

Facility Name & ID Number Bryn Mawr Care Inc.

0054205 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	9,269	312	47,834	57,415	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,269	312	47,834	57,415	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.40%

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Bryn Mawr Care Inc. # 0054205 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	211,896	26,317	29,316	267,529		267,529	(7,751)	259,778		1
2	Food Purchase		285,495		285,495	(19,674)	265,822	(1,216)	264,606		2
3	Housekeeping	242,240	34,315		276,555		276,555	(3,191)	273,364		3
4	Laundry	18,185	16,485		34,670		34,670	(454)	34,216		4
5	Heat and Other Utilities			159,597	159,597		159,597	(17,288)	142,309		5
6	Maintenance	64,051	23,759	135,760	223,570		223,570	18,211	241,781		6
7	Other (specify):*							9,215	9,215		7
8	TOTAL General Services	536,372	386,371	324,673	1,247,416	(19,674)	1,227,743	(2,473)	1,225,269		8
	B. Health Care and Programs										
9	Medical Director			300	300		300		300		9
10	Nursing and Medical Records	1,307,539	41,862	76,744	1,426,145		1,426,145	(2,780)	1,423,365		10
10a	Therapy			33,408	33,408		33,408	(11,049)	22,359		10a
11	Activities	165,128	8,406	636	174,170		174,170		174,170		11
12	Social Services	275,202		7,200	282,402		282,402		282,402		12
13	CNA Training										13
14	Program Transportation			95	95		95		95		14
15	Other (specify):*							10,964	10,964		15
16	TOTAL Health Care and Programs	1,747,869	50,268	118,383	1,916,520		1,916,520	(2,865)	1,913,655		16
	C. General Administration										
17	Administrative	110,859		383,622	494,481		494,481	(234,852)	259,629		17
18	Directors Fees										18
19	Professional Services			275,304	275,304	(2,931)	272,373	(179,547)	92,826		19
20	Dues, Fees, Subscriptions & Promotions			90,900	90,900		90,900	(64,754)	26,146		20
21	Clerical & General Office Expenses	111,054	11,624	81,874	204,552		204,552	95,357	299,909		21
22	Employee Benefits & Payroll Taxes			385,496	385,496	19,674	405,170	(137)	405,032		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,505	4,505		4,505	279	4,784		24
25	Other Admin. Staff Transportation			4,138	4,138		4,138	17,788	21,926		25
26	Insurance-Prop.Liab.Malpractice			172,166	172,166		172,166	13,078	185,244		26
27	Other (specify):*							38,161	38,161		27
28	TOTAL General Administration	221,913	11,624	1,398,005	1,631,542	16,743	1,648,285	(314,627)	1,333,658		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,506,154	448,263	1,841,061	4,795,478	(2,931)	4,792,547	(319,965)	4,472,582		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:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			85,319	85,319		85,319	192,550	277,869			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,529	26,529		26,529	576,635	603,164			32
33	Real Estate Taxes					2,931	2,931	244,729	247,660			33
34	Rent-Facility & Grounds			1,464,000	1,464,000		1,464,000	(1,464,000)				34
35	Rent-Equipment & Vehicles			6,539	6,539		6,539	4,040	10,579			35
36	Other (specify):*							88,109	88,109			36
37	TOTAL Ownership			1,582,387	1,582,387	2,931	1,585,318	(357,937)	1,227,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,506,154	448,263	3,423,448	6,377,865		6,377,865	(677,902)	5,699,963			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

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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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,372)	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	13,561	30		9
10	Interest and Other Investment Income	(16,276)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	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	(46,997)	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	(41,266)	21		24
25	Fund Raising, Advertising and Promotional	(5,671)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,482)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,074)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (165,593)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(512,309)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (512,309)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (677,902)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Bryn Mawr Care Inc.

