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,238		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount	kel-Tech Allocation	3,002				
			\$	Less: CILA Ins./Emp. Payroll Expenses	(13,781)				
				Less: Employee Meals	(2,157)				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Barnett & Levine	CPA		\$ 3,500			\$	Out-of-State Travel	\$	
FMGR	Legal		322						
kel-Tech Mgmt. Co.	Acct'g/Mgmt. Services		23,648				In-State Travel		
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL				TOTAL (agree to Sch. V, line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Glen Brook# 0037051

Report Period Beginning:

1/1/2014

Ending:

12/31/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Healthcare Assoc.-\$1,104 IL Assoc. ICF-DD Providers - \$200
- (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? _____
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 640 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. _____
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Glen Brook 0036384 1/1/1995
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,937
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? Yes 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? N/A
- (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. \$ 2,157 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Glen Brook, Inc.
 Detail for Sch XIX, Section F
 2014

IL Healthcare Assoc Dues	1,104
PAC Dues	96
IL Corp. Ann. Report	129
IL Association of ICF-DD Providers	200
PO Box Rental	112
Fingerprinting	360
Resident Surety Bond	500
Secretary of State	202
Finders Fee	300
Certificate of Good Standing	25
Bank Loan Origination Fee	378
Contributions	400
Less:	
PAC Dues	(96)
Finders Fee (CILA Exp.)	(300)
Contributions	(400)
 Total	 <u>\$ 3,010</u>

Glen Brook, Inc.
 Allocation of Cost for Employee
 Schedule XX, Question 12
 2014

Jordan Brown, RSD/QMRP	1/1/14-6/11/14
Salary	\$ 13,124
RSD	40% 5,250
QMRP	60% 7,874
Total	100% 13,124

Glen Brook of Vienna
 Reconciliation of Depreciation
 Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
 2014

Sch IX	\$ 15,126
kel-Tech Mgmt. Co. Alloc.	<u>734</u>
 Total on Sch V	 <u>\$ 15,860</u>

Glen Brook of Vienna
 Sch. XI

Use	Make/Model	Year Aquired	Cost	Book	S/L	Adj.	Life	Acc. Dep.
Healthcare	2006 Chevy Trailblaze	2006	15,868			3,416		5 15,868
Healthcare	2014 Ford Transit	2014	23,774	12,481		-12,481		5 594
Totals			39,642	12,481		3,416	-12,481	16,462