FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0037051

Facility Name: Glen Brook

Address: 801 N 1st St Box 698 (Number) Vienna (City) 62995 (Zip Code)

County: Johnson

Telephone Number: (618) 658-2005 **Fax #** (618) 833-4993

HFS ID Number:

Date of Initial License for Current Owners: 08/08/1995

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [X] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Ashley Alley **Telephone Number:** (618) 833-5070 x11
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 to 12/31/2013 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Ashley Alley
(Title) Asst. Comptroller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,769			4,769	13
14	TOTALS	4,769			4,769	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.66%

D. How many bed-hold days during this year were paid by the Department?
49 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/23/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/23/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided ____

Medicare Intermediary ____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	24,890	2,175	490	27,555		27,555	(65)	27,490			1
2	Food Purchase		39,066		39,066		39,066	(1,150)	37,916			2
3	Housekeeping		6,658	2,099	8,757		8,757	(1,341)	7,416			3
4	Laundry		1,175	125	1,300		1,300	(35)	1,265			4
5	Heat and Other Utilities			15,286	15,286		15,286	(1,564)	13,722			5
6	Maintenance		6,761	4,608	11,369		11,369	2,335	13,704			6
7	Other (specify):*											7
8	TOTAL General Services	24,890	55,835	22,608	103,333		103,333	(1,820)	101,513			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	211,100	3,497	18,254	232,851		232,851	960	233,811			10
10a	Therapy		167	3,197	3,364		3,364		3,364			10a
11	Activities	9,989		56	10,045		10,045		10,045			11
12	Social Services		210		210		210	(210)				12
13	CNA Training	10,603		1,225	11,828		11,828		11,828			13
14	Program Transportation		6,001	2,551	8,552		8,552	195	8,747			14
15	Other (specify):* Day Training			161,512	161,512		161,512	(161,512)				15
16	TOTAL Health Care and Programs	231,692	9,875	190,095	431,662		431,662	(160,567)	271,095			16
	C. General Administration											
17	Administrative	25,845			25,845		25,845	5,037	30,882			17
18	Directors Fees											18
19	Professional Services			26,360	26,360		26,360	(23,920)	2,440			19
20	Dues, Fees, Subscriptions & Promotions			1,939	1,939		1,939	(211)	1,728			20
21	Clerical & General Office Expenses	1,582	2,498	5,775	9,855		9,855	7,861	17,716			21
22	Employee Benefits & Payroll Taxes			36,664	36,664		36,664	2,286	38,950			22
23	Inservice Training & Education			90	90		90		90			23
24	Travel and Seminar			1,573	1,573		1,573		1,573			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,093	2,093		2,093	(552)	1,541			26
27	Other (specify):* Late Fee/Fin. Charge			86	86		86	(86)				27
28	TOTAL General Administration	27,427	2,498	74,580	104,505		104,505	(9,585)	94,920			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	284,009	68,208	287,283	639,500		639,500	(171,972)	467,528			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:** 01/01/2013 **Ending:** 12/31/2013

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,881	16,881		16,881	(5,663)	11,218			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			10,532	10,532		10,532	(501)	10,031			33
34	Rent-Facility & Grounds			42,100	42,100		42,100	(44,685)	(2,585)			34
35	Rent-Equipment & Vehicles			92	92		92	30	122			35
36	Other (specify):*			2,208	2,208		2,208	(2,181)	27			36
37	**TOTAL Ownership**			71,813	71,813		71,813	(53,000)	18,813			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			35,595	35,595		35,595		35,595			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			35,595	35,595		35,595		35,595			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	284,009	68,208	394,691	746,908		746,908	(224,972)	521,936			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: 01/01/2013 Ending: 12/31/2013

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	$ (161,512)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(812)	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	(5,813)	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				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	(86)	27		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance	(848)	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	(1,333)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pg. 5A	(14,186)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (184,690)		$	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)	(40,282)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,282)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (224,972)		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.			$		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

