FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 1/1/2015 to 12/31/2015 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: 1/1/2015 Ending: 12/31/2015

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 5856

	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		ICF/DD 16 or Less	16	5,856	6
7		TOTALS	16	5,856	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	3,177			3,177	13
14	TOTALS	3,177			3,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.25%

D. How many bed-hold days during this year were paid by the Department?
102 (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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 7/23/1990 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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	34,669	2,276	490	37,435		37,435	(1,047)	36,388			1
2	Food Purchase		49,547		49,547		49,547	(22,792)	26,755			2
3	Housekeeping		7,548	300	7,848		7,848	(3,395)	4,453			3
4	Laundry		2,039	71	2,110		2,110	(938)	1,172			4
5	Heat and Other Utilities			21,157	21,157		21,157	(9,516)	11,641			5
6	Maintenance		7,703	7,840	15,543		15,543	614	16,157			6
7	Other (specify):*											7
8	**TOTAL General Services**	34,669	69,113	29,858	133,640		133,640	(37,074)	96,566			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	391,611	2,809	17,083	411,503		411,503	(8,128)	403,375			10
10a	Therapy		512	1,985	2,497		2,497	(235)	2,262			10a
11	Activities		543		543		543		543			11
12	Social Services		186	1,050	1,236		1,236	(186)	1,050			12
13	CNA Training	14,153		1,470	15,623		15,623	(1,525)	14,098			13
14	Program Transportation		6,668	3,916	10,584		10,584	(3,418)	7,166			14
15	Other (specify):* DT Program			73,176	73,176		73,176	(73,176)				15
16	**TOTAL Health Care and Programs**	405,764	10,718	103,480	519,962		519,962	(86,668)	433,294			16
	C. General Administration											
17	Administrative	18,392			18,392		18,392	4,792	23,184			17
18	Directors Fees			600	600		600		600			18
19	Professional Services			38,693	38,693		38,693	(23,110)	15,583			19
20	Dues, Fees, Subscriptions & Promotions			3,897	3,897		3,897	85	3,982			20
21	Clerical & General Office Expenses	11,819	4,854	8,831	25,504		25,504	5,306	30,810			21
22	Employee Benefits & Payroll Taxes			63,090	63,090		63,090	(29,044)	34,046			22
23	Inservice Training & Education			621	621		621	(286)	335			23
24	Travel and Seminar			1,235	1,235		1,235		1,235			24
25	Other Admin. Staff Transportation			5,335	5,335		5,335		5,335			25
26	Insurance-Prop.Liab.Malpractice							(2,331)	(2,331)			26
27	Other (specify):* Late Fee/Finance Charge			63	63		63	(59)	4			27
28	**TOTAL General Administration**	30,211	4,854	122,365	157,430		157,430	(44,647)	112,783			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	470,644	84,685	255,703	811,032		811,032	(168,389)	642,643			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:** 1/1/2015 **Ending:** 12/31/2015

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			13,450	13,450		13,450	14,171	27,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,324	1,324		1,324	(518)	806			32
33	Real Estate Taxes			12,332	12,332		12,332	(3,838)	8,494			33
34	Rent-Facility & Grounds			79,600	79,600		79,600	(119,718)	(40,118)			34
35	Rent-Equipment & Vehicles			45	45		45	120	165			35
36	Other (specify):* **Life Ins. Officer**			595	595		595	(595)				36
37	**TOTAL Ownership**			107,346	107,346		107,346	(110,378)	(3,032)			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			28,620	28,620		28,620		28,620			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			28,620	28,620		28,620		28,620			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	470,644	84,685	391,669	946,998		946,998	(278,767)	668,231			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: 1/1/2015 Ending: 12/31/2015

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	$ (73,176)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,269)	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	13,096	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	(587)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(925)	19		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(63)	27		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance	(595)	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	(136,893)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,512)		$	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)	(77,255)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (77,255)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (278,767)		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: 1/1/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (88)	20	1
2	Personal Items/Clothing/Gifts/Etc.	(186)	12	2
3	CILA Dietary Expenses	(1,047)	1	3
4	CILA Food Expenses	(22,792)	2	4
5	CILA Housekeeping Expenses	(3,472)	3	5
6	CILA Laundry Expenses	(938)	4	6
7	CILA Utlities Expenses	(9,732)	5	7
8	CILA Maintenance Expenses	(3,606)	6	8
9	CILA Nursing Expenses	(9,150)	10	9
10	CILA Program Expenses	(235)	10a	10
11	CILA DSP Training Expenses	(1,525)	13	11
12	CILA Transportation Expenses	(3,711)	14	12
13	CILA Office Expenses	(4,062)	21	13
14	CILA Emp. Ins. & PR Tax Expenses	(29,021)	22	14
15	CILA Inservice Training Expenses	(286)	23	15
16	CILA Bldg & Liab. Ins. Expenses	(2,454)	26	16
17	CILA Real Estate Tax Expenses	(3,988)	33	17
18	CILA Building Lease Expenses	(40,600)	34	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**	(136,893)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

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	(1,047)	0	0	0	0	0	0	0	0	0	0	(1,047)	1
2	Food Purchase	(22,792)	0	0	0	0	0	0	0	0	0	0	(22,792)	2
3	Housekeeping	(3,472)	77	0	0	0	0	0	0	0	0	0	(3,395)	3
4	Laundry	(938)	0	0	0	0	0	0	0	0	0	0	(938)	4
5	Heat and Other Utilities	(9,732)	216	0	0	0	0	0	0	0	0	0	(9,516)	5
6	Maintenance	(3,606)	82	4,138	0	0	0	0	0	0	0	0	614	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(41,587)	375	4,138	0	0	0	0	0	0	0	0	(37,074)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9,150)	0	1,022	0	0	0	0	0	0	0	0	(8,128)	10
10a	Therapy	(235)	0	0	0	0	0	0	0	0	0	0	(235)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(186)	0	0	0	0	0	0	0	0	0	0	(186)	12
13	CNA Training	(1,525)	0	0	0	0	0	0	0	0	0	0	(1,525)	13
14	Program Transportation	(3,711)	293	0	0	0	0	0	0	0	0	0	(3,418)	14
15	Other (specify):*	(73,176)	0	0	0	0	0	0	0	0	0	0	(73,176)	15
16	**TOTAL Health Care and Programs**	(87,983)	293	1,022	0	0	0	0	0	0	0	0	(86,668)	16
	C. General Administration													
17	Administrative	0	0	4,792	0	0	0	0	0	0	0	0	4,792	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(925)	1,332	(23,517)	0	0	0	0	0	0	0	0	(23,110)	19
20	Fees, Subscriptions & Promotions	(188)	273	0	0	0	0	0	0	0	0	0	85	20
21	Clerical & General Office Expenses	(4,062)	1,117	8,251	0	0	0	0	0	0	0	0	5,306	21
22	Employee Benefits & Payroll Taxes	(31,290)	2,246	0	0	0	0	0	0	0	0	0	(29,044)	22
23	Inservice Training & Education	(286)	0	0	0	0	0	0	0	0	0	0	(286)	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	(2,454)	123	0	0	0	0	0	0	0	0	0	(2,331)	26
27	Other (specify):*	(63)	4	0	0	0	0	0	0	0	0	0	(59)	27
28	**TOTAL General Administration**	(39,268)	5,095	(10,474)	0	0	0	0	0	0	0	0	(44,647)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(168,838)	5,763	(5,314)	0	0	0	0	0	0	0	0	(168,389)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glen Brook # 0037051 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,096	1,075	0	0	0	0	0	0	0	0	0	14,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(587)	69	0	0	0	0	0	0	0	0	0	(518)	32
33	Real Estate Taxes	(3,988)	150	0	0	0	0	0	0	0	0	0	(3,838)	33
34	Rent-Facility & Grounds	(40,600)	0	(79,118)	0	0	0	0	0	0	0	0	(119,718)	34
35	Rent-Equipment & Vehicles	0	0	120	0	0	0	0	0	0	0	0	120	35
36	Other (specify):*	(595)	0	0	0	0	0	0	0	0	0	0	(595)	36
37	TOTAL Ownership	(32,674)	1,294	(78,998)	0	0	0	0	0	0	0	0	(110,378)	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)	(201,512)	7,057	(84,312)	0	0	0	0	0	0	0	0	(278,767)	45

