

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0035618</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Bryn Mawr Care Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>5547 North Kenmore</u> <u>Chicago</u> <u>60640</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 561-7040</u> Fax # <u>(773) 561-7543</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
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Date of Initial License for Current Owners: <u>08/01/89</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bryn Mawr Care Inc.

0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	174	Intermediate (ICF)	174	63,510	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	174	TOTALS	174	63,510	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	59,694	526	154	60,374	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,694	526	154	60,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.06%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? 1,751 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 08/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/01/89 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

	NON-ALLOWABLE	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatient				2
3	Governmental Sponsorship				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio	-2288	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patient				8
9	Non-Straightline Depreciation	=PG13*Y29	30		9
10	Interest and Other Income	-8	32		10
11	Discounts, Allowance				11
12	Non-Working Officer's Salary				12
13	Sales Tax	=IF(OR(PG1*B30="x",PG1*B30="y"),P13,P13*0.075)	02		13
14	Non-Care Related Intangible Assets				14
15	Non-Care Related Operating Expenses				15
16	Personal Expenses (Inpatient)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	-6893	20		20
21	Owner or Key-Man Incentive				21
22	Special Legal Fees & Expenses				22
23	Malpractice Insurance				23
24	Bad Debt	-17077	21		24
25	Fund Raising, Advertising, and Publicity	-4933	20		25
26	Income Taxes and Other Property Replacement	=-10200+357	21		26
27	CNA Training for Non-Care Staff				27
28	Yellow Page Advertisements				28
29	Other-Attach Schedule	=PG5A*F60			29
30	SUBTOTAL (A): (Sum of Lines 1-29)	\$ =SUM(L11:L40)		\$ =SUM(P11:P40)	30

BHF USE ONLY						
48		49		50		51
						52

=IF(Enter

B. If there are general adjustments:

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization's Pre-Operating Expenses			33
34	Adjustments for Related Organization's Costs (Schedule VII)	=SUM(Summary_B*G29:P29)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ =SUM(Z13:Z19)		36
37	TOTAL ADJUSTMENTS	\$ =L41+Z20		37

*These costs are for licensing on these

C. Are there any other adjustments and 4? If so, list reference numbers (See instructions)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transportation			\$		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)			\$ =IF(SUM(Z33:Z41)=0,0,SUM(Z33:Z41))		47

[illegible]

-5931	21	
-13436	20	
-600	12	
-5276	19	
-100	20	
-105	24	
-1200	2	
-7500	19	
-350	21	
-5567	36	
-3950	6	
=SUM(PG5B!\$F\$12:\$F\$60)		

Bryn Mawr Care Inc.