STATE OF ILLINOIS **Page 5A**

Glen Brook

ID# 0037051

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (58)	20	1
2	Personal Items/Clothing/Gifts/Etc.	(210)	12	2
3	NHA License Renewal	(103)	20	3
4	CILA Dietary Expenses	(65)	1	4
5	CILA Food Purchase Expenses	(1,150)	2	5
6	CILA Houskeeping Expenses	(1,414)	3	6
7	CILA Laundry Expenses	(35)	4	7
8	CILA Utilities Expenses	(1,779)	5	8
9	CILA Maintenance Expenses	(3,406)	6	9
10	CILA Nursing Expenses	(105)	10	10
11	CILA Transportation Expenses	(699)	14	11
12	CILA Office Expenses	(691)	21	12
13	CILA Insurance Expenses	(688)	26	13
14	CILA Rental Expenses	(3,100)	34	14
15	CILA Real Estate Taxes	(683)	33	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,186)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(65)	0	0	0	0	0	0	0	0	0	0	(65)	1
2	Food Purchase	(1,150)	0	0	0	0	0	0	0	0	0	0	(1,150)	2
3	Housekeeping	(1,414)	73	0	0	0	0	0	0	0	0	0	(1,341)	3
4	Laundry	(35)	0	0	0	0	0	0	0	0	0	0	(35)	4
5	Heat and Other Utilities	(1,779)	215	0	0	0	0	0	0	0	0	0	(1,564)	5
6	Maintenance	(3,406)	456	5,285	0	0	0	0	0	0	0	0	2,335	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,849)	744	5,285	0	0	0	0	0	0	0	0	(1,820)	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	(105)	0	1,065	0	0	0	0	0	0	0	0	960	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	(210)	0	0	0	0	0	0	0	0	0	0	(210)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(699)	894	0	0	0	0	0	0	0	0	0	195	14
15	Other (specify):*	(161,512)	0	0	0	0	0	0	0	0	0	0	(161,512)	15
16	**TOTAL Health Care and Programs**	(162,526)	894	1,065	0	0	0	0	0	0	0	0	(160,567)	16
	C. General Administration													
17	Administrative	0	0	5,037	0	0	0	0	0	0	0	0	5,037	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	80	(24,000)	0	0	0	0	0	0	0	0	(23,920)	19
20	Fees, Subscriptions & Promotions	(261)	50	0	0	0	0	0	0	0	0	0	(211)	20
21	Clerical & General Office Expenses	(691)	1,049	7,503	0	0	0	0	0	0	0	0	7,861	21
22	Employee Benefits & Payroll Taxes	(812)	3,098	0	0	0	0	0	0	0	0	0	2,286	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	(688)	136	0	0	0	0	0	0	0	0	0	(552)	26
27	Other (specify):*	(86)	0	0	0	0	0	0	0	0	0	0	(86)	27
28	**TOTAL General Administration**	(2,538)	4,413	(11,460)	0	0	0	0	0	0	0	0	(9,585)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(172,913)	6,051	(5,110)	0	0	0	0	0	0	0	0	(171,972)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(5,813)	150	0	0	0	0	0	0	0	0	0	(5,663)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(683)	182	0	0	0	0	0	0	0	0	0	(501)	33
34	Rent-Facility & Grounds	(3,100)	515	(42,100)	0	0	0	0	0	0	0	0	(44,685)	34
35	Rent-Equipment & Vehicles	0	30	0	0	0	0	0	0	0	0	0	30	35
36	Other (specify):*	(2,181)	0	0	0	0	0	0	0	0	0	0	(2,181)	36
37	**TOTAL Ownership**	(11,777)	877	(42,100)	0	0	0	0	0	0	0	0	(53,000)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(184,690)	6,928	(47,210)	0	0	0	0	0	0	0	0	(224,972)	45

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. Services
Norine Keller	50	Lincoln Square	Jonesboro	JR's Center	Anna	Workshop
		Pilot House of Cairo	Cairo	ILS 1-3 & 5-6	Anna	CILA
		Krypton	Metropolis	IlS 4	Metropolis	CILA
			Anna	ILS Land Trust	Anna	Land Trust
				CIL	Anna	CILA