ID# 0054205
 Report Period Beginning: 01/01/18
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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Office Expense - Bank Fees	\$ (7,264)	21	1
2	Theft & Damage Loss	(258)	21	2
3	Vending Income	(1,200)	02	3
4	Non-allowable Equipment Rental	(160)	35	4
5	Non-allowable Legal	(6,090)	19	5
6	Alliance for Living	(12,198)	20	6
7	Building Co - Amortization	(2,597)	36	7
8	Building Co - Fees	(10,500)	20	8
9	Building Co - Replacement Tax	(4,966)	21	9
10	Building Co - Office Expense	(25)	21	10
11	Repairs Reimbursement	(1,831)	06	11
12	Non-Allowable Interest Expense	(985)	32	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(48,074)		49

Bryn Mawr Care Inc.

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/18

Ending:

12/31/18

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				(7,721)		(30)						(7,751)	1
2	Food Purchase	(1,216)											(1,216)	2
3	Housekeeping						(3,191)						(3,191)	3
4	Laundry						(454)						(454)	4
5	Heat and Other Utilities	(19,372)			2,084								(17,288)	5
6	Maintenance	(1,831)	12,753	(941)	8,510		(280)						18,211	6
7	Other (specify):*			1,218	7,997								9,215	7
8	TOTAL General Services	(22,419)	12,753	277	10,870		(3,954)						(2,473)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(6,397)	7,829	(1,956)	(2,256)						(2,780)	10
10a	Therapy				(11,049)								(11,049)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,913	5,051								10,964	15
16	TOTAL Health Care and Programs			(484)	1,831	(1,956)	(2,256)						(2,865)	16
	C. General Administration													
17	Administrative			(356,070)	121,218								(234,852)	17
18	Directors Fees													18
19	Professional Services	(6,090)		(188,154)	14,697								(179,547)	19
20	Fees, Subscriptions & Promotions	(75,366)	10,500	112									(64,754)	20
21	Clerical & General Office Expenses	(55,261)	4,991	145,553	111	(37)							95,357	21
22	Employee Benefits & Payroll Taxes					(137)							(137)	22
23	Inservice Training & Education													23
24	Travel and Seminar			279									279	24
25	Other Admin. Staff Transportation			17,788									17,788	25
26	Insurance-Prop.Liab.Malpractice		11,268	1,552	258								13,078	26
27	Other (specify):*			9,789	28,372								38,161	27
28	TOTAL General Administration	(136,717)	26,759	(369,151)	164,656	(174)							(314,627)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,136)	39,512	(369,358)	177,357	(2,130)	(6,210)						(319,965)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bryn Mawr Care Inc.

0054205

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	13,561	173,388		5,601								192,550	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,261)	617,878	(29,058)	5,076								576,635	32
33	Real Estate Taxes		236,661		8,068								244,729	33
34	Rent-Facility & Grounds		(1,464,000)										(1,464,000)	34
35	Rent-Equipment & Vehicles	(160)		4,200									4,040	35
36	Other (specify):*	(2,597)	90,706										88,109	36
37	TOTAL Ownership	(6,457)	(345,367)	(24,858)	18,745								(357,937)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(165,593)	(305,855)	(394,216)	196,102	(2,130)	(6,210)						(677,902)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,464,000	Bryn Mawr Care, LLC		\$	\$ (1,464,000)	1
2	V	36 Amortization		Bryn Mawr Care, LLC		2,597	2,597	2
3	V	06 Repairs and Maintenance		Bryn Mawr Care, LLC		12,753	12,753	3
4	V	20 Fees		Bryn Mawr Care, LLC		10,500	10,500	4
5	V	32 Interest	82	Bryn Mawr Care, LLC		617,960	617,878	5
6	V	36 Mortgage Insurance		Bryn Mawr Care, LLC		88,109	88,109	6
7	V	26 Property Insurance		Bryn Mawr Care, LLC		11,268	11,268	7
8	V	33 Real Estate Taxes		Bryn Mawr Care, LLC		236,661	236,661	8
9	V	30 Depreciation		Bryn Mawr Care, LLC		173,388	173,388	9
10	V	21 Replacement Tax		Bryn Mawr Care, LLC		4,966	4,966	10
11	V	21 Office Expense		Bryn Mawr Care, LLC		25	25	11
12	V							12
13	V							13
14	Total		\$ 1,464,082			\$ 1,158,227	\$ * (305,855)	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.	\$ 14,616	GENERATIONS HC NETWORK, LLC		\$ 13,675	\$ (941)
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		1,218	1,218
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC			
18	V	10 NURSING	41,760	GENERATIONS HC NETWORK, LLC		35,363	(6,397)
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		5,913	5,913
20	V	17 ADMINISTRATIVE	383,622	GENERATIONS HC NETWORK, LLC		27,552	(356,070)
21	V	19 PROFESSIONAL FEES	199,140	GENERATIONS HC NETWORK, LLC		10,986	(188,154)
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		112	112
23	V	21 CLERICAL & GENERAL	9,396	GENERATIONS HC NETWORK, LLC		154,949	145,553
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		279	279
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		17,788	17,788
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC		1,552	1,552
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		9,789	9,789
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC		(29,058)	(29,058)
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC		3,387	3,387
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		813	813
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 648,534			\$ 254,318	\$ * (394,216)

