



Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

**III. STATISTICAL DATA**

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	6,337	220	48,417	54,974	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,337	220	48,417	54,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 8/1/1989

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/1/1989 NO

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Bryn Mawr Care Inc. # 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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
	<b>A. General Services</b>										
1	Dietary	212,278	26,525	32,392	271,195		271,195	(13,536)	257,659		1
2	Food Purchase		280,091		280,091	(20,057)	260,034	(1,111)	258,923		2
3	Housekeeping	222,251	37,843		260,094		260,094	(3,055)	257,039		3
4	Laundry	3,063	19,457		22,520		22,520	(446)	22,074		4
5	Heat and Other Utilities			142,791	142,791		142,791	(15,594)	127,197		5
6	Maintenance	54,831	17,584	187,324	259,739		259,739	(3,093)	256,646		6
7	Other (specify):*							11,379	11,379		7
8	<b>TOTAL General Services</b>	492,423	381,500	362,507	1,236,430	(20,057)	1,216,373	(25,456)	1,190,917		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600	6,496	10,096		9
10	Nursing and Medical Records	1,248,674	42,331	75,041	1,366,046		1,366,046	(669)	1,365,377		10
10a	Therapy			29,760	29,760		29,760	(13,544)	16,216		10a
11	Activities	171,728	10,858	2,532	185,118		185,118		185,118		11
12	Social Services	282,628		7,200	289,828		289,828		289,828		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							10,114	10,114		15
16	<b>TOTAL Health Care and Programs</b>	1,703,030	53,189	118,133	1,874,352		1,874,352	2,397	1,876,749		16
	<b>C. General Administration</b>										
17	Administrative	102,181		93,960	196,141		196,141	(247,627)	(51,486)		17
18	Directors Fees										18
19	Professional Services			565,344	565,344	(4,269)	561,075	(178,409)	382,666		19
20	Dues, Fees, Subscriptions & Promotions			64,268	64,268		64,268	(28,172)	36,096		20
21	Clerical & General Office Expenses	93,194	14,313	53,407	160,914		160,914	113,828	274,742		21
22	Employee Benefits & Payroll Taxes			381,263	381,263	20,057	401,320		401,320		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,773	5,773		5,773	182	5,955		24
25	Other Admin. Staff Transportation			1,228	1,228		1,228	11,103	12,331		25
26	Insurance-Prop.Liab.Malpractice			126,480	126,480		126,480	13,143	139,623		26
27	Other (specify):*							42,199	42,199		27
28	<b>TOTAL General Administration</b>	195,375	14,313	1,291,723	1,501,411	15,787	1,517,198	(273,753)	1,243,446		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,390,828	449,002	1,772,363	4,612,193	(4,269)	4,607,924	(296,812)	4,311,112		29

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

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

Facility Name & ID Number Bryn Mawr Care Inc.

#0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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			72,676	72,676		72,676	215,815	288,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,926	29,926		29,926	622,961	652,887			32
33	Real Estate Taxes					4,269	4,269	233,412	237,681			33
34	Rent-Facility & Grounds			1,464,000	1,464,000		1,464,000	(1,464,000)				34
35	Rent-Equipment & Vehicles			6,131	6,131		6,131	5,006	11,137			35
36	Other (specify):*							90,202	90,202			36
37	<b>TOTAL Ownership</b>			1,572,733	1,572,733	4,269	1,577,002	(296,604)	1,280,398			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>											44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,390,828	449,002	3,345,096	6,184,926		6,184,926	(593,416)	5,591,510			45

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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning:

**01/01/17**

Ending:

**12/31/17**

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(17,634)	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	32,581	30		9
10	Interest and Other Investment Income	(8,637)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	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	(15,522)	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	(16,372)	21		24
25	Fund Raising, Advertising and Promotional	(3,516)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,791)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (68,902)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(524,513)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (524,513)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (593,415)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Bryn Mawr Care Inc.ID# 0054205Report Period Beginning: 01/01/17Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (7,274)	21	1
2	Theft and Damage Loss	(39)	21	2
3	Non-Allowable Interest	(950)	32	3
4	Vending Income	(1,100)	02	4
5	Additional R&M	2,063	06	5
6	Capitalized R&M	(8,330)	06	6
7	Alliance for Living	(9,435)	20	7
8	Non-Allowable Legal	(2,754)	19	8
9	Building Co - Amortization	(2,597)	36	9
10	Building Co - Fees	(350)	20	10
11	Building Co - Audit	(8,900)	19	11
12	Building Co - Replacement Tax	(100)	21	12
13	Building Co - Office Expense	(25)	21	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	<b>Total</b>	(39,791)		49

Bryn Mawr Care Inc.