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Houskeeping	$	kel-Tech Management Co.	25.00%	$ 73	$ 73	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	215	215	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	456	456	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	894	894	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	80	80	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	50	50	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	1,049	1,049	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	3,098	3,098	8
9	V	26	Insurance		kel-Tech Management Co.	25.00%	136	136	9
10	V	30	Depreciation		kel-Tech Management Co.	25.00%	150	150	10
11	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	182	182	11
12	V	34	Rent- Facility		kel-Tech Management Co.	25.00%	515	515	12
13	V	35	Rent - Equipment		kel-Tech Management Co.	25.00%	30	30	13
14	Total			$			$ 6,928	$ * 6,928	14

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing	$	kel-Tech Management Co.	25.00%	$ 1,065	$ 1,065	15
16	V	17	Administration		kel-Tech Management Co.	25.00%	5,037	5,037	16
17	V	21	Clerical		kel-Tech Management Co.	25.00%	7,503	7,503	17
18	V	6	Maintenance		kel-Tech Management Co.	25.00%	5,285	5,285	18
19	V								19
20	V								20
21	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	21
22	V	34	Building Lease	42,100	Glen Brook Land Trust	100.00%		(42,100)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,100			$ 18,890	$ * (47,210)	39

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Jacob L. Alley	50	Lincoln Square	Jonesboro				1
2	Diana Alley	50	Lincoln Square	Jonesboro				2
3	Jacob L. Alley	30	Krypton	Metropolis				3
4	Diana Alley	30	Krypton	Metropolis				4
5	James K. Keller Family Trust	50	Pilot House	Cairo				5
6	JoAnn Keller	50	Pilot House	Cairo				6
7	JoAnn Keller	50	Mulberry Manor	Anna				7
8	James K. Keller Family Trust	50	Mulberry Manor	Anna				8
9	Don Pippins	50			CIL	Anna	CILA	9
10	Denise Pippins	50			CIL	Anna	CILA	10
11	Don Pippins	50			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	11
12	Jacob L. Alley	50			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	12
13	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	13
14	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	14
15	Don Pippins	25			Independent Living Se	Anna	CILA	15
16	Jacob L. Alley	25			Independent Living Se	Anna	CILA	16
17	James A. Keller	25			Independent Living Se	Anna	CILA	17
18	James K. Keller Family Trust	25			Independent Living Se	Anna	CILA	18
19	Don Pippins	25			ILS Land Trust	Anna	Land Trust	19
20	Jacob L. Alley	25			ILS Land Trust	Anna	Land Trust	20
21	James A. Keller	25			ILS Land Trust	Anna	Land Trust	21
22	James K. Keller Family Trust	25			ILS Land Trust	Anna	Land Trust	22
23	JoAnn Keller	25			JR Center	Anna	Workshop	23
24	Don Pippins	12.5			JR Center	Anna	Workshop	24
25	JoAnn Keller	25			ILS Land Trust	Anna	Land Trust	25
26	Jacob L. Alley, II	20			Krypton	Metropolis	CILA	26
27	Josh Alley	20			Krypton	Metropolis	CILA	27
28	Jacob L. Alley	30			Krypton	Metropolis	CILA	28
29	Diana Alley	30			Krypton	Metropolis	CILA	29
30								30