ID#

0035618

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Facility Name & ID Number	Bryn Mawr Care Inc.	#	0035618	Report Period Beginning:	01/01/11	Ending:	12/31/11
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VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	\$ 20,880	S.I.R. MANAGEMENT, INC.	100.00%	\$ 9,587	\$ (11,293)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	761	761	16
17	V	10	NURSING	41,760	S.I.R. MANAGEMENT, INC.	100.00%	14,037	(27,723)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,412	2,412	18
19	V	19	PROFESSIONAL FEES	134,136	S.I.R. MANAGEMENT, INC.	100.00%	11,487	(122,649)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,049	1,049	20
21	V	21	CLERICAL & GENERAL	41,760	S.I.R. MANAGEMENT, INC.	100.00%	47,229	5,469	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	626	626	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,633	8,633	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,303	1,303	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,141	4,141	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(7,889)	(7,889)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,283	6,283	27
28	V								28
29	V	17	ADMINISTRATIVE	426,495	S.I.R. MANAGEMENT, INC.	100.00%	24,028	(402,467)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,726		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	88,739	88,739	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	18,511	18,511	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 665,031			\$ 232,663	\$ * (434,094)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 20,880	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,589	\$ (14,291)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,146	1,146	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	6,854	6,854	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,187	1,187	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	70,036	70,036	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	13,624	13,624	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,814	15,814	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	20,880	S.I.R. MANAGEMENT, INC.	100.00%	8,142	(12,738)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,375	1,375	25
26	V								26
27	V	6	MAINTENANCE SALARIES	39,882	S.I.R. MANAGEMENT, INC.	100.00%	37,370	(2,512)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	7,491	7,491	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,333	2,333	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	954	954	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	51	51	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	65	65	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	110	110	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	7,450	7,450	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,423	6,423	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,860	5,860	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	846	846	38
39	Total			\$ 81,642			\$ 193,720	\$ * 112,078	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3	Housekeeping	16,567	Xcel Supply, LLC	100.00%	15,562	(1,004)	16
17	V	4	Laundry		Xcel Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	20,765	Xcel Supply, LLC	100.00%	19,506	(1,259)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	32	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			\$ 37,331			\$ 35,068	\$ * (2,263)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 83,953	\$ 83,953	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	83,953	CCS Employee Benefits Group	100.00%		(83,953)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 83,953			\$ 83,953	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			ALBANY CARE INC	EVANSTON	BRYN MAWR CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	ASHLEY BARRISH	1.437%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST DATED 9/1/2004	13.506%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	CELESTE GIANNINI TRUST DTD 3/13/00	1.437%	ELMWOOD CARE, INC.	ELMWOOD PARK	EXTENDED CARE-OWNER'S CO	LINCOLNWOOD	MANAGEMENT CO.	4
5	DANIEL ROTHNER	2.299%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	5
6	B. BART BARRISH	1.437%	GREENWOOD CARE, INC.	EVANSTON	CCS VEBA	EVANSTON	HEALTH INSURANCE	6
7	ERIC ROTHNER	46.552%	MAPLEWOOD CARE, INC.	ELGIN				7
8	GLENDA STRICKLAND	2.874%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	JESSE REYNOLDS DESCENDENTS TRUST	2.874%	REGENCY REHABILITATION CENTER,LLC	NILES				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	13.506%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11	DARCEY BARRISH	1.437%	WILSON CARE, INC.	CHICAGO				11
12	MELISSA ROTHNER	2.299%	APPLEWOOD REHABILITATION CENTER	MATTESON				12
13	MICHAEL R GIANNINI TRUST DTD 3/13/00	1.437%						13
14	RACHEL ROTHNER	2.299%						14
15	KIRSTEN BARRISH	1.437%						15
16	WILLIAM ROTHNER	2.299%						16
17	SARAH BARRISH	2.874%						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

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Giannini	Shareholder	Administrative	1.44%	See Attached	2.52	6.30%	Alloc. Salary	\$ 12,038	17-7	1
2	Bryan Barrish	Shareholder	Administrative	13.51%	See Attached	2.88	6.40%	Alloc. Salary	14,416	17-7	2
3	Kristen Barrish	Shareholder	Clerical	1.44%	See Attached	2.88	7.20%	Alloc. Salary	3,246	21-7	3
4	Sarah Barrish	Shareholder	Administrative	2.87%	See Attached	3.6	7.20%	Alloc. Salary	8,631	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	3.6	7.20%	Alloc. Salary	6,589	1-7	5
6	Eric Rothner	Shareholder	Administrative	46.56%	See Attached	0.43	0.92%	Alloc. Salary	9,825	17-7	6
7	Adam Vales	Relative	Clerical	0.00%	See Attached	0.5	1.25%	Alloc. Salary	888	22-7	7
8	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.12	0.30%	Alloc. Salary	468	17-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual										11
12	costs to reflect only amounts anticipated to be considered allowable by the IL Dept of HFS										12
13								TOTAL	\$ 56,101		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	\$ 133,007	\$ 59,965	60,374	\$ 9,587	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		60,374	761	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	60,374	14,037	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		60,374	2,412	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	60,374	11,487	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		60,374	1,049	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	60,374	47,229	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		60,374	626	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		60,374	8,633	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		60,374	1,303	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		60,374	4,141	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		60,374	(7,889)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		60,374	6,283	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	60,374	24,028	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		60,374	1,726	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	60,374	88,739	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		60,374	18,511	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,227,764	\$ 2,435,627		\$ 232,663	25

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY SALARIES	PATIENT DAYS	837,569	13	\$ 91,408	\$ 91,408	60,374	\$ 6,589	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		60,374	1,146	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	60,374	6,854	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		60,374	1,187	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	60,374	70,036	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		60,374	13,624	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		60,374	15,814	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	20,880	8,142	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		20,880	1,375	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	39,882	37,370	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		39,882	7,491	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		928	2,333	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		928	954	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		928	51	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		928	65	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		928	110	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		928	7,450	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		928	6,423	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		928	5,860	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		928	846	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 193,719	25

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Xcel Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Direct Allocation			\$	\$		\$	1
2	3	Housekeeping	Direct Allocation						15,562	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						19,506	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	32	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation							10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		35,068	25

Ending: 12/31/11

(847)905-4040

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Bryn Mawr Care Inc. # 0035618 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Private Bank		X	Mortgage			\$	17,940,658			\$	865,978	1	
2													2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	Lake Forest Bank		X	A/R Line				500,000				9,284	6	
7	Alloc. from SIR Management	X										6,423	7	
8	See Supplemental Schedule												8	
9	TOTAL Facility Related						\$	18,440,658				\$	881,685	9
	B. Non-Facility Related*													
10	Interest Income		X									(8)	10	
11	Interest Income - Bldg. Co.		X									(378)	11	
12	Alloc. from SIR Management	X										(7,889)	12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	(8,275)	14
15	TOTALS (line 9+line14)						\$	18,440,658				\$	873,410	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 90,206 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							\$	\$			1
2											2
3											3
4											4
5											5
6											6
7	TOTAL Long-Term										7
	Working Capital										
8							\$	\$			8
9											9
10											10
11											11
12											12
13											13
14	TOTAL Working Capital										14
	B. Non-Facility Related*										
15							\$	\$			15
16											16
17											17
18											18
19											19
20	TOTAL Non-Facility Related										20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 report.				\$	115,240	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.)				\$	128,043	2
3. Under or (over) accrual (line 2 minus line 1).				\$	12,803	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	128,500	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.)				\$	846	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 \$ 428 For 2010 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.				\$	142,149	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	104,290	8		
		2007	103,177	9		
		2008	104,212	10		
		2009	110,190	11		
		2010	122,183	12		
2011 Accrual = \$122,183 x 1.05 = \$128,500 (Rounded)						
Allocated from SIR Management = \$5,860						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Bryn Mawr Care Inc.</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0035618</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</u>

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-08-202-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>111,120.63</u>	\$ <u>111,120.63</u>
2. <u>14-08-202-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>11,062.40</u>	\$ <u>11,062.40</u>
3. <u>See Attached</u>	<u>See Attached</u>	\$ <u>76,900.85</u>	\$ <u>5,540.68</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>199,083.88</u>	\$ <u>127,723.71</u>

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Bryn Mawr Care Inc.</u>	COUNTY	<u>Cook</u>
---------------	----------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0035618

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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?

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,120

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1989</u>	<u>\$ 63,070</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 63,070	3

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	1,573,885			78,694	78,694	218,848	67
68	Related Party Allocations (Pages 12H & 12I)	118,244	3,391		4,826	1,435	56,335	68
69	Financial Statement Depreciation		61,298			(61,298)		69
70	TOTAL (lines 4 thru 69)	\$ 5,201,565	\$ 214,891		\$ 217,000	\$ 2,109	\$ 1,801,440	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bryn Mawr Care Inc.

0035618

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,201,565	\$ 214,891		\$ 217,000	\$ 2,109	\$ 1,801,440	1
2	Flooring & Lockers	2008	5,617		20	281	281	1,030	2
3	Elevator Work	2008	14,430		20	722	722	2,646	3
4	Freezer Work	2008	11,549		20	2,310	2,310	7,699	4
5	Exhaust Fan	2008	7,962		20	398	398	1,227	5
6	Doors / Plumbing / Walls	2008	5,170		20	259	259	1,034	6
7	Fire Door	2008	7,570		20	379	379	1,514	7
8	Sewer Line	2008	4,800		20	240	240	900	8
9	Kitchen Work	2008	6,300		20	315	315	1,129	9
10	Freezer Repair	2008	5,080		20	254	254	889	10
11	Condenser For Cooler	2008	4,978		20	249	249	809	11
12	Phoenix Bathtubs	2008	4,000		20	200	200	633	12
13	Elevator Work	2008	4,644		20	232	232	735	13
14	Boiler Repair	2008	2,945		20	147	147	564	14
15	Heating Pipe, Radiator Valves, Connectors	2008	2,880		20	144	144	456	15
16	Nurse Call System	2009	13,768		20	688	688	1,950	16
17	Freezer Door	2009	5,540		20	277	277	693	17
18	New Grease Trap	2009	9,261		20	463	463	1,042	18
19	Boiler - Steam Traps, Controller	2009	4,876		20	244	244	711	19
20	Radiator, Piping, Valves	2009	6,879		20	344	344	889	20
21	Master Keylock System	2009	2,662		20	133	133	299	21
22	Elevator Keys - Braille	2009	5,650		20	283	283	753	22
23	Sprinkler System - Piping	2009	2,675		20	134	134	390	23
24	Boiler Repair - Power Burner	2010	5,603		20	280	280	560	24
25	Boiler Repair - Burner Control	2010	7,548		20	377	377	755	25
26	Book Shelves	2011	3,950		20	66	66	66	26
27	Tuck Pointing	2011	7,500		20	94	94	94	27
28	Fire Door	2011	12,850		20	268	268	268	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,378,252	\$ 214,891		\$ 226,780	\$ 11,889	\$ 1,831,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bryn Mawr Care Inc.