Report Period Beginning:                     ID#                    0054205                      
 Ending:                     01/01/17                      
                    12/31/17                    

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bryn Mawr Care Inc.# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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				(13,412)		(124)						(13,536)	1
2	Food Purchase	(1,111)											(1,111)	2
3	Housekeeping						(3,055)						(3,055)	3
4	Laundry						(446)						(446)	4
5	Heat and Other Utilities	(17,634)			2,040								(15,594)	5
6	Maintenance	(6,267)	12,691	(11,507)	2,491		(501)						(3,093)	6
7	Other (specify):*			1,316	10,063								11,379	7
8	<b>TOTAL General Services</b>	<b>(25,012)</b>	<b>12,691</b>	<b>(10,191)</b>	<b>1,182</b>		<b>(4,126)</b>						<b>(25,456)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director			6,496									6,496	9
10	Nursing and Medical Records			(4,463)	8,510	(2,521)	(2,195)						(669)	10
10a	Therapy				(13,544)								(13,544)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,821	4,293								10,114	15
16	<b>TOTAL Health Care and Programs</b>			<b>7,854</b>	<b>(741)</b>	<b>(2,521)</b>	<b>(2,195)</b>						<b>2,397</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(360,212)	112,585								(247,627)	17
18	Directors Fees													18
19	Professional Services	(11,654)	8,900	(191,588)	15,933								(178,409)	19
20	Fees, Subscriptions & Promotions	(28,823)	350	301									(28,172)	20
21	Clerical & General Office Expenses	(23,810)	125	137,452	163	(74)	(28)						113,828	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			182									182	24
25	Other Admin. Staff Transportation			11,103									11,103	25
26	Insurance-Prop.Liab.Malpractice		11,078	1,853	212								13,143	26
27	Other (specify):*			14,468	27,731								42,199	27
28	<b>TOTAL General Administration</b>	<b>(64,287)</b>	<b>20,453</b>	<b>(386,441)</b>	<b>156,624</b>	<b>(74)</b>	<b>(28)</b>						<b>(273,753)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(89,299)</b>	<b>33,144</b>	<b>(388,778)</b>	<b>157,065</b>	<b>(2,595)</b>	<b>(6,349)</b>						<b>(296,812)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bryn Mawr Care Inc. # 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	32,581	176,034		7,200								215,815	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,587)	631,049	(4,503)	6,002								622,961	32
33	Real Estate Taxes		224,443		8,969								233,412	33
34	Rent-Facility & Grounds		(1,464,000)										(1,464,000)	34
35	Rent-Equipment & Vehicles			5,006									5,006	35
36	Other (specify):*	(2,597)	92,799										90,202	36
37	<b>TOTAL Ownership</b>	<b>20,397</b>	<b>(339,675)</b>	<b>503</b>	<b>22,171</b>								<b>(296,604)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(68,902)</b>	<b>(306,531)</b>	<b>(388,275)</b>	<b>179,236</b>	<b>(2,595)</b>	<b>(6,349)</b>						<b>(593,416)</b>	<b>45</b>