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James A. Keller	Owner/Admin.	Administrator	50.00		4	10.00	Admin.	$ 18,030	17-1	1
2	Norine Keller	Officer	Director	50.00				Director	7,815	21-1	2
3											3
4	James M. Keller	RSD	RSD	0.00		40	100.00	RSD	7,977	10-1	4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	1,065	19-3	8
9	Jacob Alley							Maintenance	4,069	19-3	9
10	James A. Keller							Administration	5,037	19-3	10
11											11
12											12
13								TOTAL	$ 43,993		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: 01/01/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Houskeeping	Mgmt Fee Contribution	335,796	8	$ 1,016	$	24,000	$ 73	1
2	5	Utilities Elec/Gas	Mgmt Fee Contribution	335,796	8	2,633		24,000	188	2
3	5	Utilities Water	Mgmt Fee Contribution	335,796	8	380		24,000	27	3
4	6	Maint. Building	Mgmt Fee Contribution	335,796	8	220		24,000	16	4
5	6	Maint. Supplies	Mgmt Fee Contribution	335,796	8	916		24,000	65	5
6	6	Grounds Maint.	Mgmt Fee Contribution	335,796	8	1,046		24,000	75	6
7	14	Maint. Vehicle	Mgmt Fee Contribution	335,796	8	1,133		24,000	81	7
8	14	Repairs Vehicle	Mgmt Fee Contribution	335,796	8	3,326		24,000	238	8
9	14	Transportation	Mgmt Fee Contribution	335,796	8	7,026		24,000	502	9
10	14	Insurance Vehicles	Mgmt Fee Contribution	335,796	8	1,028		24,000	73	10
11	19	Legal & Accounting	Mgmt Fee Contribution	335,796	8	1,115		24,000	80	11
12	20	Dues Fees Subscriptions	Mgmt Fee Contribution	335,796	8	699		24,000	50	12
13	21	G & A Supplies	Mgmt Fee Contribution	335,796	8	6,651		24,000	475	13
14	21	Postage	Mgmt Fee Contribution	335,796	8	2,122		24,000	152	14
15	21	Bank Charges	Mgmt Fee Contribution	335,796	8	131		24,000	9	15
16	21	IT Services	Mgmt Fee Contribution	335,796	8	1,580		24,000	113	16
17	21	Copier Expense Service Calls	Mgmt Fee Contribution	335,796	8	72		24,000	5	17
18	21	G&A Misc.	Mgmt Fee Contribution	335,796	8	195		24,000	14	18
19	21	Software Expense	Mgmt Fee Contribution	335,796	8	796		24,000	57	19
20	21	Telephone	Mgmt Fee Contribution	335,796	8	1,514		24,000	108	20
21	21	Cell Phone Expense	Mgmt Fee Contribution	335,796	8	1,246		24,000	89	21
22	21	Utilities - Internet	Mgmt Fee Contribution	335,796	8	369		24,000	26	22
23	22	Ins. Emp. Group	Mgmt Fee Contribution	335,796	8	19,832		24,000	1,417	23
24	22	Insurance W/C	Mgmt Fee Contribution	335,796	8	3,124		24,000	223	24
25	TOTALS					$ 58,170	$		$ 4,156	25

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Payroll Tax Expense	Mgmt Fee Contribution	335,796	8	$ 20,383	$	24,000	$ 1,457	1
2	22	Misc. Emp Benefits	Mgmt Fee Contribution	335,796	8	(7)		24,000	(1)	2
3	26	Insurance Bldg & Liab	Mgmt Fee Contribution	335,796	8	1,898		24,000	136	3
4	30	Depreciation	Mgmt Fee Contribution	335,796	8	2,100		24,000	150	4
5	33	Real Estate Taxes	Mgmt Fee Contribution	335,796	8	1,553		24,000	111	5
6	34	Lease Bldg	Mgmt Fee Contribution	335,796	8	7,200		24,000	515	6
7	35	Lease Equip	Mgmt Fee Contribution	335,796	8	425		24,000	30	7
8	10	Nursing	Mgmt Fee Contribution	335,796	8	14,898	14,898	24,000	1,065	8
9	17	Administration	Mgmt Fee Contribution	335,796	8	70,454	70,454	24,000	5,035	9
10	21	Clerical	Mgmt Fee Contribution	335,796	8	104,937	104,937	24,000	7,500	10
11	6	Maintenance	Mgmt Fee Contribution	335,796	8	73,919	73,919	24,000	5,283	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 297,760	$ 264,208		$ 21,281	25