* 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	\$ 14,616	GENERATIONS HC NETWORK, LLC	\$ 6,895	\$ (7,721)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	1,155	1,155	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	7,829	7,829	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	1,302	1,302	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	121,218	121,218	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	14,386	14,386	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	28,372	28,372	21
22	V							22
23	V							23
24	V	10A	DIRECTOR OF SPECIAL REHAB	33,408	GENERATIONS HC NETWORK, LLC	22,359	(11,049)	24
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	3,749	3,749	25
26	V							26
27	V	6	MAINTENANCE SALARIES	31,444	GENERATIONS HC NETWORK, LLC	38,749	7,305	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	6,842	6,842	28
29	V							29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	2,084	2,084	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	1,205	1,205	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	311	311	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	111	111	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	258	258	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	5,601	5,601	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	5,076	5,076	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	8,068	8,068	37
38	V							38
39	Total		\$ 79,468			\$ 275,570	\$ * 196,102	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	06 Maintenance	\$	MAC Rx, LLC		\$	\$	15
16	V	10 Nursing and Medical Records	22,698	MAC Rx, LLC		20,742	(1,956)	16
17	V	10A Therapy		MAC Rx, LLC				17
18	V	19 Professional Services		MAC Rx, LLC				18
19	V	21 Clerical & General Office Expenses	424	MAC Rx, LLC		387	(37)	19
20	V	22 Employee Benefits	1,592	MAC Rx, LLC		1,455	(137)	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 24,714			\$ 22,584	\$ * (2,130)	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	\$ 311	Big Ten Supply, LLC	100.00%	\$ 281	\$ (30)	15
16	V	3 Housekeeping	33,318	Big Ten Supply, LLC	100.00%	30,128	(3,191)	16
17	V	4 Laundry	4,743	Big Ten Supply, LLC	100.00%	4,289	(454)	17
18	V	6 Repairs & Maintenance	2,921	Big Ten Supply, LLC	100.00%	2,642	(280)	18
19	V	10 Nursing And Medical Records	23,557	Big Ten Supply, LLC	100.00%	21,301	(2,256)	19
20	V	10A Therapy		Big Ten Supply, LLC	100.00%			20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 64,851			\$ 58,641	\$ * (6,210)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Bryn Mawr Care Inc.

0054205

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	2.47	6.18%	Alloc. Salary	\$ 17,646	17-7	1	
2	Kirsten Schloss	Shareholder	Maintenance	1.44%	See Attached	2.82	7.06%	Alloc. Salary	7,280	6-7	2	
3	Sarah Barrish	Shareholder	Administrative	2.87%	See Attached	3.53	7.06%	Alloc. Salary	8,875	17-7	3	
4	Michael Giannini	Relative	Administrative		See Attached	2.47	6.18%	Alloc. Salary	12,761	17-7	4	
5	Nenita Guzman	Relative	Dietary		See Attached	3.53	7.06%	Alloc. Salary	6,895	1-7	5	
6	Lori Barrish	Relative	Administrative		See Attached	40	100.00%	Salary	110,859	17-1	6	
7	Clark Collins	Relative			See Attached	0.92	2.29%	Alloc. Salary	1,147	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	\$ 165,463		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: 01/01/18 Ending: 12/31/18

