

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0035618

Facility Name: Bryn Mawr Care Inc.

Address: 5547 North Kenmore Chicago 60640
Number City Zip Code

County: Cook

Telephone Number: (773) 561-7040 Fax # (773) 561-7543

HFS ID Number:

Date of Initial License for Current Owners: 08/01/89

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bryn Mawr Care Inc.

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

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	63,684	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	174	TOTALS	174	63,684	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	59,612	1,524	58	61,194	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,612	1,524	58	61,194	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.09%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? 645 (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 8/1/1989

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 8/1/1989 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: 12/31/12 Fiscal Year: 12/31/12

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	184,943	20,744	34,045	239,732		239,732	(18,089)	221,643			1
2	Food Purchase		307,800		307,800	(19,984)	287,816	(1,176)	286,640			2
3	Housekeeping	160,576	30,931		191,507		191,507		191,507			3
4	Laundry		13,410	4,212	17,622		17,622		17,622			4
5	Heat and Other Utilities			111,679	111,679		111,679	(5,436)	106,243			5
6	Maintenance	52,043	29,917	150,306	232,266		232,266	(6,432)	225,834			6
7	Other (specify):*							5,843	5,843			7
8	TOTAL General Services	397,562	402,802	300,242	1,100,606	(19,984)	1,080,622	(25,290)	1,055,332			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,152,099	30,365	58,375	1,240,839		1,240,839	(20,359)	1,220,480			10
10a	Therapy			20,880	20,880		20,880	(10,833)	10,047			10a
11	Activities	127,057	12,000	2,308	141,365		141,365		141,365			11
12	Social Services	255,410		6,600	262,010		262,010		262,010			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,255	5,255			15
16	TOTAL Health Care and Programs	1,534,566	42,365	91,763	1,668,694		1,668,694	(25,937)	1,642,757			16
	C. General Administration											
17	Administrative	132,728		444,604	577,332		577,332	(348,057)	229,275			17
18	Directors Fees											18
19	Professional Services			183,945	183,945	(3,059)	180,886	(111,484)	69,402			19
20	Dues, Fees, Subscriptions & Promotions			44,394	44,394		44,394	(33,356)	11,038			20
21	Clerical & General Office Expenses	75,175	12,314	87,814	175,303		175,303	84,596	259,899			21
22	Employee Benefits & Payroll Taxes			380,524	380,524	19,984	400,508		400,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,485	1,485		1,485	692	2,177			24
25	Other Admin. Staff Transportation			2,397	2,397		2,397	8,833	11,230			25
26	Insurance-Prop.Liab.Malpractice			115,000	115,000		115,000	13,311	128,311			26
27	Other (specify):*							43,338	43,338			27
28	TOTAL General Administration	207,903	12,314	1,260,163	1,480,380	16,925	1,497,305	(342,127)	1,155,177			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,140,031	457,481	1,652,168	4,249,680	(3,059)	4,246,621	(393,355)	3,853,266			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			53,773	53,773		53,773	226,260	280,033			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,347	11,347		11,347	831,225	842,572			32
33	Real Estate Taxes					3,059	3,059	124,462	127,521			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			6,078	6,078		6,078	5,636	11,714			35
36	Other (specify):*							89,090	89,090			36
37	TOTAL Ownership			1,571,198	1,571,198	3,059	1,574,257	(223,327)	1,350,930			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			467,244	467,244		467,244		467,244			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			467,244	467,244		467,244		467,244			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,140,031	457,481	3,690,610	6,288,122		6,288,122	(616,681)	5,671,441			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,612)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	55,879	30		9
10	Interest and Other Investment Income	(22,564)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(14,223)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,645)	21		24
25	Fund Raising, Advertising and Promotional	(3,818)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,046)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(80,161)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (85,266)		\$	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)	(531,415)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (531,415)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (616,681)		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

ID#

0035618

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Expense	\$ (933)	21	1
2	Bank Fees	(6,400)	21	2
3	PAC Dues - Alliance for Living	(15,745)	20	3
4	Capitalized R&M	(4,870)	06	4
5	Non-Allowable Legal	(6,815)	19	5
6	Misc Income	(17)	21	6
7	Additional 2012 Seminar	105	24	7
8				8
9	Bulding Company:			9
10	Professional Fees	(7,750)	19	10
11	Fees	(400)	21	11
12	Amortization	(5,567)	36	12
13	Office Expense	(20)	21	13
14	Capitalized R&M	(30,216)	06	14
15				15
16	Non Allowable Professional Fees	(433)	19	16
17	Vending Income	(1,100)	02	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(80,161)		49

ID#0035618

Report Period Beginning:01/01/12

Ending:12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

Facility Name & ID Number	Bryn Mawr Care Inc.	#	0035618	Report Period Beginning:	01/01/12	Ending:	12/31/12
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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%	\$ 7,962	\$ (12,918)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	623	623	16
17	V	10	NURSING	41,760	S.I.R. MANAGEMENT, INC.	100.00%	14,282	(27,478)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,402	2,402	18
19	V	19	PROFESSIONAL FEES	129,960	S.I.R. MANAGEMENT, INC.	100.00%	11,665	(118,295)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	430	430	20
21	V	21	CLERICAL & GENERAL	41,760	S.I.R. MANAGEMENT, INC.	100.00%	54,473	12,713	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	587	587	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,833	8,833	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,344	1,344	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,639	9,639	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(7,389)	(7,389)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,636	5,636	27
28	V								28
29	V	17	ADMINISTRATIVE	444,604	S.I.R. MANAGEMENT, INC.	100.00%	24,334	(420,270)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	201	201	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	91,858	91,858	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	17,953	17,953	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 678,964			\$ 244,833	\$ * (434,131)	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	\$ 24,530	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,441	\$ (18,089)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,092	1,092	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,119	7,119	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,198	1,198	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	72,213	72,213	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	13,807	13,807	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,746	15,746	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	20,880	S.I.R. MANAGEMENT, INC.	100.00%	10,047	(10,833)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,655	1,655	25
26	V								26
27	V	6	MAINTENANCE SALARIES	21,229	S.I.R. MANAGEMENT, INC.	100.00%	22,701	1,472	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,128	4,128	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,176	2,176	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	506	506	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%	66	66	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	115	115	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,309	8,309	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,137	6,137	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,287	3,287	37
38	V								38
39	Total			\$ 66,639			\$ 176,794	\$ * 110,155	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 41,517	\$ 41,517	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	41,517	CCS Employee Benefits Group	100.00%		(41,517)	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			\$ 41,517			\$ 41,517	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number	Bryn Mawr Care Inc.	#	0035618	Report Period Beginning:	01/01/12	Ending:	12/31/12
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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 Schedule V		2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

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

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

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

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								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

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

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	Relative	Administrative	0.00%	See Attached	2.51	6.28%	Alloc. Salary	\$ 12,052	17-7	1
2	Bryan Barrish	Relative	Administrative	0.00%	See Attached	2.87	6.38%	Alloc. Salary	14,348	17-7	2
3	Kristen Barrish	Shareholder	Clerical	1.44%	See Attached	2.87	7.18%	Alloc. Salary	3,343	21-7	3
4	Sarah Barrish	Shareholder	Administrative	2.87%	See Attached	3.59	7.18%	Alloc. Salary	8,676	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	3.59	7.18%	Alloc. Salary	6,441	1-7	5
6	Adam Vales	Relative	Clerical	0.00%	See Attached	0.28	0.70%	Alloc. Salary	504	22-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 45,364		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

Facility Name & ID Number	Bryn Mawr Care Inc.
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0035618

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 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						\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	852,976	13	\$ 110,978	\$ 47,841	61,194	\$ 7,962	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		61,194	623	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	61,194	14,282	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		61,194	2,402	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	61,194	11,665	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		61,194	430	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	61,194	54,473	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		61,194	587	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		61,194	8,833	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		61,194	1,344	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		61,194	9,639	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		61,194	(7,389)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		61,194	5,636	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	61,194	24,334	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		61,194	201	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	61,194	91,858	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		61,194	17,953	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,412,714	\$ 2,543,620		\$ 244,833	25

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

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	852,976	13	\$ 89,778	\$ 89,778	61,194	\$ 6,441	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		61,194	1,092	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	61,194	7,119	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		61,194	1,198	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	61,194	72,213	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		61,194	13,807	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		61,194	15,746	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	20,880	10,047	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		20,880	1,655	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	21,229	22,701	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		21,229	4,128	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		924	2,176	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		924	506	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		924	51	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		924	66	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		924	115	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		924	8,309	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		924	6,137	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		924	3,287	23
24										24
25	TOTALS					\$ 2,596,289	\$ 1,763,707		\$ 176,794	25

Ending: 12/31/12

(847)905-4040

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

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

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: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$	17,712,531			\$	855,263	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	A/R Line				350,000				11,347	6
7	Alloc. from SIR Management	X										6,137	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	18,062,531			\$	872,747	9
	B. Non-Facility Related*												
10	Interest Income		X									(22,564)	10
11	Interest Income - Bldg. Co.		X									(222)	11
12	Alloc. from SIR Management	X										(7,389)	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(30,175)	14
15	TOTALS (line 9+line14)						\$	18,062,531			\$	842,572	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 89,090 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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 2011 report.		\$	128,500	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.)		\$	124,962	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,538)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	3,059	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 \$ 8,599 For 02;09 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.		\$	127,521	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	103,177	8	
		2008	104,212	9	
		2009	110,190	10	
		2010	122,183	11	
		2011	121,675	12	
2012 Accrual = \$121,675 x 1.05 = \$128,000 (Rounded)					
Allocated from SIR Management = \$3,287					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

FACILITY NAME Bryn Mawr Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035618

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(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. 14-08-202-002-0000	Long Term Care Property	\$ 110,658.44	\$ 110,658.44
2. 14-08-202-003-0000	Long Term Care Property	\$ 11,016.37	\$ 11,016.37
3. See Attached	See Attached	\$ 101,165.17	\$ 5,684.20
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 222,839.98	\$ 127,359.01

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bryn Mawr Care Inc. COUNTY Cook

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</u> <u>Applicable to</u> <u>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? YES NO

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

Facility Name & ID Number Bryn Mawr Care Inc.

0035618

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Related Building Company (Pages 12F & 12G)		1,717,574	77,820		85,395	7,575	301,402	67
68	Related Party Allocations (Pages 12H & 12I)		139,756	4,374		5,368	994	63,388	68
69	Financial Statement Depreciation			53,773			(53,773)		69
70	TOTAL (lines 4 thru 69)		\$ 5,454,691	\$ 178,775		\$ 217,652	\$ 38,877	\$ 2,039,201	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:

01/01/12

Ending:

12/31/12

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 12A, Carried Forward		\$ 5,454,691	\$ 178,775		\$ 217,652	\$ 38,877	\$ 2,039,201	1
2	Nurse Call System	2009	13,768		20	688	688	2,639	2
3	Freezer Door	2009	5,540		20	277	277	970	3
4	New Grease Trap	2009	9,261		20	463	463	1,505	4
5	Boiler - Steam Traps, Controller	2009	4,876		20	244	244	955	5
6	Radiator, Piping, Valves	2009	6,879		20	344	344	1,232	6
7	Master Keylock System	2009	2,662		20	133	133	433	7
8	Elevator Keys - Braille	2009	5,650		20	283	283	1,036	8
9	Sprinkler System - Piping	2009	2,675		20	134	134	524	9
10	Boiler Repair- Power Burner	2010	5,603		20	560	560	1,634	10
11	Boiler Repair- Burner Control	2010	7,548		20	755	755	1,573	11
12	Book Shelves	2011	3,950		20	198	198	263	12
13	Replace Heating Pipe From 3Rd To 4Th, And 6Th Floors	2012	4,870		20	244	244	134	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)		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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	Totals from Page 12B, Carried Forward		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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
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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)		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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	Totals from Page 12C, Carried Forward		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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
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21									21
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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)		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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	Totals from Page 12D, Carried Forward		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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
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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)		\$ 5,527,973	\$ 178,775		\$ 221,974	\$ 43,199	\$ 2,052,098	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:

01/01/12

Ending:

12/31/12

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								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	408,577		20	19,303	19,303	96,515	9
10	Wall Work, Plumbing, Tiles, Painting	2009	43,200		20	2,160	2,160	8,640	10
11	Flooring	2009	38,573		20	1,929	1,929	7,715	11
12	Tub Liners	2009	7,425		20	371	371	1,485	12
13	Tub Liners	2009	3,325		20	166	166	665	13
14	Flooring	2009	14,250		20	713	713	2,850	14
15	Tub Liners	2009	5,460		20	273	273	1,092	15
16	Bathroom - Wall Work, Plumbing, Tiles, Painting	2009	266,400		20	13,320	13,320	53,280	16
17	Office - Remodeling Walls, Floor, & Closet	2009	6,000		20	300	300	1,200	17
18	Activity Room - Ceiling Tiles, Walls, & Closet	2009	3,400		20	170	170	680	18
19	Laundry & Bathrooms - Sink, Toilets, Faucets, & Walls	2009	11,300		20	565	565	2,260	19
20	Entry - Remodeling Door, Windows, & Frame	2009	16,530		20	827	827	3,306	20
21	Reception & Lobby	2009	36,580		20	1,829	1,829	7,316	21
22	Dining Room - Wall Soffit & Water Line	2009	16,496		20	825	825	3,299	22
23	Painting - Walls & Doors, Entry Hall/Lobby, Back Hall	2009	25,200		20	1,260	1,260	5,040	23
24	Smoke Room - Closets	2009	8,964		20	448	448	1,793	24
25	Nurse Station - Replace/Install New Cabinets	2009	21,000		20	1,050	1,050	4,200	25
26	Bathrooms (10) - Wall Work, Plumbing, Tiles, Painting	2010	72,000		20	3,600	3,600	10,800	26
27	Bathrooms (6) - Wall Work, Plumbing, Tiles, Painting	2010	57,600		20	2,880	2,880	8,640	27
28	Elevator Cab	2010	11,925		20	596	596	1,789	28
29	Sprinkler System	2010	138,280		20	6,914	6,914	20,742	29
30	Painting - Floors 1-3	2010	130,500		20	6,525	6,525	19,575	30
31	Emergency Staircase	2010	4,550		20	228	228	683	31
32	Wallbase Replacement	2010	6,268		20	313	313	940	32
33	Tuck Pointing	2011	7,500		20	375	375	750	33
34	Fire Door	2011	12,850			643	643	1,286	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:

01/01/12

Ending:

12/31/12

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		\$	\$		\$ 643	\$ 643	\$ 1,286	1
2	Electric Air Cleaner	2010	4,842		20	242	242	726	2
3	Window Treatments	2010	2,515		20	126	126	377	3
4	Hot Water Valve	2010	3,950		20	198	198	593	4
5	Handrail Guards	2010	2,596		20	130	130	389	5
6	Bathtub Liners	2010	10,875		20	544	544	1,631	6
7	Satellite and Cabling	2010	11,788		20	589	589	1,768	7
8	Window Treatment - 1st Floor	2010	5,785		20	289	289	868	8
9	Stair Treads	2010	3,806		20	190	190	571	9
10	Rekey Doors	2010	9,735		20	487	487	1,460	10
11	Hot Water Risers	2010	4,300		20	215	215	645	11
12	Bathroom Work	2010	2,790		20	140	140	419	12
13	HVAC Cooler	2010	3,188		20	159	159	478	13
14	Wallbase Replacement	2010	6,287		20	314	314	943	14
15	Door Casings	2010	7,000		20	350	350	1,050	15
16	Oxygen Rooms	2010	13,250		20	663	663	1,988	16
17	Sprinkler System- Design	2010	15,300		20	765	765	2,295	17
18	Fire Alarm Upgrade	2011	42,500		20	2,125	2,125	4,250	18
19	Painting	2011	43,500		20	2,175	2,175	4,350	19
20	Water Heater	2011	7,075		20	354	354	708	20
21	Elevator Work	2011	8,500		20	425	425	850	21
22	Door Casings	2011	10,500		20	525	525	1,050	22
23	Electrical Wiring Upgrade	2012	25,100		20	1,255	1,255	1,255	23
24	Fire Dampers	2012	56,521		20	2,826	2,826	2,826	24
25	Sprinklers-Mechanical Room	2012	7,552		20	378	378	378	25
26	Built in Bookshelves	2012	3,950		20	198	198	198	26
27	Replace Valves in hot water boiler	2012	3,490		20	174	174	174	27
28	Replace vent-pipe & faucets	2012	5,980		20	299	299	299	28
29	Re-paint kitchen & day rooms	2012	5,414		20	271	271	271	29
30	Replace Damaged floor tiles	2012	3,640		20	182	182	182	30
31	Bathroom drywall, plaster and primer work	2012	4,172		20	209	209	209	31
32	Replace Condenser for walk-in cooler	2012	4,390		20	220	220	220	32
33	New Handrails	2012	3,130		20	157	157	157	33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,717,574	\$		\$ 85,395	\$ 85,395	\$ 301,402	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:

01/01/12

Ending:

12/31/12

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>SIR Properties - SIR Management</u>	2009	17,936		35	460	460	1,399	3
4	<u>SIR Properties - SIR Management</u>	1993	32,476	1,031	35	928	(103)	18,094	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Alloc. - S.I.R. Management</u>	1993	8,234	229	20	408	179	8,164	9
10	<u>Alloc. - S.I.R. Management</u>	1994	26		20			26	10
11	<u>Alloc. - S.I.R. Management</u>	1995	188		20	9	9	164	11
12	<u>Alloc. - S.I.R. Management</u>	1997	12,652	283	20	621	338	9,977	12
13	<u>Alloc. - S.I.R. Management</u>	1999	995		20	50	50	659	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	1,175		20	59	59	736	15
16	<u>Alloc. - S.I.R. Management</u>	2007	3,774	257	20	189	(68)	980	16
17	<u>Alloc. - S.I.R. Management</u>	2008	10,400	994	20	656	(338)	3,176	17
18	<u>Alloc. - S.I.R. Management</u>	2009	25,843	236	20	1,292	1,056	4,192	18
19	<u>Alloc. - S.I.R. Management</u>	2011	639	64	20	64		91	19
20	<u>Alloc. - S.I.R. Management</u>	2012	2,046	43	20	43		43	20
21									21
22	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2012	1,989	1,058	20	9	(1,049)	9	22
23	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2010	1,960		20	98	98	229	23
24	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2009	1,950	122	20	97	(25)	370	24
25	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2007	569	46	20	28	(18)	171	25
26	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2002	129		20	6	6	68	26
27	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1999	4,115		20	206	206	2,778	27
28	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1998	1,967		20	98	98	1,426	28
29	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1997	122		20	6	6	101	29
30	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1994	309	8	20	15	7	286	30
31	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1993	527	3	20	26	23	514	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)		\$ 139,756	\$ 4,374		\$ 5,368	\$ 994	\$ 63,388	34

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	\$ 685,863	\$ 38,199	\$ 57,348	\$ 19,149	10	\$ 366,504	71
72	Current Year Purchases	81,034	6,823	328	(6,495)	10	328	72
73	Fully Depreciated Assets	355,471				10	355,471	73
74								74
75	TOTALS	\$ 1,122,368	\$ 45,022	\$ 57,677	\$ 12,655		\$ 722,303	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	\$	\$	\$	5	\$ 15,436	76
77		Allocated from SIR Management	2011	2,522	357	383	26	5	882	77
78										78
79										79
80	TOTALS			\$ 17,958	\$ 357	\$ 383	\$ 26		\$ 16,318	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)	\$ 6,731,369
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 224,154
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 280,033
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 55,879
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,790,719

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy:
- ☐ YES☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$11,714
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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?

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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.)

		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	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
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			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	\$ 64,702	\$ 219,987	1
2	Cash-Patient Deposits	32,139	32,139	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,335,327	1,335,327	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,633	30,629	6
7	Other Prepaid Expenses	2,046	2,046	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	81,930	81,930	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,545,777	\$ 1,702,058	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	3,048,889	15
16	Equipment, at Historical Cost	1,232,759	1,673,862	16
17	Accumulated Depreciation (book methods)	(1,693,527)	(3,022,137)	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>	48,980	577,538	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,068,220	\$ 3,812,850	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,613,997	\$ 5,514,908	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 130,885	\$ 157,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,143	32,143	28
29	Short-Term Notes Payable	350,000	350,000	29
30	Accrued Salaries Payable	173,492	173,492	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,590	11,590	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,000	32
33	Accrued Interest Payable		70,850	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	24,500	24,500	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	199,015	199,015	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 921,625	\$ 1,147,309	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,712,531	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)	\$	\$ 17,712,531	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 921,625	\$ 18,859,840	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,692,372	\$ (13,344,932)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,613,997	\$ 5,514,908	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,638,633	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)	\$ 1,638,635	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	575,737	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	(522,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 53,737	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)	\$ 1,692,372	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			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,831,579	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,831,579	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***	22,564	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,564	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	9,716	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,716	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,863,859	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,100,606	31
32	Health Care	1,668,694	32
33	General Administration	1,480,380	33
	B. Capital Expense		
34	Ownership	1,571,198	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	467,244	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,288,122	40
41	Income before Income Taxes (line 30 minus line 40)**	575,737	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 575,737	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,630,759	44
45	Private Pay - Net Inpatient Revenue	200,820	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)	\$ 6,831,579	49

* 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.

****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	1,961	2,091	\$ 82,315	\$ 39.37	1
2	Assistant Director of Nursing	1,108	1,213	36,455	30.05	2
3	Registered Nurses	2,750	2,962	83,026	28.03	3
4	Licensed Practical Nurses	11,775	12,571	268,438	21.35	4
5	CNAs & Orderlies	51,985	56,289	579,210	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,961	2,091	24,413	11.68	9
10	Activity Assistants	9,655	10,731	102,644	9.57	10
11	Social Service Workers	16,109	17,256	255,410	14.80	11
12	Dietician					12
13	Food Service Supervisor	3,997	4,430	69,853	15.77	13
14	Head Cook	3,194	3,538	34,277	9.69	14
15	Cook Helpers/Assistants	8,003	8,514	80,813	9.49	15
16	Dishwashers					16
17	Maintenance Workers	3,741	4,022	52,043	12.94	17
18	Housekeepers	15,840	17,043	160,576	9.42	18
19	Laundry					19
20	Administrator	1,940	2,386	86,481	36.25	20
21	Assistant Administrator	1,952	2,160	46,247	21.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,048	4,498	75,175	16.71	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	3,897	4,916	102,655	20.88	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	143,916	156,711	\$ 2,140,031 *	\$ 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	Monthly	\$ 34,045	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	12,103	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	46	2,308	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)	46	\$ 125,808		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 (1/1/12-10/23/12)	Administrator	0.00%	\$ 70,138	Workers' Compensation Insurance		\$ 32,900	IDPH License Fee		\$ 1,992		
Cynthia Schofield (10/24/12-12/31/12)	Administrator	0.00%	16,343	Unemployment Compensation Insurance		49,286	Advertising: Employee Recruitment		877		
Dorothy Jackson	Asst Admin	0.00%	46,247	FICA Taxes		161,767	Health Care Worker Background Check		760		
				Employee Health Insurance		107,691	(Indicate # of checks performed <u>76</u>)				
				Employee Meals		19,984	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Fingerprinting		3,186		
				Other Benefit		3,096	Allocated from SIR Management		430		
				Chicago Head Tax		2,116	Dues & Subscriptions		496		
				Union Pension		21,168	Licenses & Permits		3,297		
				401K Matching Contributions		2,500					
							Less: Public Relations Expense	(	)		
							Non-allowable advertising	(	)		
							Yellow page advertising	(	)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 400,508	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,038		
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		
S.I.R. Mangement - Dir. Of Administrative Services			\$ 41,760			\$	Out-of-State Travel		\$		
S.I.R. Mangement -Ancillary Charges			44,460								
S.I.R. Management - Consulting Fee			358,384				In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)											
C. Professional Services				TOTAL							
Vendor/Payee	Type		Amount			\$					
SIR Management	Dir. Of Regulatory Services		\$ 20,880								
SIR Management	Accounting		36,000								
Frost, Ruttenberg, and Rothblatt	Accounting		13,399								
SIR Management	Bookkeeping Services		73,080								
See Attached	Legal		28,709								
Personnel Planners	Unemployment Consulting		1,444								
Property Valuation Services	Property Appraisal		2,500								
Legat Architects	Safety Code Consult.		436				Seminar Expense		1,590		
Pinnacle Consulting	Employee Satisfaction		2,561				Allocated from SIR Management		587		
Schain, Burney, Banks & Kenny	adj pg 5a		433								
Plante Moran	Accounting		1,444								
See Supplemetal Schedule			3,059				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)		\$ 2,177		

*** 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 \$16,066

(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. \$ 1,162 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. \$ 467,244
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. \$ 19,984 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. \$

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. \$ N/A

(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 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