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capaha Bank		X	Line of Credit		5/4/13			5/4/14	5.5000		6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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.)**

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 9,040	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.)		$ 9,014	2
3. Under or (over) accrual (line 2 minus line 1).		$ (26)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,558	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.		$ 10,532	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008	7,580	8
2009	8,686	9
2010	8,865	10
2011	8,935	11
2012	9,014	12

Sch IX	10,532
kel-Tech Allocation	182
Non-Allowable CILA	(683)
Sch V Line 33, Col. 8	10,031

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-05-238-008	Woodcrest Hills Lot 24 & 25	$ 9,014.26	$ 9,014.26
2.	06-32-214-001	PT NE QTR.	$ 623.16	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 9,637.42	$ 9,014.26

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

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 [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HealthCare	85,000	1989	$ 18,000	1
2					2
3	TOTALS	85,000		$ 18,000	3

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1990	1990	$ 220,501	$	40	$ 5,513	$ 5,513	$ 129,554	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements/Landscape			1990	2,156		20			2,156	9
10	Sidewalk/Driveway			1990	6,200		20			6,097	10
11	Driveway & Parking Lot			2004	12,802	378	15	854	476	8,112	11
12	Landscaping			2005	3,934	232	15	262	30	2,227	12
13	Tile Floor - Living Room			2006	2,784	164	15	186	22	1,325	13
14	Sprinkler Sys - Pendents			2006	6,450	381	15	430	49	3,064	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	
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)		$ 254,827	$ 1,155		$ 7,245	$ 6,090	$ 152,535	70

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 13,741	$ 208	$ 1,884	$ 1,676		$ 9,106	71
72	Current Year Purchases	4,894	4,528	1,039	(3,489)		440	72
73	Fully Depreciated Assets	20,804					20,804	73
74	Non-Care Assets	10,371	10,371		(10,371)		1,039	74
75	TOTALS	$ 49,810	$ 15,107	$ 2,923	$ (12,184)		$ 31,389	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	$	$	$		$ 26,717	76
77	Healthcare	2004 Chevy Trailblazer	2006	15,868	619		(619)		15,868	77
78	Healthcare	2007 Kia Spectra	2012	4,500		900	900		1,650	78
79										79
80	TOTALS			$ 47,085	$ 619	$ 900	$ 281		$ 44,235	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)	$ 369,722	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,881	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 11,068	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,813)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 228,159	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	furnishings/Appliances New 2013	$ 10,371	$ 10,371	$ 10,371	86
87	CILA				87
88					88
89					89
90					90
91	TOTALS	$ 10,371	$ 10,371	$ 10,371	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.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 92 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.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	44

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	86

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)	231	1,353		1,584
4	Clinical Wages (b)	450	2,638		3,088
5	In-House Trainer Wages (c)	865	5,066		5,931
6	Transportation				
7	Contractual Payments	245	980		1,225
8	CNA Competency Tests				
9	TOTALS	$ 1,791	$ 10,037	$	$ 11,828
10	SUM OF line 9, col. 1 and 2 (e)	$ 11,828			

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	5

(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.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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.

STATE OF ILLINOIS

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 10,737	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	150,968		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)	34,068		8
9	Other(specify): DSP Trn'g Reimb.	3,997		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 199,770	$	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	26,742		15
16	Equipment, at Historical Cost	96,167		16
17	Accumulated Depreciation (book methods)	(114,142)		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)**	$ 8,767	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 208,537	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,018	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	150		28
29	Short-Term Notes Payable	1,664		29
30	Accrued Salaries Payable	9,916		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,326		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,934		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Credit Card Payable	1,391		36
37	Payroll Liabilities	(3,833)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 29,566	$	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	Line of Credit - Capaha Bank	5,000		43
44	N/P - Kel-Tech Mgmt. Co.	15,000		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 20,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 49,566	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 158,971	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 208,537	$	48