0035618

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring 4th	2008	34,228		20	1,711	1,711	6,846	9
10	Flooring 3rd	2008	34,228		20	1,711	1,711	6,846	10
11	Flooring 2nd	2008	34,228		20	1,711	1,711	6,846	11
12	Flooring 6th	2008	34,228		20	1,711	1,711	6,846	12
13	Flooring 5th	2008	34,228		20	1,711	1,711	6,846	13
14	Handrails	2008	42,874		20	2,144	2,144	8,575	14
15	Resident Bathrooms	2008	57,600		20	2,880	2,880	11,520	15
16	Landscape Project	2008	23,553		20	1,178	1,178	4,711	16
17	Landscape Project	2008	21,011		20	1,051	1,051	4,202	17
18	Tile Flooring	2008	12,283		20	614	614	2,457	18
19	Resident Bathrooms	2008	57,600		20	2,880	2,880	11,520	19
20	HVAC Units	2008	22,516		20	1,126	1,126	4,503	20
21	Wall Work, Plumbing, Tiles, Painting	2009	43,200		20	2,160	2,160	6,480	21
22	Flooring	2009	38,573		20	1,929	1,929	5,786	22
23	Tub Liners	2009	7,425		20	371	371	1,114	23
24	Tub Liners	2009	3,325		20	166	166	499	24
25	Flooring	2009	14,250		20	713	713	2,138	25
26	Tub Liners	2009	5,460		20	273	273	819	26
27	Bathroom - Wall Work, Plumbing, Tiles, Painting	2009	266,400		20	13,320	13,320	39,960	27
28	Office - Remodeling Walls, Floor, & Closet	2009	6,000		20	300	300	900	28
29	Activity Room - Ceiling Tiles, Walls, & Closet	2009	3,400		20	170	170	510	29
30	Laundry & Bathrooms - Sink, Toilets, Faucets, & Walls	2009	11,300		20	565	565	1,695	30
31	Entry - Remodeling Door, Windows, & Frame	2009	16,530		20	827	827	2,480	31
32	Reception & Lobby	2009	36,580		20	1,829	1,829	5,487	32
33	Dining Room - Wall Soffit & Water Line	2009	16,496		20	825	825	2,474	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bryn Mawr Care Inc.

0035618

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Painting - Walls & Doors, Entry Hall/Lobby, Back Hall	2009	25,200		20	1,260	1,260	3,780	2
3	Smoke Room - Closets	2009	8,964		20	448	448	1,345	3
4	Nurse Station - Replace/Install New Cabinets	2009	21,000		20	1,050	1,050	3,150	4
5	Bathrooms (10) - Wall Work, Plumbing, Tiles, Painting	2010	72,000		20	3,600	3,600	7,200	5
6	Bathrooms (6) - Wall Work, Plumbing, Tiles, Painting	2010	57,600		20	2,880	2,880	5,760	6
7	Elevator Cab	2010	11,925		20	596	596	1,193	7
8	Sprinkler System	2010	138,280		20	6,914	6,914	13,828	8
9	Painting - Floors 1-3	2010	130,500		20	6,525	6,525	13,050	9
10	Emergency Staircase	2010	4,550		20	228	228	455	10
11	Wallbase Replacement	2010	6,268		20	313	313	627	11
12					20				12
13	Electric Air Cleaner	2010	4,842		20	242	242	484	13
14	Window Treatments	2010	2,515		20	126	126	252	14
15	Hot Water Valve	2010	3,950		20	198	198	395	15
16	Handrail Guards	2010	2,596		20	130	130	260	16
17	Bathtub Liners	2010	10,875		20	544	544	1,088	17
18	Satellite and Cabling	2010	11,788		20	589	589	1,179	18
19	Window Treatment - 1st Floor	2010	5,785		20	289	289	579	19
20	Stair Treads	2010	3,806		20	190	190	381	20
21	Rekey Doors	2010	9,735		20	487	487	974	21
22	Hot Water Risers	2010	4,300		20	215	215	430	22
23	Bathroom Work	2010	2,790		20	140	140	279	23
24	HVAC Cooler	2010	3,188		20	159	159	319	24
25	Wallbase Replacement	2010	6,287		20	314	314	629	25
26	Door Casings	2010	7,000		20	350	350	700	26
27	Oxygen Rooms	2010	13,250		20	663	663	1,325	27
28	Sprinkler System- Design	2010	15,300		20	765	765	1,530	28
29	Fire Alarm Upgrade	2011	42,500		20	2,125	2,125	2,125	29
30	Painting	2011	43,500		20	2,175	2,175	2,175	30
31	Water Heater	2011	7,075		20	354	354	354	31
32	Elevator Work	2011	8,500		20	425	425	425	32
33	Door Casings	2011	10,500		20	525	525	525	33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,573,885	\$		\$ 78,694	\$ 78,694	\$ 218,848	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Bryn Mawr Care Inc.

0035618

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1993	32,614	1,035	35	932	(103)	16,307	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Alloc. - S.I.R. Management</u>	1993	8,269	230	20	410	180	7,788	9
10	<u>Alloc. - S.I.R. Management</u>	1994	26		20			26	10
11	<u>Alloc. - S.I.R. Management</u>	1995	189		20	9	9	155	11
12	<u>Alloc. - S.I.R. Management</u>	1997	12,706	285	20	623	338	9,396	12
13	<u>Alloc. - S.I.R. Management</u>	1999	999		20	50	50	612	13
14	<u>Alloc. - S.I.R. Management</u>	1999	9,735		20			9,735	14
15	<u>Alloc. - S.I.R. Management</u>	2000	1,180		20	59	59	681	15
16	<u>Alloc. - S.I.R. Management</u>	2007	3,790	350	20	189	(161)	795	16
17	<u>Alloc. - S.I.R. Management</u>	2008	10,444	998	20	658	(340)	2,531	17
18	<u>Alloc. - S.I.R. Management</u>	2009	25,953	237	20	1,298	1,061	2,913	18
19	<u>Alloc. - S.I.R. Management</u>	2011	642	27	20	13	(14)	13	19
20									20
21	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2010	1,968		20	98	98	131	21
22	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2009	1,958	171	20	98	(73)	274	22
23	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2007	571	47	20	29	(18)	143	23
24	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2002	129		20	6	6	62	24
25	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1999	4,133		20	207	207	2,583	25
26	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1998	1,975		20	99	99	1,333	26
27	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1997	123		20	6	6	95	27
28	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1994	311	8	20	16	8	272	28
29	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1993	529	3	20	26	23	490	29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 118,244	\$ 3,391		\$ 4,826	\$ 1,435	\$ 56,335	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 720,377	\$ 3,739	\$ 59,495	\$ 55,756	10	\$ 385,196	71
72	Current Year Purchases	325	8	8		10	8	72
73	Fully Depreciated Assets	321,000		16	16	10	321,000	73
74								74
75	TOTALS	\$ 1,041,702	\$ 3,747	\$ 59,519	\$ 55,772		\$ 706,204	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		1998 CHEVY VAN	2001	\$ 15,436	\$	\$ 900	\$ 900	5	\$ 15,436	76
77		Allocated from SIR Management	2011	2,533	312	358	46	5	502	77
78										78
79										79
80	TOTALS			\$ 17,969	\$ 312	\$ 1,258	\$ 946		\$ 15,938	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 6,500,993	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,950	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 287,557	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 68,607	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,553,318	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Television & TV Mounts	\$ 42,310	92
93			93
94			94
95		\$ 42,310	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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:
- *

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

15. Is Movable equipment rental included in building rental?
- YES
- XNO
16. Rental Amount for movable equipment: \$12,429
- Description: See Attached Schedule

(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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	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	N/A	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): See Supplemental									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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 44,686	\$ 189,769	1
2	Cash-Patient Deposits	39,074	39,074	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,293,387	1,293,387	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,494	30,391	6
7	Other Prepaid Expenses	5,142	5,142	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,411,783	\$ 1,557,763	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		207,475	13
14	Buildings, at Historical Cost		1,327,223	14
15	Leasehold Improvements, at Historical Cost	1,480,008	2,998,086	15
16	Equipment, at Historical Cost	1,225,602	1,594,842	16
17	Accumulated Depreciation (book methods)	(1,639,754)	(2,806,292)	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): <u>See Attached Schedule</u>	14,525	629,246	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,080,381	\$ 3,950,580	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,492,164	\$ 5,508,343	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,305	\$ 95,306	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,083	39,083	28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	172,965	172,965	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,819	8,819	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,500	32
33	Accrued Interest Payable		71,763	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	18,700	18,700	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	18,659	18,659	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 853,531	\$ 1,053,795	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,940,658	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 17,940,658	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 853,531	\$ 18,994,453	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,638,633	\$ (13,486,110)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,492,164	\$ 5,508,343	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,802,182	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,802,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	636,853	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	(800,400)	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)	\$ (163,547)	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)	\$ 1,638,633	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,501,882	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,501,882	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,628	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,628	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,503,518	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,038,266	31
32	Health Care	1,733,335	32
33	General Administration	1,436,643	33
	B. Capital Expense		
34	Ownership	1,563,156	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	95,265	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,866,665	40
41	Income before Income Taxes (line 30 minus line 40)**	636,853	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 636,853	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,901	2,099	\$ 79,046	\$ 37.66	1
2	Assistant Director of Nursing	1,877	2,086	66,886	32.06	2
3	Registered Nurses	2,425	2,694	76,118	28.25	3
4	Licensed Practical Nurses	11,839	13,155	297,953	22.65	4
5	CNAs & Orderlies	50,307	55,897	577,413	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,027	2,252	34,192	15.18	9
10	Activity Assistants	10,228	11,364	109,326	9.62	10
11	Social Service Workers	15,258	16,954	261,257	15.41	11
12	Dietician					12
13	Food Service Supervisor	3,895	4,328	66,125	15.28	13
14	Head Cook	3,051	3,390	32,917	9.71	14
15	Cook Helpers/Assistants	8,311	9,234	87,539	9.48	15
16	Dishwashers					16
17	Maintenance Workers	3,430	3,811	50,043	13.13	17
18	Housekeepers	14,715	16,350	158,755	9.71	18
19	Laundry					19
20	Administrator	1,896	2,080	84,191	40.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,555	6,035	101,313	16.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,809	4,232	83,209	19.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,691	3,691	15,225	4.12	33
34	TOTAL (lines 1 - 33)	144,215	159,652	\$ 2,181,508 *	\$ 13.66	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	598	\$ 30,475	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	41,760	10-03	38
39	Pharmacist Consultant	Monthly	11,094	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	2,066	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Specialized Rehab</u>	Monthly	20,880	10a-03	47
48	<u>Psychiatric Director</u>	Monthly	6,600	12-03	48
49	TOTAL (lines 35 - 48)	630	\$ 120,987		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Patrick Baalke	Aministrator	0.00%	\$ 84,191	Workers' Compensation Insurance	\$ 35,127	IDPH License Fee	\$		
				Unemployment Compensation Insurance	32,774	Advertising: Employee Recruitment	477		
				FICA Taxes	162,572	Health Care Worker Background Check			
				Employee Health Insurance	128,681	(Indicate # of checks performed 10)	70		
				Employee Meals	19,035	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Fingerprinting	5,150		
				Other Benefit	4,277	Advertising and Promotions	4,933		
				Chicago Head Tax	3,710	Dues & Subscriptions	511		
				Union Pension	22,146	Licenses & Permits	4,069		
				401K Matching Contributions	1,925	See Supplemental Schedule	1,049		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(4,933)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 84,191	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,326	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
SIR Management - Mangement Fees			\$ 342,975			\$	Out-of-State Travel	\$	
SIR Management - Director of Administrative Services			41,760						
SIR Management - Ancillary Administrative Charges			41,760				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
SIR Management	Admin. Legal Services		\$ 20,880						
SIR Management	Accounting		36,000						
Frost, Ruttenberg, and Rothblatt	Accounting		16,733						
SIR Management	Bookkeeping Services		77,256						
See Attached	Legal		7,950						
Personnel Planners	Unemployment Consulting		1,244						
LTC Solutions	Computer Services		1,500						
Legat Architects	Safety Code Consult.		6,335				Seminar Expense	1,815	
Pinnacle Consulting	Employee Satisfaction		2,503				Allocated from SIR Management	626	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$	(agree to Sch. V, line 24, col. 8)		\$ 2,441

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Alliance for Living \$13,572
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,146 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 95,265
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. \$ 19,035 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ None
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT