

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</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></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>8/1/1989</u></td><td colspan="2" rowspan="5"> 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><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____		Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Date of Initial License for Current Owners: <u>8/1/1989</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		Type of Ownership:		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></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 _____							In the event there are further questions about this report, please contact:		Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>		Email Address: _____	
Officer or Administrator of Provider	(Signed) _____																																																																																		
	(Type or Print Name) _____																																																																																		
	(Title) _____																																																																																		
Paid Preparer	(Signed) _____ *																																																																																		
	* Subject to the attached Accountants Consulting Report (Date) _____																																																																																		
	(Print Name and Title) _____																																																																																		
	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																																																																																		
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																																																																																	
Date of Initial License for Current Owners: <u>8/1/1989</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																																																																																	
Type of Ownership:																																																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></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 _____																																		
☐	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 _____																																																																																
In the event there are further questions about this report, please contact:																																																																																			
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																																																																																			
Email Address: _____																																																																																			

Facility Name & ID Number Bryn Mawr Care

0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	
	Level of Care	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	19,959	621	37,020	57,600	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,959	621	37,020	57,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.45%

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

None (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 _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Bryn Mawr Care # 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16
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	202,162	24,619	30,644	257,425		257,425	(12,964)	244,461			1
2	Food Purchase		284,976		284,976	(19,599)	265,377	(1,231)	264,146			2
3	Housekeeping	203,402	36,680		240,082		240,082	(2,533)	237,549			3
4	Laundry		17,037		17,037		17,037	(497)	16,540			4
5	Heat and Other Utilities			138,510	138,510		138,510	(12,379)	126,131			5
6	Maintenance	45,228	14,019	170,834	230,081		230,081	(3,030)	227,051			6
7	Other (specify):*							13,821	13,821			7
8	TOTAL General Services	450,792	377,331	339,988	1,168,111	(19,599)	1,148,512	(18,813)	1,129,699			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600	1,213	4,813			9
10	Nursing and Medical Records	1,173,767	33,551	74,547	1,281,865		1,281,865	(6,730)	1,275,135			10
10a	Therapy			29,232	29,232		29,232	(14,143)	15,089			10a
11	Activities	149,620	10,309	2,574	162,503		162,503		162,503			11
12	Social Services	249,097		7,200	256,297		256,297		256,297			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,465	9,465			15
16	TOTAL Health Care and Programs	1,572,484	43,860	117,153	1,733,497		1,733,497	(10,195)	1,723,302			16
	C. General Administration											
17	Administrative	114,965		91,872	206,837		206,837	35,729	242,566			17
18	Directors Fees											18
19	Professional Services			561,604	561,604	(4,933)	556,671	(493,087)	63,584			19
20	Dues, Fees, Subscriptions & Promotions			52,113	52,113		52,113	(26,247)	25,866			20
21	Clerical & General Office Expenses	136,601	12,860	75,778	225,239		225,239	88,002	313,241			21
22	Employee Benefits & Payroll Taxes			379,147	379,147	19,599	398,746	(11)	398,736			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,367	4,367		4,367	569	4,936			24
25	Other Admin. Staff Transportation			900	900		900	8,376	9,276			25
26	Insurance-Prop.Liab.Malpractice			140,622	140,622		140,622	15,800	156,422			26
27	Other (specify):*							38,632	38,632			27
28	TOTAL General Administration	251,566	12,860	1,306,403	1,570,829	14,666	1,585,495	(332,237)	1,253,258			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,274,842	434,051	1,763,544	4,472,437	(4,933)	4,467,504	(361,245)	4,106,258			29

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

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

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			48,873	48,873		48,873	171,769	220,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,449	15,449		15,449	639,195	654,644			32
33	Real Estate Taxes					4,933	4,933	246,576	251,509			33
34	Rent-Facility & Grounds			1,451,500	1,451,500		1,451,500	(1,451,500)				34
35	Rent-Equipment & Vehicles			6,435	6,435		6,435	6,188	12,623			35
36	Other (specify):*							91,743	91,743			36
37	TOTAL Ownership			1,522,257	1,522,257	4,933	1,527,190	(296,029)	1,231,161			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											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,274,842	434,051	3,285,801	5,994,694		5,994,694	(657,274)	5,337,420			45

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

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	(14,674)	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	(3,519)	30		9
10	Interest and Other Investment Income	(6,690)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	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	(13,327)	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	(34,261)	21		24
25	Fund Raising, Advertising and Promotional	(3,956)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,041)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(33,970)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,469)		\$	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)	(544,805)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (544,805)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (657,274)		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

Bryn Mawr Care

ID#	0035618
Report Period Beginning:	01/01/16
Ending:	12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Bank Fees	\$ (7,111)	21	1
2	Theft and Damage Loss	(325)	21	2
3	Vending Income	(1,200)	02	3
4	Prior Period Adjustment - Pharmacy Expense	(1,500)	10	4
5	Additional R&M	1,948	06	5
6	Capitalized R&M	(5,760)	06	6
7	PAC Dues	(10,947)	20	7
8	Building Company - Fees	(350)	21	8
9	Building Company - Office Expense	(25)	21	9
10	Building Company - Professional Fees	(8,700)	19	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				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		0		48
49	Total	(33,970)		49

Bryn Mawr Care

	ID#	0035618
Report Period Beginning:		01/01/16
Ending:		12/31/16

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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bryn Mawr Care # 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(12,962)	(2)							(12,964)	1
2	Food Purchase	(1,231)											(1,231)	2
3	Housekeeping					(2,533)							(2,533)	3
4	Laundry					(497)							(497)	4
5	Heat and Other Utilities	(14,674)			2,295								(12,379)	5
6	Maintenance	(3,812)	1,098	(18,671)	18,385	(30)							(3,030)	6
7	Other (specify):*				13,821								13,821	7
8	TOTAL General Services	(19,717)	1,098	(18,671)	21,539	(3,062)							(18,813)	8
	B. Health Care and Programs													
9	Medical Director			1,213									1,213	9
10	Nursing and Medical Records	(1,500)		(10,139)	8,578	(1,884)	(1,785)						(6,730)	10
10a	Therapy				(14,143)								(14,143)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,302	4,163								9,465	15
16	TOTAL Health Care and Programs	(1,500)		(3,624)	(1,402)	(1,884)	(1,785)						(10,195)	16
	C. General Administration													
17	Administrative			(64,383)	100,112								35,729	17
18	Directors Fees													18
19	Professional Services	(8,700)	8,700	(509,832)	16,745								(493,087)	19
20	Fees, Subscriptions & Promotions	(28,230)		1,983									(26,247)	20
21	Clerical & General Office Expenses	(44,113)	375	131,658	147		(66)						88,002	21
22	Employee Benefits & Payroll Taxes						(11)						(11)	22
23	Inservice Training & Education													23
24	Travel and Seminar			569									569	24
25	Other Admin. Staff Transportation			8,376									8,376	25
26	Insurance-Prop.Liab.Malpractice		13,563	2,034	203								15,800	26
27	Other (specify):*			14,121	24,511								38,632	27
28	TOTAL General Administration	(81,043)	22,638	(415,474)	141,718		(76)						(332,237)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(102,260)	23,736	(437,769)	161,855	(4,946)	(1,861)						(361,245)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bryn Mawr Care # 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,519)	168,069		7,219								171,769	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,690)	643,659	(4,717)	6,943								639,195	32
33	Real Estate Taxes		237,963		8,613								246,576	33
34	Rent-Facility & Grounds		(1,451,500)										(1,451,500)	34
35	Rent-Equipment & Vehicles			6,188									6,188	35
36	Other (specify):*		91,743										91,743	36
37	TOTAL Ownership	(10,209)	(310,066)	1,471	22,775								(296,029)	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													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(112,469)	(286,330)	(436,298)	184,630	(4,946)	(1,861)						(657,274)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,451,500	Bryn Mawr Care, LLC	100.00%	\$	(1,451,500)	1
2	V	32	Interest	212	Bryn Mawr Care, LLC	100.00%	643,871	643,659	2
3	V	21	Fees		Bryn Mawr Care, LLC	100.00%	350	350	3
4	V	36	Mortgage Insurance		Bryn Mawr Care, LLC	100.00%	91,743	91,743	4
5	V	21	Office Expense		Bryn Mawr Care, LLC	100.00%	25	25	5
6	V	19	Professional Fees		Bryn Mawr Care, LLC	100.00%	8,700	8,700	6
7	V	26	Property Insurance		Bryn Mawr Care, LLC	100.00%	13,563	13,563	7
8	V	33	Real Estate Taxes		Bryn Mawr Care, LLC	100.00%	237,963	237,963	8
9	V	06	Repairs and Maintenance		Bryn Mawr Care, LLC	100.00%	1,098	1,098	9
10	V	30	Depreciation		Bryn Mawr Care, LLC	100.00%	168,069	168,069	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,451,712			\$ 1,165,382	\$ * (286,330)	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		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.	\$ 25,056	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 6,385	\$ (18,671)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,213	1,213	16
17	V	10	NURSING	50,112	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	39,973	(10,139)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,302	5,302	18
19	V	17	ADMINISTRATIVE	91,872	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	27,489	(64,383)	19
20	V	19	PROFESSIONAL FEES	514,647	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,815	(509,832)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,983	1,983	21
22	V	21	CLERICAL & GENERAL	8,352	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	140,010	131,658	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	569	569	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,376	8,376	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,034	2,034	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	14,121	14,121	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(4,717)	(4,717)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,230	5,230	28
29	V	35	EQUIPMENT RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	958	958	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			\$ 690,039			\$ 253,741	\$ * (436,298)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 20,880	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 7,918	\$ (12,962)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,386	1,386	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,578	8,578	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,495	1,495	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	100,112	100,112	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	16,176	16,176	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	24,511	24,511	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	29,232	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	15,089	(14,143)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,668	2,668	25
26	V								26
27	V	6	MAINTENANCE SALARIES	52,515	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	70,000	17,485	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	12,435	12,435	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,295	2,295	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	900	900	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	569	569	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	147	147	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	203	203	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	7,219	7,219	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,943	6,943	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,613	8,613	37
38	V								38
39	Total			\$ 102,627			\$ 287,257	\$ * 184,630	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$ 25	Big Ten Supply, LLC	100.00%	\$ 23	\$ (2)	15
16	V	3	Housekeeping	34,570	Big Ten Supply, LLC	100.00%	32,038	(2,533)	16
17	V	4	Laundry	6,780	Big Ten Supply, LLC	100.00%	6,283	(497)	17
18	V	6	Repairs & Maintenance	415	Big Ten Supply, LLC	100.00%	384	(30)	18
19	V	10	Nursing And Medical Records	25,720	Big Ten Supply, LLC	100.00%	23,835	(1,884)	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			\$ 67,510			\$ 62,563	\$ * (4,946)	39

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

Facility Name & ID Number	Bryn Mawr Care	#	0035618	Report Period Beginning:	01/01/16	Ending:	12/31/16
--------------------------------------	-----------------------	----------	----------------	---------------------------------	-----------------	----------------	-----------------

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 24,781	MAC Rx, LLC	100.00%	\$ 22,996	\$ (1,785)	15
16	V	21	Clerical & General Office Expenses	910	MAC Rx, LLC	100.00%	844	(66)	16
17	V	22	Employee Benefits	148	MAC Rx, LLC	100.00%	137	(11)	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			\$ 25,839			\$ 23,978	\$ * (1,861)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

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.

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.

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.

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.

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	1.44%	ALBANY CARE INC	EVANSTON	BRYN MAWR CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	B. BART BARRISH	1.44%	GENERATIONS AT APPLEWOOD LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST DATED 9/1/2004	13.51%	GENERATIONS AT COLUMBUS PARK, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	CELESTE GIANNINI TRUST DTD 3/13/00	1.44%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	4
5	DANIEL ROTHNER	2.30%	GENERATIONS AT ELMWOOD PARK, INC.	ELMWOOD PARK	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	DARCEY BARRISH	1.44%	GREENWOOD CARE, INC.	EVANSTON	MAC Rx LLC	DES PLAINES	PHARMACY	6
7	ERIC ROTHNER	46.55%	GENERATIONS AT NEIGHBORS REHABILITATION CENTER,LLC	BYRON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	7
8	GLENDA STRICKLAND	2.87%	GENERATIONS AT REGENCY, LLC	NILES				8
9	JESSE REYNOLDS DESCENDENTS TRUST	2.87%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	13.51%	WILSON CARE, INC.	CHICAGO				10
11	KIRSTEN SCHLOSS	1.44%	WESLEY REHABILITATION CENTER	AUBURN, IN				11
12	MELISSA ROTHNER	2.30%	GENERATIONS AT OAKTON, LLC	DES PLAINES				12
13	MICHAEL R GIANNINI TRUST DTD 3/13/00	1.44%						13
14	RACHEL ROTHNER	2.30%						14
15	SARAH BARRISH	2.87%						15
16	WILLIAM ROTHNER	2.30%						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

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	Bryan Barrish	Relative	Administrative		See Attached	3.24	7.20%	Alloc. Salary	\$ 16,176	17-7	1
2	Kirsten Schloss	Shareholder	Maintenance	1.44%	See Attached	4.04	8.08%	Alloc. Salary	7,725	6-7	2
3	Sarah Barrish	Shareholder	Administrative	2.87%	See Attached	4.04	8.08%	Alloc. Salary	9,973	17-7	3
4	Michael Giannini	Relative	Administrative		See Attached	2.83	7.08%	Alloc. Salary	13,750	17-7	4
5	Nenita Guzman	Relative	Dietary		See Attached	4.04	8.08%	Alloc. Salary	7,918	1-7	5
6	Lori Barrish	Relative	Administrative		See Attached	55.00	100.00%	Salary	114,965	17-1	6
7	Clark Collins	Relative	Administrative		See Attached	1.10	2.75%	Alloc. Salary	1,375	Var	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	\$ 171,882		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

Ending: 12/31/16

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

Ending: 12/31/16

(847) 675 -0555

	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	6	REPAIRS AND MAINT.	PATIENT DAYS	712,171	14	\$ 78,945	\$	57,600	\$ 6,385	1
2	9	MEDICAL DIRECTOR CONSULT	PATIENT DAYS	712,171	14	15,000		57,600	1,213	2
3	10	NURSING	PATIENT DAYS	712,171	14	494,227		57,600	39,973	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	712,171	14	65,558	494,227	57,600	5,302	4
5	17	ADMINISTRATIVE	PATIENT DAYS	712,171	14	339,874	339,874	57,600	27,489	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	712,171	14	59,533		57,600	4,815	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	712,171	14	24,522		57,600	1,983	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	712,171	14	1,731,089	1,318,665	57,600	140,010	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	712,171	14	7,033		57,600	569	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	712,171	14	103,561		57,600	8,376	10
11	26	INSURANCE	PATIENT DAYS	712,171	14	25,150		57,600	2,034	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	712,171	14	174,591		57,600	14,121	12
13	32	INTEREST	PATIENT DAYS	712,171	14	(58,326)		57,600	(4,717)	13
14	35	AUTO RENTAL	PATIENT DAYS	712,171	14	64,663		57,600	5,230	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	712,171	14	11,842		57,600	958	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,137,262	\$ 2,152,767		\$ 253,741	25

Facility Name & ID Number Bryn Mawr Care# 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 SIR MGMT.INC & GENERATIONS HC NETW
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

	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	DIETARY SALARIES	PATIENT DAYS	712,171	14	\$ 97,898	\$ 97,898	57,600	\$ 7,918	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		57,600	1,386	2
3	10	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	57,600	8,578	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		57,600	1,495	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	57,600	100,112	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		57,600	16,176	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		57,600	24,511	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	29,232	15,089	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		29,232	2,668	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	52,515	70,000	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		52,515	12,435	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		1,042	2,295	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		1,042	900	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		1,042	569	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		1,042	147	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		1,042	203	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		1,042	7,219	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		1,042	6,943	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		1,042	8,613	23
24										24
25	TOTALS					\$ 3,035,001	\$ 1,932,526		\$ 287,257	25

Facility Name & ID Number Bryn Mawr Care # 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Big Ten Supply, LLC
Street Address 15632 West Sprucewood Lane
City / State / Zip Code Libertyville, IL 60048
Phone Number (312)502-5882
Fax Number (847)816-3425

	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	Dietary	Direct Allocation			\$	\$		23	1
	2	Housekeeping	Direct Allocation						32,038	2
	3	Laundry	Direct Allocation						6,283	3
	4	Repairs & Maintenance	Direct Allocation						384	4
	5	Nursing And Medical Records	Direct Allocation						23,835	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				\$	\$		62,563	25

Ending: 12/31/16

(224)220-2730

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	10	Nursing And Medical Records	Direct Allocation		\$	\$		22,996	1
2	21	Clerical & General Office Expense	Direct Allocation					844	2
3	22	Employee Benefits	Direct Allocation					137	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				\$	\$		23,978	25

Facility Name & ID Number Bryn Mawr Care # 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 12/31/16

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

Ending: 12/31/16

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

Facility Name & ID Number Bryn Mawr Care # 0035618 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 12/31/16

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

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			\$	16,574,758			\$	643,871	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				550,000				15,449	6
7	Alloc from SIR Mgmt Inc/Generations HC											6,943	7
8					-								8
9	TOTAL Facility Related						\$	17,124,758			\$	666,263	9
	B. Non-Facility Related*												
10	Interest Income		X									(6,690)	10
11	Interest Income - Bldg Co		X									(212)	11
12	Allocated from SIR/Generation	X										(4,717)	12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(11,619)	14
15	TOTALS (line 9+line14)						\$	17,124,758			\$	654,644	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 91,743 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.)

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.)

B. Real Estate Taxes

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	<u>Bryn Mawr Care</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0035618</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-6300	FAX #:	(847) 236-6301

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0035618

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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?

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

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:

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

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	174		1989	1969	\$ 1,443,623	\$ 42,808		\$	(42,808)	\$ 1,443,623	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1989		3,323		20			3,323	9
10	Various		1990		21,607		20	86	86	21,136	10
11	Various		1991		99,075		20			99,069	11
12	Various		1992		37,297		20			37,296	12
13	Various		1993		18,516		20			18,516	13
14	Various		1994		33,458		20			33,458	14
15	Various		1995		64,419		20			66,877	15
16	Various		1996		130,280		20	3,103	3,103	130,273	16
17	Various		1997		192,708		20	9,086	9,086	181,722	17
18	Various		1998		163,775		20	8,189	8,189	151,773	18
19	Various		1999		29,826		20	1,491	1,491	25,476	19
20	Various		2000		120,434		20	6,022	6,022	101,113	20
21	Various		2001		121,537		20	4,939	4,939	99,006	21
22	Various		2002		697,409		20			697,409	22
23	Various		2003		33,644		20	1,403	1,403	24,526	23
24	Various		2004		67,643		20	3,366	3,366	42,119	24
25	Various		2005		96,040		20	4,639	4,639	56,037	25
26	Various		2006		91,024		20	4,614	4,614	49,970	26
27	Various		2007		43,798		20	3,106	3,106	29,475	27
28	Various		2008		87,925		20	3,819	3,819	44,210	28
29	Various		2009		51,311		20	2,566	2,566	19,555	29
30	Various		2010		13,151		20	1,315	1,315	8,467	30
31	Various		2011		3,950		20	198	198	1,053	31
32	Various		2012		4,870		20	487	487	2,394	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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)		1,831,358	83,001		91,571	8,570	651,798	67
68	Related Party Allocations (Pages 12H & 12I)		177,343	4,314		5,213	899	96,885	68
69	Financial Statement Depreciation			48,873			(48,873)		69
70	TOTAL (lines 4 thru 69)		\$ 5,679,344	\$ 178,996		\$ 155,211	\$ (23,785)	\$ 4,136,558	70

**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 12A, Carried Forward		\$ 5,679,344	\$ 178,996		\$ 155,211	\$ (23,785)	\$ 4,136,558	1
2	Emergency Lighting	2013	9,768		20	488	488	1,709	2
3	Kitchen Exhaust System	2013	10,497		20	525	525	1,924	3
4	Burgular Alarm Doors - 3,4,5,6 Floors	2014	5,425		20	1,085	1,085	2,351	4
5	Boiler Work	2015	7,477		20	374	374	405	5
6	Repipe Boiler Steam Line And Hand Sink Drain Line	2015	3,495		20	350	350	524	6
7	Repiped Drain Line For Ejector Pump & Bathroom Sinks	2016	2,900		20	145	145	145	7
8	Repaired Sprinklers	2016	2,860		20	143	143	143	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)		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	34

**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		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	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)		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	34

**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		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	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)		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	34

**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		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	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)		\$ 5,721,766	\$ 178,996		\$ 158,321	\$ (20,675)	\$ 4,143,760	34

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

Facility Name & ID Number Bryn Mawr Care

0035618

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	408,577		20	20,429	20,429	174,853	9
10	Various	2009	524,103		20	26,205	26,205	209,647	10
11	Various	2010	529,130		20	26,457	26,457	185,199	11
12	Tuck Pointing	2011	7,500		20	375	375	2,250	12
13	Fire Door	2011	12,850		20	643	643	3,858	13
14	Fire Alarm Upgrade	2011	42,500		20	2,125	2,125	12,750	14
15	Painting	2011	43,500		20	2,175	2,175	13,050	15
16	Water Heater	2011	7,075		20	354	354	2,124	16
17	Elevator Work	2011	8,500		20	425	425	2,550	17
18	Door Casings	2011	10,500		20	525	525	3,150	18
19	Electrical Wiring Upgrade	2012	25,100		20	1,255	1,255	6,275	19
20	Fire Dampers	2012	56,521		20	2,826	2,826	14,130	20
21	Sprinklers- Mechanical Rooms	2012	7,552		20	378	378	1,890	21
22	Built in Bookshelves	2012	3,950		20	198	198	990	22
23	Replace Valves In Hot Water Boiler	2012	3,490		20	174	174	870	23
24	Replace vent- pipe and Faucets	2012	5,980		20	299	299	1,495	24
25	Repaint kitchen & Day Rooms	2012	5,414		20	271	271	1,355	25
26	Replace Damaged floor tiles	2012	3,640		20	182	182	910	26
27	Bathroom drywall, plaster and primer work	2012	4,172		20	209	209	1,045	27
28	Replace Condenser for walk in cooler	2012	4,390		20	220	220	1,100	28
29	New Handrails	2012	3,130		20	157	157	785	29
30	Camera Security System	2013	5,064		20	253	253	1,012	30
31	Fire Alarm Device	2013	3,511		20	176	176	704	31
32	Sprinkler System/Alarm	2013	5,775		20	289	289	1,156	32
33	Kitchen Duct System	2014	10,753		20	538	538	1,613	33
34	TOTAL (lines 1 thru 33)		\$ 1,742,677	\$		\$ 87,137	\$ 87,137	\$ 644,760	34

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

Facility Name & ID Number Bryn Mawr Care

0035618

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12F, Carried Forward		\$ 1,742,677	\$		\$ 87,137	\$ 87,137	\$ 644,760	1
2 Replace Kitchen Gas Line	2014	2,800		20	140	140	420	2
3 Air Conditioners	2014	6,237		20	312	312	936	3
4 Replaced Gas Lines	2015	21,910		20	1,096	1,096	2,192	4
5 Hot water heater	2015	3,885		20	194	194	388	5
6 Install handrail and crash rail	2015	2,555		20	128	128	256	6
7 Masonry & Concrete Repair in Kitchen	2015	3,100		20	155	155	310	7
8 Replace Piping	2016	6,400		20	320	320	320	8
9 Installed Door Protection	2016	3,253		20	163	163	163	9
10 Upgrade Wireless Network	2016	9,083		20	454	454	454	10
11 Replaced Boiler Burner	2016	26,865		20	1,343	1,343	1,343	11
12 Tile work in elevator and new flooring	2016	2,593		20	130	130	257	12
13								13
14 Depreciation			83,001			(83,001)		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)		\$ 1,831,358	\$ 83,001		\$ 91,571	\$ 8,570	\$ 651,798	34

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

Facility Name & ID Number Bryn Mawr Care

0035618

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from SIR Management/Generations HC Network	2009	40,457	1,037	39	1,037		7,305	3
4	SIR Properties - SIR Management/Generations HC Network	1993	36,626	1,163	35	1,046	(117)	24,592	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from SIR Management/Generations HC Network	1993	9,286	259	20		(259)	9,286	9
10	Allocated from SIR Management/Generations HC Network	1994	29		20			29	10
11	Allocated from SIR Management/Generations HC Network	1995	212		20			212	11
12	Allocated from SIR Management/Generations HC Network	1997	14,269		20		696	14,029	12
13	Allocated from SIR Management/Generations HC Network	1999	1,122		20		56	967	13
14	Allocated from SIR Management/Generations HC Network	1999	9,735		20			9,735	14
15	Allocated from SIR Management/Generations HC Network	2000	1,325		20		66	1,096	15
16	Allocated from SIR Management/Generations HC Network	2007	4,256		20		213	1,957	16
17	Allocated from SIR Management/Generations HC Network	2008	11,729	1,173	20	739	(434)	6,539	17
18	Allocated from SIR Management/Generations HC Network	2009	29,145	267	20	1,457	1,190	10,557	18
19	Allocated from SIR Management/Generations HC Network	2011	721	72	20	72		391	19
20	Allocated from SIR Management/Generations HC Network	2012	2,307	115	20	115		510	20
21	Allocated from SIR Management/Generations HC Network	2014	324	32	20	16	(16)	42	21
22	Allocated from SIR Management/Generations HC Network	2016	421	9	20	9		9	22
23									23
24	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	2012	2,244	113	20	112	(1)	450	24
25	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	2010	2,210		20	111	111	700	25
26	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	2009	2,199	49	20	110	61	858	26
27	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	2007	641	13	20	32	19	321	27
28	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	2002	145		20	7	7	106	28
29	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	1999	4,641		20	232	232	4,061	29
30	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	1998	2,218		20	111	111	2,052	30
31	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	1997	138		20	7	7	138	31
32	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	1994	349	9	20		(9)	349	32
33	Allocated from SIR Properties - SIR Mgmt/Generations HC Netw	1993	594	3	20		(3)	594	33
34	TOTAL (lines 1 thru 33)		\$ 177,343	\$ 4,314		\$ 5,213	\$ 1,930	\$ 96,885	34

**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 12H, Carried Forward		\$ 177,343	\$ 4,314		\$ 5,213	\$ 899	\$ 96,885	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)		\$ 177,343	\$ 4,314		\$ 5,213	\$ 899	\$ 96,885	34

**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	\$ 814,714	\$ 44,890	\$ 61,795	\$ 16,905	10	\$ 557,138	71
72	Current Year Purchases	3,300	27	281	254	10	281	72
73	Fully Depreciated Assets	382,538				10	382,538	73
74								74
75	TOTALS	\$ 1,200,552	\$ 44,917	\$ 62,076	\$ 17,159		\$ 939,957	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
77		Allocated from SIR Management	2016	2,844	249	246	(3)	5	2,188
78									
79									
80	TOTALS			\$ 18,280	\$ 249	\$ 246	\$ (3)		\$ 17,624

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)			\$ 7,003,668	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 224,162	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 220,643	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (3,519)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 5,101,341	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Stair Addition	\$ 1,100,245
93		
94		
95		\$ 1,100,245

* 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?

YESNO
- 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 NO
16. Rental Amount for movable equipment: \$ 7,393 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	Allocated from SIR/Generations HN		\$	\$ 5,230	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 5,230	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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

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)	\$			

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	

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): 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.

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	\$ 6,817	\$ 163,596	1
2	Cash-Patient Deposits	26,139	26,139	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	514,546	514,546	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,960	60,240	6
7	Other Prepaid Expenses	7,192	7,192	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): <u>See Attached Schedule</u>	185,478	185,478	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 961,132	\$ 1,157,191	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	1,507,750	3,163,844	15
16	Equipment, at Historical Cost	1,241,529	1,685,703	16
17	Accumulated Depreciation (book methods)	(1,889,167)	(3,879,569)	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>	1,100,245	1,740,965	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,960,357	\$ 4,245,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,921,489	\$ 5,402,832	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 167,394	\$ 167,394	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,139	26,139	28
29	Short-Term Notes Payable	550,000	550,000	29
30	Accrued Salaries Payable	150,498	150,498	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,177	10,177	31
32	Accrued Real Estate Taxes(Sch.IX-B)		197,000	32
33	Accrued Interest Payable		53,177	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	9,700	195,178	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 913,908	\$ 1,349,563	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,574,758	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,051,054	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 17,625,812	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 913,908	\$ 18,975,375	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,007,581	\$ (13,572,543)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,921,489	\$ 5,402,832	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,976,911	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)	\$ 1,976,913	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	65,468	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	(34,800)	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)	\$ 30,668	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)	\$ 2,007,581	24 *

* This must agree with page 17, line 47.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,029,482	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,029,482	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***	6,690	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,690	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	23,990	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,990	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,060,162	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,168,111	31
32	Health Care	1,733,497	32
33	General Administration	1,570,829	33
	B. Capital Expense		
34	Ownership	1,522,257	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,994,694	40
41	Income before Income Taxes (line 30 minus line 40)**	65,468	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 65,468	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,083,573	44
45	Private Pay - Net Inpatient Revenue	87,607	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	3,858,302	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,029,482	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	1,913	2,091	\$ 77,663	\$ 37.14	1
2	Assistant Director of Nursing	1,941	2,091	63,754	30.49	2
3	Registered Nurses	1,592	1,873	53,998	28.83	3
4	Licensed Practical Nurses	13,426	14,393	322,456	22.40	4
5	CNAs & Orderlies	50,957	53,468	610,242	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,375	14,134	149,620	10.59	10
11	Social Service Workers	15,328	16,250	239,158	14.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,578	16,890	202,162	11.97	15
16	Dishwashers					16
17	Maintenance Workers	2,960	3,280	45,228	13.79	17
18	Housekeepers	17,063	18,596	203,402	10.94	18
19	Laundry					19
20	Administrator	1,829	2,091	114,965	54.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,413	8,251	136,601	16.56	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	2,201	2,615	45,654	17.46	31
32	Other Health Care(specify)					32
33	Other(specify)	1,939	1,939	9,939	5.13	33
34	TOTAL (lines 1 - 33)	147,515	157,962	\$ 2,274,842 *	\$ 14.40	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	\$ 30,644	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	50,112	10-03	38
39	Pharmacist Consultant	Monthly	19,635	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	Monthly	2,574	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	7,200	12-03	47
48	Specialized Rehab	Monthly	29,232	10A-03	48
49	TOTAL (lines 35 - 48)		\$ 147,797		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Lori R. Barrish	Administrator	0.00%	\$ 114,965
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,965
B. Administrative - Other			
Description			Amount
SIR/Generations HN - Director of Admin Services			\$ 50,112
SIR/Generations HN - Ancillary Admin Charges			41,760
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 91,872
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting		\$ 14,200
Plante Moran	Accounting		1,100
SIR/Generations HN	Bookkeeping		77,256
SIR/Generations HN	Dir. Of Regulatory Services		25,056
SIR/Generations HN	Dir. Of Financial Services		42,000
SIR/Generations HN	Dir. of Admissions		35,496
SIR/Generations HN	Computer Support Charges		22,968
SIR/Generations HN	Dir. Of IT		10,440
SIR/Generations HN	Consulting		301,431
Personnel Planners	Unemployment Tax Consult		1,944
See Attached	Legal		7,759
See Supplemental Schedule			21,953
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 561,603
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 27,072
Unemployment Compensation Insurance			46,969
FICA Taxes			172,980
Employee Health Insurance			101,953
Employee Meals			19,599
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension Plan			22,738
401K Match			2,600
Life Insurance			415
Other Employee Benefits			4,420
Allocated from MAC Rx LLC			(11)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 398,735
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,992
Advertising: Employee Recruitment			927
Health Care Worker Background Check (Indicate # of checks performed)		448	4,476
Patient Background Checks		68	680
Dues and Subscriptions			13,351
License and Permits			2,457
Allocated from SIR/Generations HN			1,983
Less: Public Relations Expense		()	
Non-allowable advertising		()	
Yellow page advertising		()	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 25,867
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			4,367
Allocated from SIR/Generations HN			569
Entertainment Expense		()	
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 4,936

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Bryn Mawr Care		STATE OF ILLINOIS	#	0035618	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>Alliance for Living \$22,572</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>881</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u> </u> NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u> </u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>N/A</u>							
(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? 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.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ <u>19,599</u> <u>No</u> Indicate the amount. \$ <u>N/A</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>None</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>N/A</u>							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							