***(See instructions.)**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 248,500	1	
2	Restatements (describe):		2	
3	**Adjustment made on Previous Y/E**	280	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 248,780	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(31,809)	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	(58,000)	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)**	$ (89,809)	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)**	$ 158,971	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 547,541	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 547,541	3
	B. Ancillary Revenue		
4	Day Care	161,512	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 161,512	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	5,792	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)**	$ 5,792	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 254	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)**	$ 715,099	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	103,333	31
32	Health Care	431,662	32
33	General Administration	104,505	33
	B. Capital Expense		
34	Ownership	71,813	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	35,595	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 746,908	40
41	**Income before Income Taxes (line 30 minus line 40)****	(31,809)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (31,809)	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: 01/01/2013 Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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	1,039	1,072	9,989	9.32	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	1,601	1,851	24,890	13.45	12
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	208	208	18,030	86.68	20
21	Assistant Administrator					21
22	Other Administrative	104	104	7,815	75.14	22
23	Office Manager					23
24	Clerical	180	180	1,582	8.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	708	708	21,289	30.07	28
29	Resident Services Coordinator	472	472	14,193	30.07	29
30	Habilitation Aides (DD Homes)	17,390	18,353	186,221	10.15	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,702	22,948	$ 284,009 *	$ 12.38	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	12	$ 490	1-3	35
36	Medical Director	18	3,300		36
37	Medical Records Consultant				37
38	Nurse Consultant	400	15,000	10-3	38
39	Pharmacist Consultant	3	161	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	975	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental Consultant	As Needed	1,023	10a-3	46
47	QMRP Consultant	40	788	10a-3	47
48	Psychologist Consultant	40	1,600	10a-3	48
49	TOTAL (lines 35 - 48)	526	$ 23,337		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James A. Keller	Administrator	50	$ 18,030
Norine Keller	Director	50	7,815
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 25,845

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Barnett & Levine	CPA	$ 2,330
FMGR	Legal	30
kel-Tech Mgmt. Co.	Acct'g/Mgmt. Services	24,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,360

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,231
Unemployment Compensation Insurance	5,177
FICA Taxes	21,522
Employee Health Insurance	587
Employee Meals	812
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	335
kel-Tech Allocation	3,098
Less: Employee Meals	(812)
TOTAL (agree to Schedule V, line 22, col.8)	$ 38,950

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
See Pg. 24	1,678
kel-Tech Allocation	50
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,728

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	754
Seminar Expense	819
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,573

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Amount of Expense Amortized Per Year								
					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:** 01/01/2013 **Ending:** 12/31/2013

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 Association $801**

(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. $ **312** 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 01/01/1995

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **35,595**
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? **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. $ **812** 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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Glen Brook, In.
Detail for Sch XIX, Section F
2013

Subscriptions/Memberships		156
IL Healtcare Assoc Dues		736
IL Corp. Ann. Report		129
PAC Dues		131
PO Box Rental		106
Fingerprinting		280
Delivery Fee/Intuit Fee		46
Resident Surety Bond		225
NHA License Renewal		103
Less:		
	PAC Dues	(131)
	NHA License Renewal	(103)
Total		$ 1,678

Glen Brook, Inc.
Detail for Sch V, Line 36, Column 3
2013

Officer's Life Insurance	848
Tax Penalties	27
State Income Tax	1333
Total	$2,208

Glen Brook, Inc.
Allocation of Cost for Employee
Schedule XX, Question 12
2013

Jimmy Keller, RSD/QMRP	1/1/13-3/20/13		
Salary			$ 7,977
	RSD	40%	3,191
	QMRP	60%	4,786
Total		100%	7,977
Jordan Brown, RSD/QMRP	3/20/13-12/31/13		
Salary			$ 27,334
	RSD	40%	10,994
	QMRP	60%	16,400
Total		100%	27,394

Glen Brook of Vienna
Reconciliation of Depreciation
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
2013

Sch IX	$ 11,068
CILA Depreciation Expenses kel-Tech Mgmt. Co. Alloc.	150
Total on Sch V	$ 11,218