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [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%	$ 77	$ 77	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	216	216	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	82	82	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	293	293	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	1,332	1,332	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	273	273	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	1,117	1,117	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	2,246	2,246	8
9	V	26	Insurance		kel-Tech Management Co.	25.00%	123	123	9
10	V	27	Late Fee/Finance Charge		kel-Tech Management Co.	25.00%	4	4	10
11	V	30	Depreciation		kel-Tech Management Co.	25.00%	1,075	1,075	11
12	V	32	Interest Notes		kel-Tech Management Co.	25.00%	69	69	12
13	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	150	150	13
14	Total			$			$ 7,057	$ * 7,057	14

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	34	Rent- Facility	$	kel-Tech Management Co.	25.00%	$ 482	$ 482	15
16	V	35	Rent - Equipment		kel-Tech Management Co.	25.00%	120	120	16
17	V	10	Nursing		kel-Tech Management Co.	25.00%	1,022	1,022	17
18	V	17	Administration		kel-Tech Management Co.	25.00%	4,792	4,792	18
19	V	21	Clerical		kel-Tech Management Co.	25.00%	8,251	8,251	19
20	V	6	Maintenance		kel-Tech Management Co.	25.00%	4,138	4,138	20
21	V								21
22	V								22
23	V	19	Professional Services	23,517	kel-Tech Management Co.	25.00%		(23,517)	23
24	V	34	Building Lease	79,600	Glen Brook Land Trust	100.00%		(79,600)	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			$ 103,117			$ 18,805	$ * (84,312)	39

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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	
						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	$ 18,392	17-1	1
2	Norine Keller	Officer	Director	50.00				Admin	7,827	21-1	2
3											3
4											4
5	James M. Keller	Quality Assurance	Quality Assurance	0.00			5.00	Q. Assurance	340	10-1	5
6											6
7											7
8	kel-Tech Allocation										8
9	Diana Alley							Nursing	1,022	19-3	9
10	Jacob Alley							Maintenance	3,890	19-3	10
11	James A. Keller							Administration	4,792	19-3	11
12											12
13								TOTAL	$ 36,263		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: 1/1/2015 Ending: 2/31/2015

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 St
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 Supplies	Mgmt Fee Contribution	351,160	9	$ 35	$	23,517	$ 2	1
2	3	Houskeeping	Mgmt Fee Contribution	351,160	9	1,096		23,517	73	2
3	3	Home/Office Décor	Mgmt Fee Contribution	351,160	9	17		23,517	1	3
4	5	Utilities Gas	Mgmt Fee Contribution	351,160	9	2,826		23,517	189	4
5	5	Utilities Water	Mgmt Fee Contribution	351,160	9	404		23,517	27	5
6	6	Maint. Building	Mgmt Fee Contribution	351,160	9	316		23,517	21	6
7	6	Maint. Supplies	Mgmt Fee Contribution	351,160	9	210		23,517	14	7
8	6	Grounds Maint.	Mgmt Fee Contribution	351,160	9	473		23,517	32	8
9	6	Preventative Maint.	Mgmt Fee Contribution	351,160	9	182		23,517	12	9
10	6	Repairs Grounds	Mgmt Fee Contribution	351,160	9	50		23,517	3	10
11	14	Repairs Vehicle	Mgmt Fee Contribution	351,160	9	114		23,517	8	11
12	14	Transportation	Mgmt Fee Contribution	351,160	9	3,233		23,517	217	12
13	14	Insurance Vehicles	Mgmt Fee Contribution	351,160	9	774		23,517	52	13
14	14	Maint. Vehicle	Mgmt Fee Contribution	351,160	9	250		23,517	17	14
15	19	ADP Payroll Services	Mgmt Fee Contribution	351,160	9	19,020		23,517	1,274	15
16	19	Legal & Accounting	Mgmt Fee Contribution	351,160	9	875		23,517	59	16
17	20	Constributions	Mgmt Fee Contribution	351,160	9	150		23,517	10	17
18	20	Dues Fees Subscriptions	Mgmt Fee Contribution	351,160	9	3,922		23,517	263	18
19	21	G & A Supplies	Mgmt Fee Contribution	351,160	9	6,012		23,517	403	19
20	21	Postage	Mgmt Fee Contribution	351,160	9	2,006		23,517	134	20
21	21	Bank Charges	Mgmt Fee Contribution	351,160	9	5		23,517	0	21
22	21	Copier Expense Service Calls	Mgmt Fee Contribution	351,160	9	23		23,517	2	22
23	21	G&A Misc.	Mgmt Fee Contribution	351,160	9	488		23,517	33	23
24										24
25	TOTALS					$ 42,481	$		$ 2,846	25

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 St.
City / State / Zip Code: Anna, IL 62906
Phone Number: (618) 833-5070 x11
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	21	Software Expense	Mgmt Fee Contribution	351,160	9	$ 2,783	$	23,517	$ 186	1
2	21	Telephone	Mgmt Fee Contribution	351,160	9	1,497		23,517	100	2
3	21	Cell Phone Expense	Mgmt Fee Contribution	351,160	9	1,243		23,517	83	3
4	21	Utilities - Internet	Mgmt Fee Contribution	351,160	9	1,037		23,517	69	4
5	21	IT Services	Mgmt Fee Contribution	351,160	9	1,581		23,517	106	5
6	22	Ins. Emp. Group	Mgmt Fee Contribution	351,160	9	10,022		23,517	671	6
7	22	Ins. W/C	Mgmt Fee Contribution	351,160	9	2,849		23,517	191	7
8	22	Payroll Tax Expense	Mgmt Fee Contribution	351,160	9	20,579		23,517	1,378	8
9	22	Misc. Emp Benefits	Mgmt Fee Contribution	351,160	9	81		23,517	5	9
10	26	Insurance Bldg & Liab	Mgmt Fee Contribution	351,160	9	1,843		23,517	123	10
11	27	Late Fee/Finance Charge	Mgmt Fee Contribution	351,160	9	54		23,517	4	11
12	30	Depreciation	Mgmt Fee Contribution	351,160	9	16,058		23,517	1,075	12
13	32	Interest Notes	Mgmt Fee Contribution	351,160	9	1,035		23,517	69	13
14	33	Real Estate Taxes	Mgmt Fee Contribution	351,160	9	2,244		23,517	150	14
15	34	Lease Bldg	Mgmt Fee Contribution	351,160	9	7,200		23,517	482	15
16	35	Lease Equip	Mgmt Fee Contribution	351,160	9	1,789		23,517	120	16
17	10	Nursing	Mgmt Fee Contribution	351,160	9	15,251	15,251	23,517	1,021	17
18	17	Administration	Mgmt Fee Contribution	351,160	9	71,523	71,523	23,517	4,790	18
19	21	Clerical	Mgmt Fee Contribution	351,160	9	123,149	123,149	23,517	8,247	19
20	6	Maintenance	Mgmt Fee Contribution	351,160	9	61,755	61,755	23,517	4,136	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 343,573	$ 271,678		$ 23,006	25

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Old National Bank		X	Auto Loan - '12 Chevy E-350	$675.00	6/11/14	$ 30,419	$ 19,457	6/11/18	3.1000	$ 737	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capaha Bank		X	Line of Credit		6/4/15			6/4/16	5.5000		6
7												7
8												8
9	TOTAL Facility Related				$675.00		$ 30,419	$ 19,457			$ 737	9
	B. Non-Facility Related*											
10	US Bank		X	Auto Loan - '14 Ford Transit	$425.00	11/20/14	23,774	18,511	11/20/18	2.8000	587	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$425.00		$ 23,774	$ 18,511			$ 587	14
15	TOTALS (line 9+line14)						$ 54,193	$ 37,968			$ 1,324	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:** 1/1/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 10,558	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.)		$ 12,332	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,774	3
4. Real Estate Tax accrual used for 2015 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.		$ 12,332	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	8,865	8
2011	8,935	9
2012	9,014	10
2013	8,798	11
2014	12,332	12

Sch IX	12,332
kel-Tech Allocation	150
Non-Allowable CILA	-3,988
Sch V Line 33, Col.8	8,494

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 8,343.74	$ 8,343.74
2.	06-32-214-001	PT NE QTR	$ 1,941.76	$
3.	08-09-135-000	PT N 1/4 SW NW QTR	$ 2,046.50	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 12,332.00	$ 8,343.74

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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	$ 140,580	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			6,200	10
11	Driveway & Parking Lot			2004	12,802	378	15	854	476	9,820	11
12	Landscaping			2005	3,934	232	15	262	30	2,751	12
13	Tile Floor - Living Room			2006	2,784	164	15	186	22	1,697	13
14	Sprinkler Sys - Pendents			2006	6,450	381	15	430	49	3,924	14
15	Tubcut Improvement in Bathrooms			2014	3,084	141	15	206	65	386	15
16	Office Remodel			2014	1,453	72	15	97	25	109	16
17	Front Porch			2013	771	33	15	51	18	128	17
18	Tub Cut Improvement in Bathroom			2014	1,000	47	15	67	20	109	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: 1/1/2015 Ending: 12/31/2015

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)		$ 261,135	$ 1,448		$ 7,666	$ 6,218	$ 167,860	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: 1/1/2015 Ending: 12/31/2015

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	$ 43,123	$ 2,855	$ 7,494	$ 4,639		$ 21,902	71
72	Current Year Purchases	2,659	531	266	(265)		266	72
73	Fully Depreciated Assets	22,944					22,944	73
74								74
75	TOTALS	$ 68,726	$ 3,386	$ 7,760	$ 4,374		$ 45,112	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	2012 E350 Chevy Van	2014	$ 27,326	$ 4,099	$ 5,465	$ 1,366	5	$ 8,881	76
77	Healthcare	2007 Kia Spectra	2012	4,500		900	900	5	3,450	77
78	Healthcare	2004 Chevy Trailblazer	2006	15,868					15,868	78
79	Healthcare	2014 Ford Transit Connect	2014	23,774	4,517	4,755	238		5,349	79
80	TOTALS			$ 71,468	$ 8,616	$ 11,120	$ 2,504		$ 33,548	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)	$ 419,329	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,450	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,546	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,096	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 246,520	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	$ 19,046	$ 1,274	$ 7,549	86
87	2014 Ford Transit - CILA	23,774	4,517	5,349	87
88	Improvements	1,771	80	237	88
89	2006 Trailblazer	15,868		15,868	89
90					90
91	TOTALS	$ 60,459	$ 5,871	$ 29,003	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: 1/1/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 45 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: 1/1/2015 Ending: 12/31/2015

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)	565	1,280		1,845
4	Clinical Wages (b)	1,102	2,497		3,599
5	In-House Trainer Wages (c)	2,667	6,042		8,709
6	Transportation				
7	Contractual Payments	490	980		1,470
8	CNA Competency Tests				
9	TOTALS	$ 4,824	$ 10,799	$	$ 15,623
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,623			