**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	\$ 1,464,000	Bryn Mawr Care, LLC	100.00%	\$	(1,464,000)	1
2	V	36 Amortization		Bryn Mawr Care, LLC	100.00%	2,597	2,597	2
3	V	06 Repairs and Maintenance		Bryn Mawr Care, LLC	100.00%	12,691	12,691	3
4	V	20 Fees		Bryn Mawr Care, LLC	100.00%	350	350	4
5	V	32 Interest	116	Bryn Mawr Care, LLC	100.00%	631,165	631,049	5
6	V	36 Mortgage Insurance		Bryn Mawr Care, LLC	100.00%	90,202	90,202	6
7	V	26 Property Insurance		Bryn Mawr Care, LLC	100.00%	11,078	11,078	7
8	V	33 Real Estate Taxes		Bryn Mawr Care, LLC	100.00%	224,443	224,443	8
9	V	30 Depreciation		Bryn Mawr Care, LLC	100.00%	176,034	176,034	9
10	V	19 Audit		Bryn Mawr Care, LLC	100.00%	8,900	8,900	10
11	V	21 Replacement Tax		Bryn Mawr Care, LLC	100.00%	100	100	11
12	V	21 Office Expense		Bryn Mawr Care, LLC	100.00%	25	25	12
13	V							13
14	Total		\$ 1,464,116			\$ 1,157,585	\$ * (306,531)	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.  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.	\$ 25,584	GENERATIONS HC NETWORK, LLC	100.00%	\$ 14,077	\$ (11,507)
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC	100.00%	1,316	1,316
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC	100.00%	6,496	6,496
18	V	10 NURSING	51,156	GENERATIONS HC NETWORK, LLC	100.00%	46,693	(4,463)
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC	100.00%	5,821	5,821
20	V	17 ADMINISTRATIVE	387,076	GENERATIONS HC NETWORK, LLC	100.00%	26,864	(360,212)
21	V	19 PROFESSIONAL FEES	193,284	GENERATIONS HC NETWORK, LLC	100.00%	1,696	(191,588)
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC	100.00%	301	301
23	V	21 CLERICAL & GENERAL	8,556	GENERATIONS HC NETWORK, LLC	100.00%	146,008	137,452
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC	100.00%	182	182
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC	100.00%	11,103	11,103
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	1,853	1,853
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC	100.00%	14,468	14,468
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	(4,503)	(4,503)
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	4,105	4,105
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	901	901
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 665,656			\$ 277,381	\$ * (388,275)

\* 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	\$ 21,300	GENERATIONS HC NETWORK, LLC	100.00%	\$ 7,888	\$ (13,412)
16	V	7 EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	100.00%	1,366	1,366
17	V	10 NURSING SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	8,510	8,510
18	V	15 EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	100.00%	1,469	1,469
19	V	17 ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	112,585	112,585
20	V	19 FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	100.00%	15,843	15,843
21	V	27 EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	100.00%	27,731	27,731
22	V						
23	V						
24	V	10A DIRECTOR OF SPECIAL REHAB	29,760	GENERATIONS HC NETWORK, LLC	100.00%	16,216	(13,544)
25	V	15 EMPLOYEE BENFITS		GENERATIONS HC NETWORK, LLC	100.00%	2,824	2,824
26	V						
27	V	6 MAINTENANCE SALARIES	46,670	GENERATIONS HC NETWORK, LLC	100.00%	47,883	1,213
28	V	7 EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	8,697	8,697
29	V						
30	V	5 UTILITIES		GENERATIONS HC NETWORK, LLC	100.00%	2,040	2,040
31	V	6 REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	100.00%	1,278	1,278
32	V	19 PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	100.00%	90	90
33	V	21 CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	100.00%	163	163
34	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	212	212
35	V	30 DEPRECIATION		GENERATIONS HC NETWORK, LLC	100.00%	7,200	7,200
36	V	32 INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	6,002	6,002
37	V	33 REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	100.00%	8,969	8,969
38	V						
39	Total		\$ 97,730			\$ 276,966	\$ * 179,236

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

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning: 01/01/17

Ending: 12/31/17

**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	06 Maintenance	\$	MAC Rx, LLC	100.00%	\$		15
16	V	10 Nursing and Medical Records	30,520	MAC Rx, LLC	100.00%	27,999	(2,521)	16
17	V	10A Therapy		MAC Rx, LLC	100.00%			17
18	V	19 Professional Services		MAC Rx, LLC	100.00%			18
19	V	21 Clerical & General Office Expenses	894	MAC Rx, LLC	100.00%	820	(74)	19
20	V	22 Employee Benefits		MAC Rx, LLC	100.00%			20
21	V	39 Ancillary		MAC Rx, LLC	100.00%			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		\$ 31,414			\$ 28,819	\$ * (2,595)	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	\$ 1,428	Big Ten Supply, LLC	100.00%	\$ 1,305	\$ (124)
16	V	3 Housekeeping	35,248	Big Ten Supply, LLC	100.00%	32,192	(3,055)
17	V	4 Laundry	5,142	Big Ten Supply, LLC	100.00%	4,696	(446)
18	V	6 Repairs & Maintenance	5,783	Big Ten Supply, LLC	100.00%	5,282	(501)
19	V	10 Nursing And Medical Records	25,318	Big Ten Supply, LLC	100.00%	23,123	(2,195)
20	V	10A Therapy		Big Ten Supply, LLC	100.00%		
21	V	21 Clerical & General	324	Big Ten Supply, LLC	100.00%	296	(28)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 73,243			\$ 66,894	\$ * (6,349)