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:

01/01/18

Ending: 12/31/18

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	813,429	20	\$ 193,743	\$ 103,385	57,415	\$ 13,675	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		57,415	1,218	2
3	9	MEDICAL DIRECTOR CONSULT	PATIENT DAYS	813,429	20			57,415		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	57,415	35,363	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		57,415	5,913	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	57,415	27,552	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		57,415	10,986	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		57,415	112	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	57,415	154,949	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		57,415	279	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	813,429	20	252,011		57,415	17,788	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		57,415	1,552	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		57,415	9,789	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		57,415	(29,058)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		57,415	3,387	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		57,415	813	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,603,079	\$ 2,954,641		\$ 254,318	25

Facility Name & ID Number Bryn Mawr Care Inc.

0054205

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	813,429	20	\$ 97,690	\$ 97,690	57,415	\$ 6,895	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		57,415	1,155	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	57,415	7,829	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		57,415	1,302	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	57,415	121,218	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		57,415	14,386	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		57,415	28,372	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	33,408	22,359	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950		33,408	3,749	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	453,836	31,444	38,749	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131		31,444	6,842	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		909	2,084	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		909	1,205	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		909	311	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		909	111	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		909	258	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		909	5,601	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		909	5,076	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		909	8,068	23
24										24
25	TOTALS					\$ 3,644,817	\$ 2,570,336		\$ 275,570	25

Facility Name & ID Number Bryn Mawr Care Inc.

0054205 Report Period Beginning: 01/01/18 Ending: 12/31/18

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					20,742	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					387	5
6	22	Employee Benefits	Direct Allocation					1,455	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				\$	\$		\$ 22,584	25

Facility Name & ID Number Bryn Mawr Care Inc.

0054205 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		\$	\$		\$ 281	1
2	3	Housekeeping	Direct Allocation					30,128	2
3	4	Laundry	Direct Allocation					4,289	3
4	6	Repairs & Maintenance	Direct Allocation					2,642	4
5	10	Nursing And Medical Records	Direct Allocation					21,301	5
6	10A	Therapy	Direct Allocation						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				\$	\$		\$ 58,641	25

Facility Name & ID Number Bryn Mawr Care Inc.

0054205 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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:

01/01/18

Ending:

12/31/18

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			
A. Directly Facility Related																		
Long-Term																		
1	Private Bank		X	Mortgage			\$	\$ 15,889,826			\$	617,960						
2																		
3																		
4																		
5																		
Working Capital																		
6	Lake Forest Bank		X	Line of Credit				520,000				25,544						
7																		
8																		
9	TOTAL Facility Related						\$	\$ 16,409,826			\$	643,504						
B. Non-Facility Related*																		
10	Interest Income		X									(16,276)						
11	Interest Income - Bldg Co		X									(82)						
12	Allocated from Generations HC	X										(23,982)						
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(40,340)						
15	TOTALS (line 9+line14)						\$	\$ 16,409,826			\$	603,164						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 88,109 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.)

Facility Name & ID Number Bryn Mawr Care Inc.

0054205

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	<u>216,000</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>228,879</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>12,879</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>231,850</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	<u>2,931</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>247,660</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>137,117</u>	8
	2014	<u>139,879</u>	9
	2015	<u>187,963</u>	10
	2016	<u>205,445</u>	11
	2017	<u>220,811</u>	12

2018 Accrual: \$220,811 x 1.05 = \$231,850 (Rounded)

Allocated from Generations HC Network LLC: \$8,068

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 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 _____

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 2017 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 2017.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>14-08-202-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>204,504.55</u>	\$ <u>204,504.55</u>
2.	<u>14-08-202-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>16,306.50</u>	\$ <u>16,306.50</u>
3.	<u>See Attached</u>	<u>Allocated from SIR/Generations HN</u>	\$ <u>137,812.17</u>	\$ <u>7,619.59</u>
4.	<u>See Attached</u>	<u>Allocated from Regency Property LLC</u>	\$ <u>899,389.48</u>	\$ <u>385.63</u>
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>1,258,012.70</u></u>	\$ <u><u>228,816.27</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? X YES _____ NO

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 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 _____
 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 2017 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 2017.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>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.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,120 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	174	1989	1969	\$ 1,443,623	\$ 173,388		\$	\$ (173,388)	\$ 1,443,623	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1989	3,323		20			3,323	9
10	Various		1990	21,607		20	86	86	21,308	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			130,275	16
17	Various		1997	192,708		20	200	200	186,494	17
18	Various		1998	163,775		20	3,811	3,811	163,774	18
19	Various		1999	29,826		20	1,491	1,491	28,458	19
20	Various		2000	120,434		20	6,021	6,021	113,156	20
21	Various		2001	121,537		20	4,941	4,941	108,888	21
22	Various		2002	697,409		20			697,409	22
23	Various		2003	33,644		20	1,404	1,404	27,331	23
24	Various		2004	67,643		20	3,367	3,367	48,850	24
25	Various		2005	96,040		20	4,638	4,638	65,315	25
26	Various		2006	91,024		20	4,413	4,413	58,795	26
27	Various		2007	43,798		20	1,274	1,274	32,727	27
28	Various		2008	87,925		20	3,820	3,820	51,848	28
29	Various		2009	51,311		20	2,566	2,566	24,686	29
30	Various		2010	13,151		20	1,315	1,315	11,097	30
31	Various		2012	4,870		20	487	487	3,368	31
32	Various		2013	20,265		20	1,013	1,013	5,660	32
33	Various		2014	5,425		20	1,085	1,085	4,521	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:

01/01/18

Ending:

12/31/18

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		1,839,909			91,995	91,995	834,917	67
68		135,868	2,740		4,011	1,271	88,968	68
69			85,319			(85,319)		69
70		\$ 5,668,160	\$ 261,447		\$ 137,939	\$ (123,509)	\$ 4,410,007	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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,668,160	\$ 261,447		\$ 137,939	\$ (123,509)	\$ 4,410,007	1
2	Boiler Work	2015	7,477		20	374	374	1,153	2
3	Repipe Boiler Steam Line And Hand Sink Drain Line	2015	3,495		20	350	350	1,223	3
4	Repiped Drainline For Ejector Pump & Bathroom Sinks	2016	2,900		20	145	145	326	4
5	Repaired Sprinklers	2016	2,860		20	143	143	346	5
6	New Stairwell,Wiring,Hvac,Sewer,Roofing,Flooring,& Architect F	2017	1,599,168		20	79,958	79,958	139,927	6
7	Repaired Boiler	2017	2,845		20	142	142	285	7
8	North Dining Room & Activity Room Vinyl Tiles Installation	2018	15,568		20	1,816	1,816	1,816	8
9	Steam Boiler Work	2018	3,885		20	194	194	194	9
10	Steam Boiler Condensor Pump	2018	2,835		20	47	47	47	10
11	Boiler Work	2018	19,797		20	907	907	907	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)		\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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:

01/01/18

Ending:

12/31/18

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		\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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)	\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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:

01/01/18

Ending:

12/31/18

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		\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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)	\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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:

01/01/18

Ending:

12/31/18

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		\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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)	\$ 7,328,990	\$ 261,447		\$ 222,015	\$ (39,433)	\$ 4,556,231	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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	408,577		20	20,429	20,429	215,711	9
10	Various	2009	524,103		20	26,205	26,205	262,057	10
11	Various	2010	529,130		20	26,457	26,457	238,113	11
12	Tuck Pointing	2011	7,500		20	375	375	3,000	12
13	Fire Door	2011	12,850		20	643	643	5,144	13
14	Fire Alarm Upgrade	2011	42,500		20	2,125	2,125	17,000	14
15	Painting	2011	43,500		20	2,175	2,175	17,400	15
16	Water Heater	2011	7,075		20	354	354	2,832	16
17	Elevator Work	2011	8,500		20	425	425	3,400	17
18	Door Casings	2011	10,500		20	525	525	4,200	18
19	Electrical Wiring Upgrade	2012	25,100		20	1,255	1,255	8,785	19
20	Fire Dampers	2012	56,521		20	2,826	2,826	19,782	20
21	Sprinklers- Mechanical Rooms	2012	7,552		20	378	378	2,646	21
22	Built in Bookshelves	2012	3,950		20	198	198	1,386	22
23	Replace Valves In Hot Water Boiler	2012	3,490		20	175	175	1,218	23
24	Replace vent- pipe and Faucets	2012	5,980		20	299	299	2,093	24
25	Repaint kitchen & Day Rooms	2012	5,414		20	271	271	1,897	25
26	Replace Damaged floor tiles	2012	3,640		20	182	182	1,274	26
27	Bathroom drywall, plaster and primer work	2012	4,172		20	209	209	1,463	27
28	Replace Condenser for walk in cooler	2012	4,390		20	220	220	1,540	28
29	New Handrails	2012	3,130		20	157	157	1,099	29
30	Camera Security System	2013	5,064		20	253	253	1,518	30
31	Fire Alarm Device	2013	3,511		20	176	176	1,056	31
32	Sprinkler System/Alarm	2013	5,775		20	289	289	1,734	32
33	Kitchen Duct System	2014	10,753		20	538	538	2,689	33
34	TOTAL (lines 1 thru 33)		\$ 1,742,677	\$		\$ 87,134	\$ 87,134	\$ 819,037	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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,742,677	\$		\$ 87,134	\$ 87,134	\$ 819,037	1
2	Replace Kitchen Gas Line	2014	2,800		20	140	140	700	2
3	Air Conditioners	2014	6,237		20	312	312	1,560	3
4	Replaced Gas Lines	2015	21,910		20	1,096	1,096	4,384	4
5	Hot water heater	2015	3,885		20	194	194	776	5
6	Install handrail and crash rail	2015	2,555		20	128	128	512	6
7	Masonry & Concrete Repair in Kitchen	2015	3,100		20	155	155	620	7
8	Replace Piping	2016	6,400		20	320	320	960	8
9	Installed Door Protection	2016	3,253		20	163	163	489	9
10	Replaced Boiler Burner	2016	26,865		20	1,343	1,343	4,029	10
11	Tile work in elevator and new flooring	2016	2,593		20	130	130	517	11
12	Security Cameras	2017	3,561		20	178	178	356	12
13	Window wall cabinets	2017	2,500		20	125	125	250	13
14	Repaired pip condensate line	2017	2,985		20	149	149	298	14
15	New Opening East Wall	2018	4,000		20	200	200	200	15
16	Power Door Holder	2018	4,588		20	229	229	229	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,839,909	\$		\$ 91,995	\$	\$ 834,917	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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	17,645	476	39	452	(23)	4,091	3
4	Allocated from S.I.R. Properties/GHN	1993	31,949	1,014	35	913	(101)	23,277	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	8,100	226	20		(226)	8,100	9
10	Allocated from Generations Healthcare Network, LLC	1994	25		20			25	10
11	Allocated from Generations Healthcare Network, LLC	1995	185		20			185	11
12	Allocated from Generations Healthcare Network, LLC	1997	12,446	279	20		(279)	12,446	12
13	Allocated from Generations Healthcare Network, LLC	1999	979		20	49	49	942	13
14	Allocated from Generations Healthcare Network, LLC	1999	9,735		20			9,735	14
15	Allocated from Generations Healthcare Network, LLC	2000	1,155		20	58	58	1,071	15
16	Allocated from Generations Healthcare Network, LLC	2007	3,713		20	186	186	2,078	16
17	Allocated from Generations Healthcare Network, LLC	2008	10,231	196	20	378	182	6,727	17
18	Allocated from Generations Healthcare Network, LLC	2009	25,423	232	20	1,271	1,039	11,751	18
19	Allocated from Generations Healthcare Network, LLC	2011	629	63	20	63		467	19
20	Allocated from Generations Healthcare Network, LLC	2012	2,013	101	20	101		646	20
21	Allocated from Generations Healthcare Network, LLC	2014	282	28	20	14	(14)	65	21
22	Allocated from Generations Healthcare Network, LLC	2016	367	18	20	18		44	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	1,957	85	20	98	12	588	25
26	Allocated from S.I.R. Properties/GHN	2010	1,928		20	96	96	803	26
27	Allocated from S.I.R. Properties/GHN	2009	1,918		20	96	96	940	27
28	Allocated from S.I.R. Properties/GHN	2007	189	11	20	9	(2)	113	28
29	Allocated from S.I.R. Properties/GHN	2002	127		20	6	6	105	29
30	Allocated from S.I.R. Properties/GHN	1999	4,048		20	202	202	3,947	30
31	Allocated from S.I.R. Properties/GHN	1994	304	8	20		(8)	304	31
32	Allocated from S.I.R. Properties/GHN	1993	518	3	20		(3)	518	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 135,868	\$ 2,740		\$ 4,011	\$ 1,271	\$ 88,968	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:

01/01/18

Ending:

12/31/18

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		\$ 135,868	\$ 2,740		\$ 4,011	\$ 1,271	\$ 88,968	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)	\$ 135,868	\$ 2,740		\$ 4,011	\$ 1,271	\$ 88,968	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	\$ 727,571	\$ 2,468	\$ 54,089	\$ 51,621	10	\$ 563,974	71
72	Current Year Purchases	9,161	57	897	840	10	897	72
73	Fully Depreciated Assets	477,433		468	468	10	477,433	73
74								74
75	TOTALS	\$ 1,214,165	\$ 2,525	\$ 55,454	\$ 52,929		\$ 1,042,304	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 Heal	2018	5,316	335	400	65	5	2,472	77
78										78
79										79
80	TOTALS			\$ 20,752	\$ 335	\$ 400	\$ 65		\$ 17,908	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)	\$ 8,626,978	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 264,308	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 277,869	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,561	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,616,443	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.

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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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? _____

16. Rental Amount for movable equipment: \$ 7,192 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>3,387</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>3,387</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bryn Mawr Care Inc.# 0054205Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 53,126	\$ 286,607	1
2	Cash-Patient Deposits	28,647	28,647	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	838,041	838,041	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,727	3,727	6
7	Other Prepaid Expenses	2,824	40,146	7
8	Accounts Receivable (owners or related parties)	510,000	510,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,436,365	\$ 1,707,168	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		207,475	13
14	Buildings, at Historical Cost		1,327,223	14
15	Leasehold Improvements, at Historical Cost	2,956,454	4,816,555	15
16	Equipment, at Historical Cost	1,251,440	1,714,947	16
17	Accumulated Depreciation (book methods)	(2,047,162)	(4,386,986)	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>		346,686	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,160,732	\$ 4,025,900	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,597,097	\$ 5,733,068	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,065,931	\$ 1,065,933	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,737	28,737	28
29	Short-Term Notes Payable	520,000	520,000	29
30	Accrued Salaries Payable	174,228	174,228	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,755	10,755	31
32	Accrued Real Estate Taxes(Sch.IX-B)		231,850	32
33	Accrued Interest Payable		50,980	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	7,500	7,500	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,807,151	\$ 2,089,983	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,889,826	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>		946,898	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,836,724	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,807,151	\$ 18,926,707	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,789,946	\$ (13,193,639)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,597,097	\$ 5,733,068	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,714,468	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,714,464	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	75,482	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 75,482	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,789,946	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bryn Mawr Care Inc.

0054205

Report Period Beginning: 01/01/18

Ending: 12/31/18

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,434,040	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,434,040	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,276	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,276	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,031	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,031	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,453,347	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,247,416	31
32	Health Care	1,916,520	32
33	General Administration	1,631,542	33
B. Capital Expense			
34	Ownership	1,582,387	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,377,865	40
41	Income before Income Taxes (line 30 minus line 40)**	75,482	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 75,482	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,047,781	44
45	Private Pay - Net Inpatient Revenue	42,120	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Managed Care</u>	5,344,139	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,434,040	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:

01/01/18

Ending:

12/31/18

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	1,994	2,264	\$ 84,800	\$ 37.46	1
2	Assistant Director of Nursing	1,511	1,781	52,397	29.42	2
3	Registered Nurses	3,610	3,845	125,292	32.59	3
4	Licensed Practical Nurses	10,242	11,223	271,764	24.21	4
5	CNAs & Orderlies	50,768	54,698	740,366	13.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,466	12,341	165,128	13.38	10
11	Social Service Workers	16,783	18,161	266,934	14.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,653	16,854	211,896	12.57	15
16	Dishwashers					16
17	Maintenance Workers	3,927	4,294	64,051	14.92	17
18	Housekeepers	17,385	18,889	242,240	12.82	18
19	Laundry	1,471	1,514	18,185	12.01	19
20	Administrator	1,849	2,086	111,909	53.65	20
21	Assistant Administrator			(1,050)		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,953	5,506	111,054	20.17	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	1,806	2,099	32,920	15.68	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,438	1,438	8,268	5.75	33
34	TOTAL (lines 1 - 33)	144,856	156,993	\$ 2,506,154 *	\$ 15.96	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	\$ 29,316	01-03	35
36	Medical Director	Monthly	300	09-03	36
37	Medical Records Consultant	Monthly	400	10-03	37
38	Nurse Consultant	Monthly	41,760	10-03	38
39	Pharmacist Consultant	Monthly	13,616	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	636	11-03	44
45	Social Service Consultant	Monthly	7,200	12-03	45
46	Other(specify)				46
47	<u>Specialized Rehab</u>	Monthly	33,408	10A-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 126,636		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	564	\$ 20,803	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8	165	10-03	52
53	TOTAL (lines 50 - 52)	572	\$ 20,968		53

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

0054205

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

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		\$ 110,859	Workers' Compensation Insurance	\$ 28,526	IDPH License Fee	\$ 1,920	
				Unemployment Compensation Insurance	32,495	Advertising: Employee Recruitment	3,404	
				FICA Taxes	190,128	Health Care Worker Background Check (Indicate # of checks performed <u>589</u>)	5,892	
				Employee Health Insurance	96,091	Patient Background Checks <u>118</u>	1,180	
				Employee Meals	19,674	Dues and Subscriptions	11,955	
				Illinois Municipal Retirement Fund (IMRF)*		License and Permits	1,683	
				Union Pension Plan	26,854	Allocated from Generations HC Network	112	
				Employee Insurance - Life	1,465			
				Employee Benefits - Other	7,158	Less: Public Relations Expense	()	
				401K Matching Contr.	2,642	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,859	TOTAL (agree to Schedule V, line 22, col.8)		\$ 405,033	TOTAL (agree to Sch. V, line 20, col. 8)	
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
Dir. of Administrative Services			\$ 58,464				Out-of-State Travel	\$
Ancillary Administrative Charges			52,200					
SIR/Generations HN - Consulting Fees			272,958				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 383,622				Seminar Expense	4,505
							Allocated from Generations HC Network	279
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				()	
Marcum LLP	Accounting		\$ 15,050				(agree to Sch. V, line 24, col. 8)	
RSM US LLP	Accounting		1,950				\$ 4,784	
Plante Moran	Accounting		1,125					
SIR/Generations HN	Bookkeeping		83,520					
SIR/Generations HN	Dir. Of Regulatory Services		18,792					
SIR/Generations HN	Dir. Of Financial Services		42,540					
Personnel Planners	Unemployment Tax Consultant		1,944					
SIR/Generations HN	Computer Support Charges		27,144					
SIR/Generations HN	Dir. Of Information Tech		12,528					
SIR/Generations HN	Dir. Of Business Development		41,760					
See Attached	Legal Fees		7,704					
See Supplemental Schedule			21,248					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 275,305					

* Attach copy of IMRF notifications

**See instructions.

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

Report Period Beginning:

01/01/18

Ending:

12/31/18**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. \$ 1,262 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. \$ 19,674 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
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.