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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: 1/1/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 77,215	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(7,916)		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)	27,265		8
9	Other(specify): DSP Trn'g	3,997		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 100,561	$	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	140,237		16
17	Accumulated Depreciation (book methods)	(131,216)		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)**	$ 41,300	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 141,861	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,709	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	21		29
30	Accrued Salaries Payable	2,672		30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,183)		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	Credit Card Payable	4,124		36
37	A/P - Glen Brook Land Trust	6,021		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 32,274	$	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	N/P - Auto Loans	37,969		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 37,969	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 70,243	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 71,618	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 141,861	$	48

***(See instructions.)**

Facility Name & ID Number Glen Brook **#** 0037051 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):	117,471	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 117,471	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,853)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (45,853)	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)**	$ 71,618	24 *

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

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	$ 802,713	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 802,713	3
	B. Ancillary Revenue		
4	Day Care	73,176	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 73,176	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	11,806	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)**	$ 11,806	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			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)**	$ 887,695	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	133,640	31
32	Health Care	519,962	32
33	General Administration	157,430	33
	B. Capital Expense		
34	Ownership	107,346	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	28,620	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 946,998	40
41	**Income before Income Taxes (line 30 minus line 40)****	(59,303)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (59,303)	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: 1/1/2015 Ending: 12/31/2015

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	2,248	2,395	23,095	9.64	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	3,266	3,400	32,881	9.67	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	311	311	26,059	83.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,159	1,159	11,209	9.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	830	830	29,312	35.32	28
29	Resident Services Coordinator	1,707	1,739	42,551	24.47	29
30	Habilitation Aides (DD Homes)	28,718	29,219	305,537	10.46	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	38,239	39,053	$ 470,644 *	$ 12.05	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	26	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	420	16,425	10-3	38
39	Pharmacist Consultant	12	200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	750	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	21	1,050	12-3	45
46	Other(specify)				46
47	Psychologist Consultant	16	660	10a-3	47
48	Behavioral Consultant	6	575	10a-3	48
49	TOTAL (lines 35 - 48)	523	$ 24,950		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: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James A. Keller	Administrator	50	$ 18,392
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 18,392

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	$ 14,980
FMGR	Legal	68
kel-Tech Management	Acct'g/Mgmt Services	23,517
Cornerstone Ins. Group	Affordable Care Act	128
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 38,693

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,762
Unemployment Compensation Insurance	5,891
FICA Taxes	35,605
Employee Health Insurance	1,925
Employee Meals	2,269
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	638
kel-Tech Allocation	2,246
Less: CILA Ins./Emp. Payroll Expenses	(29,021)
Less: Employee Meals	(2,269)
TOTAL (agree to Schedule V, line 22, col.8)	$ 34,046

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	3,709
kel-Tech Allocation	273
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,982

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Sprinfield CEU's Seminar	262
Seminar Expense	
Management Training Seminar	398
CEU's Administrator	575
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,235

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Glen Brook # 0037051 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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:** 1/1/2015 **Ending:** 12/31/2015

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.-$1,200**

(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. $ **392** 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. $ **28,620**
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. $ **2,269** 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
2015

IL Healthcare Assoc Dues	1,200
PAC Dues	88
IL Corp. Ann. Report	129
PO Box Rental	112
Fingerprinting	235
Secretary of State	404
Intuit Online Bill Pay	282
SAMS Club Membership Fee	90
ACA Fee	257
AWIS Annual W/C Fee	1,000
Contributions	100
Less:	
PAC Dues	(88)
Contributions	(100)
Total	$ 3,709

Glen Brook of Vienna
Reconciliation of Depreciation
Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2
2015

Sch IX	$ 26,546
kel-Tech Mgmt. Co. Alloc.	1,075
Total on Sch V	$ 27,621

Glen Brook of Vienna
Real Estate Taxes Reconciliation
Sch IX, Line 37, Col. 1
2015

Sch IX	$ 12,332
kel-Tech Mgmt. Co. Alloc.	150

CILA Properties R/E Taxes	(3,998)
Total on Sch V	$ 8,484