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

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





Facility Name &amp; ID Number

Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	2.77	6.93%	Alloc. Salary	\$ 15,843	17-7	1	
2	Kirsten Schloss	Shareholder	Maintenance	1.44%	See Attached	3.96	7.92%	Alloc. Salary	7,537	6-7	2	
3	Sarah Barrish	Shareholder	Administrative	2.87%	See Attached	3.96	7.92%	Alloc. Salary	9,885	17-7	3	
4	Michael Giannini	Relative	Administrative		See Attached	2.77	6.93%	Alloc. Salary	13,467	17-7	4	
5	Nenita Guzman	Relative	Dietary		See Attached	3.96	7.92%	Alloc. Salary	7,888	1-7	5	
6	Lori Barrish	Relative	Administrative		See Attached	40.00	100.00%	Salary	102,181	17-1	6	
7	Clark Collins	Relative	Administrative		See Attached	1.27	3.18%	Alloc. Salary	1,586	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	\$ 158,387		13	

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

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

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 GENERATIONS HC NETWORK, LLC  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V 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	6	REPAIRS AND MAINT.	PATIENT DAYS	693,985	14	\$ 177,702	\$ 95,737	54,974	\$ 14,077	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	693,985	14	16,617		54,974	1,316	2
3	9	MEDICAL DIRECTOR CONSUM	PATIENT DAYS	693,985	14	82,000		54,974	6,496	3
4	10	NURSING	PATIENT DAYS	693,985	14	589,441	589,441	54,974	46,693	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	693,985	14	73,484		54,974	5,821	5
6	17	ADMINISTRATIVE	PATIENT DAYS	693,985	14	339,126	339,126	54,974	26,864	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	693,985	14	21,409		54,974	1,696	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	693,985	14	3,801		54,974	301	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	693,985	14	1,843,191	1,656,700	54,974	146,008	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	693,985	14	2,295		54,974	182	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	693,985	14	140,164		54,974	11,103	11
12	26	INSURANCE	PATIENT DAYS	693,985	14	23,394		54,974	1,853	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	693,985	14	182,645		54,974	14,468	13
14	32	INTEREST	PATIENT DAYS	693,985	14	(56,845)		54,974	(4,503)	14
15	35	AUTO RENTAL	PATIENT DAYS	693,985	14	51,827		54,974	4,105	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	693,985	14	11,377		54,974	901	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,501,628	\$ 2,681,003		\$ 277,381	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 GENERATIONS HC NETWORK, LLC  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V 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	DIETARY SALARIES	PATIENT DAYS	693,985	14	\$ 99,579	\$ 99,579	54,974	\$ 7,888	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	693,985	14	17,250	54,974	1,366	2	
3	10	NURSING SALARIES	PATIENT DAYS	693,985	14	107,435	107,435	54,974	8,510	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	693,985	14	18,544	54,974	1,469	4	
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	693,985	14	1,421,258	1,421,258	54,974	112,585	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	693,985	14	200,000	54,974	15,843	6	
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	693,985	14	350,079	54,974	27,731	7	
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	329,142	13	179,343	179,343	29,760	16,216	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	329,142	13	31,236	29,760	2,824	11	
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	366,497	14	376,026	376,026	46,670	47,883	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	366,497	14	68,296	46,670	8,697	14	
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,877	14	25,758	1,020	2,040	16	
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,877	14	16,130	1,020	1,278	17	
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,877	14	1,139	1,020	90	18	
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,877	14	2,063	1,020	163	19	
20	26	INSURANCE	ALLOCATED SQ FT	12,877	14	2,682	1,020	212	20	
21	30	DEPRECIATION	ALLOCATED SQ FT	12,877	14	90,892	1,020	7,200	21	
22	32	INTEREST	ALLOCATED SQ FT	12,877	14	75,767	1,020	6,002	22	
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,877	14	113,223	1,020	8,969	23	
24										24
25	TOTALS					\$ 3,196,700	\$ 2,183,641	\$ 276,966	25	

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 MAC Rx, LLC  
 Street Address 2307 S. Mount Prospect Road  
 City / State / Zip Code Des Plaines, IL 60018  
 Phone Number ( 224)220-2700  
 Fax Number ( 224)220-2730

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	06	Maintenance	Direct Allocation		\$	\$		\$	1
2	10	Nursing And Medical Records	Direct Allocation					27,999	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					820	5
6	22	Employee Benefits	Direct Allocation						6
7	39	Ancillary	Direct Allocation						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				\$	\$		\$ 28,819	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	Dietary	Direct Allocation		\$	\$		1,305	1
2	3	Housekeeping	Direct Allocation					32,192	2
3	4	Laundry	Direct Allocation					4,696	3
4	6	Repairs & Maintenance	Direct Allocation					5,282	4
5	10	Nursing And Medical Records	Direct Allocation					23,123	5
6	10A	Therapy	Direct Allocation						6
7	21	Clerical & General	Direct Allocation					296	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				\$	\$		66,894	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Private Bank		X	Mortgage			\$	\$ 16,238,873			\$	631,165						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6	Lake Forest Bank		X	Line of Credit				650,000				28,976						
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$ 16,888,873			\$	660,141						
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X									(8,637)						
11	Interest Income - Bldg Co		X									(116)						
12	Allocated from Generations HC		X									1,499						
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(7,254)						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 16,888,873			\$	652,887						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 90,202      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.)





**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 Bryn Mawr Care Inc. COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0054205  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**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 Applicable to Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation 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.**

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205 Report Period Beginning:

01/01/17 Ending:

12/31/17

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: Facility, 1989, \$63,070, 1. Row 2: (blank), 2. Row 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
<b>Improvement Type**</b>										
9	Various		1989	3,323		20			3,323	9
10	Various		1990	21,607		20	86	86	21,221	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			130,273	16
17	Various		1997	192,708		20	4,572	4,572	186,294	17
18	Various		1998	163,775		20	8,189	8,189	159,962	18
19	Various		1999	29,826		20	1,491	1,491	26,967	19
20	Various		2000	120,434		20	6,022	6,022	107,134	20
21	Various		2001	121,537		20	4,939	4,939	103,945	21
22	Various		2002	697,409		20			697,409	22
23	Various		2003	33,644		20	1,403	1,403	25,928	23
24	Various		2004	67,643		20	3,366	3,366	45,485	24
25	Various		2005	96,040		20	4,639	4,639	60,676	25
26	Various		2006	91,024		20	4,411	4,411	54,381	26
27	Various		2007	43,798		20	1,978	1,978	31,453	27
28	Various		2008	87,925		20	3,819	3,819	48,028	28
29	Various		2009	51,311		20	2,566	2,566	22,121	29
30	Various		2010	13,151		20	1,315	1,315	9,782	30
31	Various		2012	4,870		20	487	487	2,881	31
32	Various		2013	20,265		20	1,013	1,013	4,647	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		1,831,321	89,669		91,571	1,902	742,917	67
68		151,291	4,309		5,037	728	94,173	68
69			72,676			(72,676)		69
70		\$ 5,669,570	\$ 209,462		\$ 146,903	\$ (62,559)	\$ 4,277,840	70

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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		\$ 5,669,570	\$ 209,462		\$ 146,903	\$ (62,559)	\$ 4,277,840	1
2	2014	5,425		20	1,085	1,085	3,436	2
3	2015	7,477		20	374	374	779	3
4	2015	3,495		20	350	350	874	4
5	2016	2,900		20	145	145	181	5
6	2016	2,860		20	143	143	203	6
7	2017	1,599,168		20	79,958	79,958	79,958	7
8	2017			20				8
9	2017			20				9
10	2017	2,845		20	142	142	142	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		\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	34

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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	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		\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	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	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		\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	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)	\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	34

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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	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		\$ 7,293,741	\$ 209,462		\$ 229,100	\$ 19,638	\$ 4,363,413	34

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

Facility Name &amp; ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Various	2008	408,577		20	20,429	20,429	195,282	9
10	Various	2009	524,103		20	26,205	26,205	235,852	10
11	Various	2010	529,130		20	26,457	26,457	211,656	11
12	Tuck Pointing	2011	7,500		20	375	375	2,625	12
13	Fire Door	2011	12,850		20	643	643	4,501	13
14	Fire Alarm Upgrade	2011	42,500		20	2,125	2,125	14,875	14
15	Painting	2011	43,500		20	2,175	2,175	15,225	15
16	Water Heater	2011	7,075		20	354	354	2,478	16
17	Elevator Work	2011	8,500		20	425	425	2,975	17
18	Door Casings	2011	10,500		20	525	525	3,675	18
19	Electrical Wiring Upgrade	2012	25,100		20	1,255	1,255	7,530	19
20	Fire Dampers	2012	56,521		20	2,826	2,826	16,956	20
21	Sprinklers- Mechanical Rooms	2012	7,552		20	378	378	2,268	21
22	Built in Bookshelves	2012	3,950		20	198	198	1,188	22
23	Replace Valves In Hot Water Boiler	2012	3,490		20	174	174	1,044	23
24	Replace vent- pipe and Faucets	2012	5,980		20	299	299	1,794	24
25	Repaint kitchen & Day Rooms	2012	5,414		20	271	271	1,626	25
26	Replace Damaged floor tiles	2012	3,640		20	182	182	1,092	26
27	Bathroom drywall, plaster and primer work	2012	4,172		20	209	209	1,254	27
28	Replace Condenser for walk in cooler	2012	4,390		20	220	220	1,320	28
29	New Handrails	2012	3,130		20	157	157	942	29
30	Camera Security System	2013	5,064		20	253	253	1,265	30
31	Fire Alarm Device	2013	3,511		20	176	176	880	31
32	Sprinkler System/Alarm	2013	5,775		20	289	289	1,445	32
33	Kitchen Duct System	2014	10,753		20	538	538	2,151	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,742,677	\$		\$ 87,138	\$ 87,138	\$ 731,899	34

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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	<b>Totals from Page 12F, Carried Forward</b>		\$ 1,742,677	\$		\$ 87,138	\$	\$ 731,899	1
2	Replace Kitchen Gas Line	2014	2,800		20	140	140	560	2
3	Air Conditioners	2014	6,237		20	312	312	1,248	3
4	Replaced Gas Lines	2015	21,910		20	1,096	1,096	3,288	4
5	Hot water heater	2015	3,885		20	194	194	582	5
6	Install handrail and crash rail	2015	2,555		20	128	128	384	6
7	Masonry & Concrete Repair in Kitchen	2015	3,100		20	155	155	465	7
8	Replace Piping	2016	6,400		20	320	320	640	8
9	Installed Door Protection	2016	3,253		20	163	163	326	9
10	Replaced Boiler Burner	2016	26,865		20	1,343	1,343	2,686	10
11	Tile work in elevator and new flooring	2016	2,593		20	130	130	387	11
12	Security Cameras	2017	3,561		20	178	178	178	12
13	Window wall cabinets	2017	2,500		20	125	125	125	13
14	Repaired pip condensate line	2017	2,985		20	149	149	149	14
15									15
16	Depreciation			89,669			(89,669)		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	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,831,321	\$ 89,669		\$ 91,571	\$ (85,236)	\$ 742,917	34

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

Facility Name &amp; ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	Allocation from Generations Healthcare Network	2009	19,803	525	39	508	(17)	4,083	3
4	Allocation from SIR Properties/Generations Healthcare Network	1993	35,856	1,138	35	1,024	(114)	25,099	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from Generations Healthcare Network	1993	9,091	253	20		(253)	9,091	9
10	Allocation from Generations Healthcare Network	1994	28		20			28	10
11	Allocation from Generations Healthcare Network	1995	208		20			208	11
12	Allocation from Generations Healthcare Network	1997	13,968	626	20	234	(392)	13,968	12
13	Allocation from Generations Healthcare Network	1999	1,098		20	55	55	1,002	13
14	Allocation from Generations Healthcare Network	1999	9,735		20			9,735	14
15	Allocation from Generations Healthcare Network	2000	1,297		20	65	65	1,137	15
16	Allocation from Generations Healthcare Network	2007	4,166		20	208	208	2,124	16
17	Allocation from Generations Healthcare Network	2008	11,483	1,148	20	724	(424)	7,125	17
18	Allocation from Generations Healthcare Network	2009	28,532	261	20	1,427	1,166	11,762	18
19	Allocation from Generations Healthcare Network	2011	706	71	20	71		453	19
20	Allocation from Generations Healthcare Network	2012	2,259	113	20	113		628	20
21	Allocation from Generations Healthcare Network	2014	317	32	20	16	(16)	57	21
22	Allocation from Generations Healthcare Network	2016	412	21	20	21		29	22
23	Allocation from SIR Properties/Generations Healthcare Network	2012	2,196	96	20	110	14	550	23
24	Allocation from SIR Properties/Generations Healthcare Network	2010	2,164		20	108	108	793	24
25	Allocation from SIR Properties/Generations Healthcare Network	2009	2,153		20	108	108	947	25
26	Allocation from SIR Properties/Generations Healthcare Network	2007	212	13	20	11	(2)	117	26
27	Allocation from SIR Properties/Generations Healthcare Network	2002	142		20	7	7	111	27
28	Allocation from SIR Properties/Generations Healthcare Network	1999	4,543		20	227	227	4,203	28
29	Allocation from SIR Properties/Generations Healthcare Network	1994	341	9	20		(9)	342	29
30	Allocation from SIR Properties/Generations Healthcare Network	1993	581	3	20		(3)	581	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 151,291	\$ 4,309		\$ 5,037	\$ 728	\$ 94,173	34

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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		\$ 151,291	\$ 4,309		\$ 5,037	\$ 728	\$ 94,173	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)	\$ 151,291	\$ 4,309		\$ 5,037	\$ 728	\$ 94,173	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	\$ 763,232	\$ 46,205	\$ 56,323	\$ 10,118	10	\$ 560,648	71
72	Current Year Purchases	18,464		1,644	1,644	10	1,644	72
73	Fully Depreciated Assets	434,984		1,241	1,241	10	434,984	73
74								74
75	TOTALS	\$ 1,216,680	\$ 46,205	\$ 59,208	\$ 13,003		\$ 997,276	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 CHEVY VAN	2001	\$ 15,436	\$	\$	\$	5	\$ 15,436	76
77		Allocated from Generations HC N	2017	2,785	243	183	(60)	5	2,326	77
78										78
79										79
80	TOTALS			\$ 18,221	\$ 243	\$ 183	\$ (60)		\$ 17,762	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,591,711	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 255,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 288,491	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,581	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,378,451	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning: 01/01/17

Ending: 12/31/17

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

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

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 7,032

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	<u>Allocated from Generations HC Network LLC</u>		\$ _____	\$ <u>4,105</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,105</u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.)

	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 36,634	\$ 171,108	1
2	Cash-Patient Deposits	23,462	23,462	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	740,386	740,386	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,088	23,088	6
7	Other Prepaid Expenses	6,548	44,632	7
8	Accounts Receivable (owners or related parties)	100,000	100,000	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 930,118	\$ 1,102,676	10
	<b>B. Long-Term Assets</b>			
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	2,914,378	4,765,892	15
16	Equipment, at Historical Cost	1,246,285	1,709,792	16
17	Accumulated Depreciation (book methods)	(1,961,843)	(4,128,279)	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>		308,593	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,198,820	\$ 4,190,696	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,128,938	\$ 5,293,372	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 555,287	\$ 555,288	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,462	23,462	28
29	Short-Term Notes Payable	650,000	999,047	29
30	Accrued Salaries Payable	168,537	168,537	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,684	10,684	31
32	Accrued Real Estate Taxes(Sch.IX-B)		216,000	32
33	Accrued Interest Payable		52,100	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	6,500	6,500	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,414,470	\$ 2,031,618	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,889,826	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>		998,944	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 16,888,770	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,414,470	\$ 18,920,388	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,714,468	\$ (13,627,016)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,128,938	\$ 5,293,372	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,007,581</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,007,581</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(293,113)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (293,113)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,714,468</b>	<b>24</b> *

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

Facility Name &amp; ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning: 01/01/17

Ending:

12/31/17

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,864,551	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,864,551	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	34	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 34	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,637	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,637	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	18,591	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 18,591	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,891,813	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,236,430	31
32	Health Care	1,874,352	32
33	General Administration	1,501,411	33
<b>B. Capital Expense</b>			
34	Ownership	1,572,733	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,184,926	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(293,113)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (293,113)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 680,773	44
45	Private Pay - Net Inpatient Revenue	32,130	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <b>Managed Care</b>	5,151,648	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,864,551	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.

Facility Name & ID Number Bryn Mawr Care Inc.

# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1,970	2,086	\$ 83,465	\$ 40.01	1
2	Assistant Director of Nursing	1,938	2,086	65,048	31.18	2
3	Registered Nurses	1,467	1,661	52,085	31.36	3
4	Licensed Practical Nurses	13,342	14,300	337,531	23.60	4
5	CNAs & Orderlies	50,780	54,376	677,212	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,784	14,534	171,728	11.82	10
11	Social Service Workers	17,543	18,859	273,636	14.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,745	17,171	212,278	12.36	15
16	Dishwashers					16
17	Maintenance Workers	3,970	4,060	54,831	13.51	17
18	Housekeepers	17,304	18,722	222,251	11.87	18
19	Laundry	271	280	3,063	10.94	19
20	Administrator	1,841	2,086	102,181	48.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,388	5,042	93,194	18.48	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	2,000	2,171	33,333	15.35	31
32	Other Health Care(specify)					32
33	Other(specify)	1,675	1,675	8,992	5.37	33
34	TOTAL (lines 1 - 33)	148,018	159,109	\$ 2,390,828 *	\$ 15.03	34

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

\*\* See instructions.

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	\$ 32,392	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	51,156	10-03	38
39	Pharmacist Consultant	Monthly	19,085	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	2,532	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	29,760	10A-03	48
49	TOTAL (lines 35 - 48)		\$ 150,525		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

Facility Name & ID Number **Bryn Mawr Care Inc.**

# **0054205**

Report Period Beginning: **01/01/17**

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Lori Barrish	Administrator	0.00%	\$ 102,181	Workers' Compensation Insurance	\$ 34,546	IDPH License Fee	\$ 1,492		
				Unemployment Compensation Insurance	40,923	Advertising: Employee Recruitment	6,521		
				FICA Taxes	180,079	Health Care Worker Background Check (Indicate # of checks performed <u>309</u> )	3,090		
				Employee Health Insurance	97,407	Patient Background Checks <u>93</u>	930		
				Employee Meals	20,057	Dues and Subscriptions	19,652		
				Illinois Municipal Retirement Fund (IMRF)*		License and Permits	4,110		
				Union Pension Plan	22,892	Allocated from Generations HC Network	301		
				401K Match	4,438				
				Other Employee Benefits	977				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,181	TOTAL (agree to Schedule V, line 22, col.8)		\$ 401,318	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 36,095
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
SIR/Generations HN - Director of Adminstrative Services			\$ 51,156				Out-of-State Travel	\$	
SIR/Generations HN - Ancillary Administrative Charges			42,804				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 93,960	TOTAL		\$	Seminar Expense	5,773	
C. Professional Services							Allocated from Generations HC Network		182
Vendor/Payee	Type		Amount				Entertainment Expense (agree to Sch. V, line 24, col. 8)		
Marcum LLP	Accounting		\$ 16,025				TOTAL		\$ 5,955
RSM US LLP	Accounting		1,751						
Plante Moran	Accounting		1,125						
SIR/Generations HN	Bookkeeping		78,828						
SIR/Generations HN	Dir. Of Regulatory Services		25,584						
SIR/Generations HN	Dir. Of Financial Services		42,000						
SIR/Generations HN	Dir. of Admissions		36,228						
SIR/Generations HN	Computer Support Charges		23,496						
SIR/Generations HN	Dir. Of Information Tech		10,644						
SIR/Generations HN	Consulting		293,116						
HK Payroll	Payroll Processing		360						
See Supplemental Schedule			36,188						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 565,344						

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Bryn Mawr Care Inc.# 0054205

Report Period Beginning:

01/01/17

Ending:

12/31/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Alliance for Living \$22,572
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,010 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$                       
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,057 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees