



Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 \_\_\_\_\_

	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	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,258	3,761	7,289	19,308	8
9	SNF/PED					9
10	ICF	20,720	7,722		28,442	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,978	11,483	7,289	47,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.60%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/02/1991

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/02/1991 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 14 and days of care provided 6,116

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER** # **0037358** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	231,007	28,767	9,289	269,063		269,063	0	269,063		1
2	Food Purchase		244,611		244,611	(38,873)	205,738	(1,680)	204,058		2
3	Housekeeping	1,493	29,051	162,732	193,276		193,276	0	193,276		3
4	Laundry	0	20,245	111,458	131,703	0	131,703	0	131,703		4
5	Heat and Other Utilities			116,015	116,015		116,015	1,237	117,252		5
6	Maintenance	68,235	23,604	22,537	114,376		114,376	13,325	127,701		6
7	Other (specify):*			8,488	8,488		8,488	718	9,206		7
8	<b>TOTAL General Services</b>	<b>300,735</b>	<b>346,278</b>	<b>430,519</b>	<b>1,077,532</b>	<b>(38,873)</b>	<b>1,038,659</b>	<b>13,600</b>	<b>1,052,259</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		2,100	2,100		2,100	0	2,100		9
10	Nursing and Medical Records	2,226,133	91,799	67,064	2,384,996		2,384,996	(2,271)	2,382,725		10
10a	Therapy	0	588	2,207	2,795		2,795	0	2,795		10a
11	Activities	219,320	22,444	2,304	244,068		244,068	0	244,068		11
12	Social Services	56,251		1,688	57,939		57,939	0	57,939		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			84	84		84	0	84		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,501,704</b>	<b>114,831</b>	<b>75,447</b>	<b>2,691,982</b>	<b>0</b>	<b>2,691,982</b>	<b>(2,271)</b>	<b>2,689,711</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	101,455		140,531	241,986		241,986	(42,289)	199,697		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			131,819	131,819		131,819	1,191	133,010		19
20	Dues, Fees, Subscriptions & Promotions			65,577	65,577		65,577	(50,454)	15,123		20
21	Clerical & General Office Expenses	243,507	32,270	328,506	604,283		604,283	(236,210)	368,073		21
22	Employee Benefits & Payroll Taxes			492,278	492,278	38,873	531,151	0	531,151		22
23	Inservice Training & Education			2,829	2,829		2,829	0	2,829		23
24	Travel and Seminar			0	0		0	209	209		24
25	Other Admin. Staff Transportation			8,808	8,808		8,808	1,201	10,009		25
26	Insurance-Prop.Liab.Malpractice			127,910	127,910		127,910	4,685	132,595		26
27	Other (specify):*			53,135	53,135		53,135	(23,412)	29,723		27
28	<b>TOTAL General Administration</b>	<b>344,962</b>	<b>32,270</b>	<b>1,351,393</b>	<b>1,728,625</b>	<b>38,873</b>	<b>1,767,498</b>	<b>(345,079)</b>	<b>1,422,419</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,147,401</b>	<b>493,379</b>	<b>1,857,359</b>	<b>5,498,139</b>	<b>0</b>	<b>5,498,139</b>	<b>(333,750)</b>	<b>5,164,389</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,880
	REPAIRS & MAINTENANCE	409
		0
		9,289
3	<b>HOUSEKEEPING</b>	
	CONTRACTED HOUSEKEEPING SERVICE	162,732
		0
		162,732
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,036
	CONTRACTED LAUNDRY SERVICE	109,422
		0
		111,458
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	61,137
	ELECTRICITY	30,254
	WATER	24,624
	CABLE TV - LOBBY	0
		0
		116,015
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5,518
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,934
	ELEVATOR MAINTENANCE & REPAIR	9,185
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,900
	FIRE SERVICE	0
		0
		0
		0
		0
		22,537
7	<b>OTHER</b>	
	SCAVENGER	8,488
	SECURITY SERVICE	0
		0
		0
		8,488
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,100
		2,100

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	61,000
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	4,868
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	SPECIAL CARE UNIT	1,196
		0
		67,064
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	114
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	13
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	2,080
		2,207
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,304
		0
		2,304
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,688
		0
		1,688
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	84
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	140,531
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,008
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	126,811
		0
		131,819
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	47,852
	EMPLOYEE WANT ADS XIX F	88
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,649
	LICENSES & PERMITS XIX F	2,970
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,387
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	2,631
		65,577
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,402
	EQUIPMENT REPAIR & MAINTENANCE	8,770
	OUTSIDE CLERICAL SERVICES	298,490
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,844
	MESSENGER SERVICE	0
		0
		328,506

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	234,359
	UNEMPLOYMENT COMPENSATION XIX D	50,178
	WORKERS COMPENSATION INSURANC XIX D	90,133
	HOSPITALIZATION INSURANCE XIX D	106,296
	EMPLOYEE BENEFITS - OTHER XIX D	11,312
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		492,278
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	2,829
		2,829
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,808
		8,808
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	127,910
		127,910
27	<b>OTHER</b>	
	BAD DEBTS VI 24	53,135
		53,135

GRAND TOTAL COLUMN 3 OTHER

1,857,359

BRIDGEVIEW HEALTH CARE CENTER  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	244,611	PATIENT MEALS	143250
LESS SALES TAX	(1,680)	ADD EMPLOYEE MEALS	27375
	-----		-----
NET FOOD	242,931	TOTAL MEALS/YEAR	170625
TOTAL PATIENT CENSUS	47,750	NET FOOD	242931
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	170625
	-----		
TOTAL PATIENT MEALS	143250	COST PER MEAL	1.42
		TIME EMPLOYEE MEALS	27375
ADD # EMPLOYEE MEALS/DAY	75		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	38873
	-----		=====
TOTAL EMPLOYEE MEALS	27375		

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER**

#0037358

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			52,802	52,802		52,802	209,960	262,762			30
31	Amortization of Pre-Op. & Org.			0	0		0	151,343	151,343			31
32	Interest			55,942	55,942		55,942	359,869	415,811			32
33	Real Estate Taxes			174,926	174,926		174,926	3,798	178,724			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)	0			34
35	Rent-Equipment & Vehicles			4,074	4,074		4,074	6,866	10,940			35
36	Other (specify):*				0		0	0	0			36
37	<b>TOTAL Ownership</b>			776,984	776,984	0	776,984	242,596	1,019,580			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		185,205	454,262	639,467		639,467	(1,262)	638,205			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			79,935	79,935		79,935	0	79,935			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	185,205	534,197	719,402	0	719,402	(1,262)	718,140			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,147,401	678,584	3,168,540	6,994,525	0	6,994,525	(92,416)	6,902,109			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	27,195	30		9
10	Interest and Other Investment Income	(16,050)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,680)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(3,387)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,135)	27		24
25	Fund Raising, Advertising and Promotional	(47,852)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	0			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (94,909)		\$ 0	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,493		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 2,493		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (92,416)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

ID# 0037358

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$	6
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			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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER# 0037358

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>1</b>	<b>A. General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,680)	0	0	0	0	0	0	0	0	0	0	(1,680)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,237	0	0	0	0	0	0	0	0	1,237	5
6	Maintenance	0	0	6,013	7,312	0	0	0	0	0	0	0	13,325	6
7	Other (specify):*	0	0	0	0	718	0	0	0	0	0	0	718	7
8	<b>TOTAL General Services</b>	<b>(1,680)</b>	<b>0</b>	<b>7,250</b>	<b>7,312</b>	<b>718</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,600</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(2,271)	0	0	0	0	0	(2,271)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,271)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,271)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(140,531)	0	98,242	0	0	0	0	0	0	0	(42,289)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,191	0	0	0	0	0	0	0	0	1,191	19
20	Fees, Subscriptions & Promotions	(51,239)	0	785	0	0	0	0	0	0	0	0	(50,454)	20
21	Clerical & General Office Expenses	0	(298,490)	53,944	8,336	0	0	0	0	0	0	0	(236,210)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	209	0	0	0	0	0	0	0	0	209	24
25	Other Admin. Staff Transportation	0	0	1,201	0	0	0	0	0	0	0	0	1,201	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,685	0	0	0	0	0	0	0	0	4,685	26
27	Other (specify):*	(53,135)	0	10,072	0	19,651	0	0	0	0	0	0	(23,412)	27
28	<b>TOTAL General Administration</b>	<b>(104,374)</b>	<b>(439,021)</b>	<b>72,087</b>	<b>106,578</b>	<b>19,651</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(345,079)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(106,054)</b>	<b>(439,021)</b>	<b>79,337</b>	<b>113,890</b>	<b>20,369</b>	<b>(2,271)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(333,750)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	27,195	172,595	10,170	0	0	0	0	0	0	0	0	209,960	30
31	Amortization of Pre-Op. & Org.	0	151,343	0	0	0	0	0	0	0	0	0	151,343	31
32	Interest	(16,050)	372,942	2,977	0	0	0	0	0	0	0	0	359,869	32
33	Real Estate Taxes	0	0	3,798	0	0	0	0	0	0	0	0	3,798	33
34	Rent-Facility & Grounds	0	(489,240)	0	0	0	0	0	0	0	0	0	(489,240)	34
35	Rent-Equipment & Vehicles	0	0	6,866	0	0	0	0	0	0	0	0	6,866	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>11,145</b>	<b>207,640</b>	<b>23,811</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>242,596</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,262)	0	0	0	0	0	(1,262)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,262)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,262)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(94,909)</b>	<b>(231,381)</b>	<b>103,148</b>	<b>113,890</b>	<b>20,369</b>	<b>(3,533)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(92,416)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<b>SCHEDULE ATTACHED</b>		<b>SCHEDULE ATTACHED</b>		<b>SCHEDULE ATTACHED</b>		

**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	17 MANAGEMENT FEE	\$ 140,531	DYNAMIC HEALTHCARE CONSULTANTS		\$	\$ (140,531)	1
2	V	21 BOOKKEEPING SERVICES	298,490	" "			(298,490)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	489,240	BRIDGEVIEW ASSOCIATES LLC			(489,240)	7
8	V	30 DEPRECIATION		" "		172,595	172,595	8
9	V	31 AMORTIZATION		" "		151,343	151,343	9
10	V	32 INTEREST		" "		372,942	372,942	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 928,261			\$ 696,880	\$ * (231,381)	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	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 1,237	\$	1,237	15
16	V	6 REPAIR & MAINT.		" " "		6,013		6,013	16
17	V	19 PROFESSIONAL FEES		" " "		1,191		1,191	17
18	V	20 DUES AND SUBSCRIPTION		" " "		785		785	18
19	V	21 CLERICAL & GENERAL		" " "		53,944		53,944	19
20	V	24 SEMINARS AND TRAVEL		" " "		209		209	20
21	V	25 AUTO EXPENSE		" " "		1,201		1,201	21
22	V	26 INSURANCE		" " "		4,685		4,685	22
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		10,072		10,072	23
24	V	30 DEPRECIATION		" " "		10,170		10,170	24
25	V	32 INTEREST		" " "		2,977		2,977	25
26	V	33 REAL ESTATE TAXES		" " "		3,798		3,798	26
27	V	35 EQUIPMENT RENTAL		" " "		6,866		6,866	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		\$			\$ 103,148	\$ *	103,148	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 7,312	\$ 7,312	15
16	V	10 DON SALARY - NON OWNER		" " "				16
17	V	17 ADMIN. CMP. - M. MAUER		" " "		19,889	19,889	17
18	V	17 ADMIN. CMP. - M. AARON		" " "		22,630	22,630	18
19	V	17 ADMIN. CMP. - F. AARON		" " "		9,787	9,787	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "				20
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "				21
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "		14,057	14,057	22
23	V	17 ADMIN. CMP. - S. LEVY		" " "		19,010	19,010	23
24	V	17 ADMIN. CMP. - HOWARD ALTER		" " "				24
25	V	17 ADMIN. CMP. - NON-OWNER		" " "		12,869	12,869	25
26	V	21 CLERICAL. CMP. - S. AARON		" " "		8,336	8,336	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$ 113,890	\$ * 113,890	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	7 EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 718	\$ 718	15
16	V	15 EMP. BEN. - DON NON OWNER		" " "				16
17	V	27 EMP. BEN. - M. MAUER		" " "		1,421	1,421	17
18	V	27 EMP. BEN. - M. AARON		" " "		2,245	2,245	18
19	V	27 EMP. BEN. - F. AARON		" " "		6,933	6,933	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "				20
21	V	27 EMP. BEN. - S. KOPLIN		" " "				21
22	V	27 EMP. BEN. - D. MAGAFAS		" " "		2,478	2,478	22
23	V	27 EMP. BEN. - S. LEVY		" " "		1,951	1,951	23
24	V	27 EMP. BEN. - H. ALTER		" " "				24
25	V	27 EMP. BEN. - NON-OWNER		" " "		2,925	2,925	25
26	V	27 EMP. BEN. - S. AARON		" " "		1,698	1,698	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$ 20,369	\$ * 20,369	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	10 MEDICAL SUPPLIES	\$ 20,220	LINCOLN MEDICAL SUPPLIES, INC.		\$ 17,949	\$ (2,271)
16	V	39 ANCILLARY EXPENSE	11,238	" " "		9,976	(1,262)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 31,458			\$ 27,925	\$ * (3,533)

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

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER** # **0037358** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

## 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	MARSHALL MAUER	ADMINISTRATIVE			SCHEDULE ATTACHED			SALARY	\$ 19,889	17-7	1
2	MAURY AARON	ADMINISTRATIVE			" "			SALARY	22,630	17-7	2
3	SHARON AARON	CLERICAL			" "			SALARY	8,336	17-7	3
4	FRED AARON	ADMINISTRATIVE			" "			SALARY	9,787	17-7	4
5	DIANA MAGAFAS	ADMINISTRATIVE			" "			SALARY	14,057	17-7	5
6	DENNIS NEHMER	MAINTENANCE			" "			SALARY	7,312	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 82,011		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 **BRIDGEVIEW HEALTH CARE CENTER**

# **0037358**

Report Period Beginning:

**01/01/2006**

Ending: **2/31/2006**

**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 Dynamic Healthcare Consultants  
 Street Address 3359 W. Main St.  
 City / State / Zip Code Skokie, IL 60076  
 Phone Number ( 847)679-8219  
 Fax Number ( 847)679-7377

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	5	UTILITIES	TOTAL PATIENT DAYS	408,951	12	\$ 10,593	\$ 47,750	\$ 1,237	1
2	6	REPAIR & MAINT.	" "	408,951	12	51,500	47,750	6,013	2
3	19	PROFESSIONAL FEES	" "	408,951	12	10,199	47,750	1,191	3
4	20	DUES AND SUBSCRIPTION	" "	408,951	12	6,724	47,750	785	4
5	21	CLERICAL & GENERAL	" "	408,951	12	461,999	356,210	53,944	5
6	24	SEMINARS AND TRAVEL	" "	408,951	12	1,791	47,750	209	6
7	25	AUTO EXPENSE	" "	408,951	12	10,284	47,750	1,201	7
8	26	INSURANCE	" "	408,951	12	40,124	47,750	4,685	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	408,951	12	86,265	47,750	10,072	9
10	30	DEPRECIATION	" "	408,951	12	87,103	47,750	10,170	10
11	32	INTEREST	" "	408,951	12	25,499	47,750	2,977	11
12	33	REAL ESTATE TAXES	" "	408,951	12	32,525	47,750	3,798	12
13	35	EQUIPMENT RENTAL	" "	408,951	12	58,806	47,750	6,866	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					\$ 883,412	\$ 356,210	\$ 103,148	25

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER**

# **0037358**

Report Period Beginning:

**01/01/2006**

Ending: **2/31/2006**

**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

Name of Related Organization Dynamic Healthcare Consultants  
 Street Address 3359 W. Main St.  
 City / State / Zip Code Skokie, IL 60076  
 Phone Number ( 847)679-8219  
 Fax Number ( 847)679-7377

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	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	12	\$ 54,933	\$ 54,933	5	\$ 7,312	1
2	10	DON SALARY - NON OWNER	" "	40	12	74,145	74,145		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	12	170,000	170,000	5	19,889	3
4	17	ADMIN. CMP. - M. AARON	" "	40	12	170,000	170,000	5	22,630	4
5	17	ADMIN. CMP. - F. AARON	" "	47	12	57,500	57,500	8	9,787	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	12	27,199	27,199		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	12	71,067	71,067		0	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	12	105,603	105,603	6	14,057	8
9	17	ADMIN. CMP. - S. LEVY	" "	45	12	162,480	162,480	5	19,010	9
10	17	ADMIN. CMP. - H. ALTER	" "	40	12	12,000	12,000		0	10
11	17	ADMIN. CMP. - NON-OWNER	" "	45	12	96,679	96,679	6	12,869	11
12	21	CLERICAL. CMP. - S. AARON	" "	40	12	71,245	71,245	5	8,336	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					\$ 1,072,851	\$ 1,072,851		\$ 113,890	25

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER**

# **0037358**

Report Period Beginning:

**01/01/2006**

Ending: **2/31/2006**

**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

Name of Related Organization Dynamic Healthcare Consultants  
 Street Address 3359 W. Main St.  
 City / State / Zip Code Skokie, IL 60076  
 Phone Number ( 847)679-8219  
 Fax Number ( 847)679-7377

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	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	12	\$ 54,933	5	\$ 7,312	1
2	17	EMP.BEN. - DON NON OWNER	" "	40	12	74,145		0	2
3	27	EMP.BEN. - M. MAUER	" "	40	12	170,000	5	19,889	3
4	27	EMP. BEN. - M. AARON	" "	40	12	170,000	5	22,630	4
5	27	EMP. BEN. - F. AARON	" "	47	12	57,500	8	9,787	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	27,199		0	6
7	27	EMP. BEN. - S. KOPLIN	" "	40	12	71,067		0	7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	12	105,603	6	14,057	8
9	27	EMP. BEN. - S. LEVY	" "	45	12	162,480	5	19,010	9
10	27	EMP. BEN. - H. ALTER	" "	40	12	12,000		0	10
11	27	EMP. BEN. - NON-OWNER	" "	45	12	96,679	6	12,869	11
12	27	EMP. BEN. - S. AARON	" "	40	12	71,245	5	8,336	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					\$ 1,072,851	\$	\$ 113,890	25

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER**

# **0037358**

Report Period Beginning:

**01/01/2006**

Ending: **2/31/2006**

**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 Dynamic Healthcare Consultants  
 Street Address 3359 W. Main St.  
 City / State / Zip Code Skokie, IL 60076  
 Phone Number ( 847)679-8219  
 Fax Number ( 847)679-7377

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	LINCOLN MEDICAL SUPPLIES				\$	\$		\$	1
2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						17,949	2
3	39 ANCILLARY EXPENSE	" "						9,976	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				\$	\$		\$ 27,925	25

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER**

# **0037358**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	CAMBRIDGE		X	MORTGAGE	\$32,051.90	11/01/06	\$ 5,722,000	\$ 5,717,518	10/1/41	5.8500	\$ 372,942	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	BANK LEUMI		X	WORKING CAPITAL	INTEREST			777,250		PRIME +	53,100	6						
7			X	INSURANCE FINANCING							2,852	7						
8												8						
9	<b>TOTAL Facility Related</b>				\$32,051.90		\$ 5,722,000	\$ 6,494,768			\$ 428,894	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0			\$ 0	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 5,722,000	\$ 6,494,768			\$ 428,894	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$   N/A                        Line #                     

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (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 2005 report.

\$ **197,000** 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.)

\$ **183,926** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(13,074)** 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **188,000** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$ 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.

\$ **174,926** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>180,886</b>	8
	2002	<b>169,450</b>	9
	2003	<b>179,476</b>	10
	2004	<b>187,467</b>	11
	2005	<b>183,926</b>	12

**FOR BHF USE ONLY**

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

13 FROM R. E. TAX STATEMENT FOR 2005 \$ 13

14 PLUS APPEAL COST FROM LINE 5 \$ 14

15 LESS REFUND FROM LINE 6 \$ 15

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-36-214-061-0000</u>	<u>NURSING HOME</u>	\$ <u>183,925.07</u>	\$ <u>183,925.07</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>183,925.07</u>	\$ <u>183,925.07</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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 BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 43,560 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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).

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>			\$ <u>304,000</u>	1
2					2
3	TOTALS			\$ 304,000	3

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	146	1995		\$ 5,092,000	\$ 130,564	39	\$ 130,564	\$	\$ 1,507,004	4
5				490,058	27,759	39	27,759		86,713	5
6										6
7										7
8	RELATED PARTY			51,796	1,328		1,480	152	19,731	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1991	1,017	32	31.5	32		487	9
10	LEASEHOLD IMPROVEMENTS		1991	2,715	143	15	143		2,715	10
11	LEASEHOLD IMPROVEMENTS		1992	85,574	2,718	31.5	2,718		40,545	11
12	LEASEHOLD IMPROVEMENTS		1993	1,600	51	31.5	51		699	12
13	LEASEHOLD IMPROVEMENTS		1994	8,141	209	39	209		2,616	13
14	1ST FLOOR CENTRAL A/C		1995	1,250	32	39	32		361	14
15	CARPET INSTALL		1995	1,303	33	39	33		370	15
16	RAIL BUMPER		1995	917	24	39	24		265	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM		1996	5,320	137	39	137		1,447	17
18	PAINTING WORK		1996	8,400	215	39	215		2,231	18
19	WALL COVERING		1996	1,435	37	39	37		381	19
20	FRONT LOBBY/WINDOW, DOOR WORK		1997	2,509	64	39	64		608	20
21	ELEVATOR REPAIR		1998	2,800	72	39	72		639	21
22	CONDENCING UNIT		1999	3,824	98	39	98		750	22
23	DRAPES		1999	5,369	138	39	138		1,020	23
24	CARPETING AND VINYL FLOORING		1999	8,540	219	39	219		1,638	24
25	DOOR WORK		1999	10,490	269	39	269		1,975	25
26	KITCHEN CABINETS		1999	5,832	149	39	149		1,117	26
27	TILES		2000	8,855	322	27.5	322		2,068	27
28	ELEVATOR REPAIR		2000	4,240	153	27.5	153		897	28
29	ROD MAIN SEWER		2000	1,100	41	27.5	41		260	29
30	DRAPERIES		2001	2,118	303	7	303		2,250	30
31	RECEPTION DESK/DOOR		2002	9,534	347	27.5	347		1,388	31
32	FLOORING / BUMPER GUARDS		2002	11,198	407	27.5	407		1,629	32
33	WALLPAPER, BORDER, ARTWORK		2002	42,079	1,530	27.5	1,530		5,902	33
34	WIRING, MOTOR		2002	9,224	336	27.5	336		1,344	34
35	HANDRAILS & GUARDS		2003	7,811	284	27.5	284		982	35
36	FENCES & CONCRETE		2003	4,023	134	15	268	134	2,749	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-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	
37	ORIENTATION BOARDS	2003	\$ 1,752	\$ 64	27.5	\$ 64	\$	\$ 1,944	37
38	COIL	2003	806	29	27.5	29		893	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		4,426	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		1,855	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		7,433	41
42	FLOOR COVERING	2004	888	32	27.5	32		79	42
43	CABINETS	2004	2,594	95	27.5	95		233	43
44	BOILER	2004	2,574	93	27.5	93		229	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		106	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		718	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		5,745	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		528	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		73	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		1,120	50
51	NETWORK CABLING	2006	855	14	27.5	14		14	51
52	COOLING TOWER REPAIR	2006	3,565	59	27.5	59		59	52
53	RANGE GUARD SYSTEM	2006	2,200	37	27.5	37		37	53
54	FANS	2006	1,108	18	27.5	18		18	54
55	DOORS	2006	1,711	29	27.5	29		29	55
56	LANDSCAPING	2006	23,665	789	15	789		789	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,017,567	\$ 173,665		\$ 173,951	\$ 286	\$ 1,719,109	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 288,770	\$ 28,629	\$ 28,026	\$ (603)		\$ 159,484	71
72	Current Year Purchases	50,795	10,159	2,540	(7,619)		2,540	72
73	Fully Depreciated Assets	83,462			0		83,462	73
74	RELATED PARTY	590,199	23,114	58,245	35,131			74
75	TOTALS	\$ 1,013,226	\$ 61,902	\$ 88,811	\$ 26,909		\$ 245,486	75

D. Vehicle Depreciation (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				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 7,334,793	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,567	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 262,762	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,195	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,964,595	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	<b>TOTAL</b>				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 3,700 Description: SEE SCHEDULE ATTACHED

(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>374</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <u>374</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

\* 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>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 206,396	\$		\$ 206,396	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			44,454			44,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			203,412			203,412	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				153,335		153,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, RADIOLOGY, LAB Other (specify):						31,870		31,870	13
14	<b>TOTAL</b>			\$		\$ 454,262	\$ 185,205		\$ 639,467	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 BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 4,984	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 120,000 )	1,432,182		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,027		6
7	Other Prepaid Expenses	34,660		7
8	Accounts Receivable (owners or related parties)	162,615		8
9	Other(specify): RE TAX ESCROW	104,241		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,811,709	\$ 0	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	383,714		15
16	Equipment, at Historical Cost	423,027		16
17	Accumulated Depreciation (book methods)	(438,092)		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): DEPOSITS	631,677		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,000,326	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,812,035	\$ 0	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 711,676	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	777,250		29
30	Accrued Salaries Payable	346,954		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,328		31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,000		32
33	Accrued Interest Payable	5,222		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,052,430	\$ 0	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,052,430	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 759,605	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,812,035	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>875,597</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>875,597</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>218,408</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(334,400)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(115,992)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>759,605</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,982,546	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,982,546	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,277	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 216,277	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	16,050	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,050	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,214,873	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,077,532	31
32	Health Care	2,691,982	32
33	General Administration	1,728,625	33
	<b>B. Capital Expense</b>		
34	Ownership	776,984	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	639,467	35
36	Provider Participation Fee	79,935	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,994,525	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	220,348	41
42	<b>Income Taxes</b>	(1,940)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 218,408	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 **BRIDGEVIEW HEALTH CARE CENTER**

# **0037358**

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

**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	1,836	2,139	\$ 72,338	\$ 33.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,427	7,439	260,622	35.03	3
4	Licensed Practical Nurses	30,452	34,870	804,963	23.08	4
5	CNAs & Orderlies	93,008	105,514	1,050,214	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,700	2,961	51,854	17.51	9
10	Activity Assistants	13,247	15,010	167,466	11.16	10
11	Social Service Workers	4,432	5,003	56,251	11.24	11
12	Dietician					12
13	Food Service Supervisor	2,833	3,318	54,629	16.46	13
14	Head Cook	3,947	4,306	41,051	9.53	14
15	Cook Helpers/Assistants	14,314	15,695	135,327	8.62	15
16	Dishwashers					16
17	Maintenance Workers	3,691	4,040	68,235	16.89	17
18	Housekeepers	144	160	1,493	9.33	18
19	Laundry					19
20	Administrator	2,093	2,408	101,455	42.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,965	11,458	243,507	21.25	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	1,857	2,169	37,996	17.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,946	216,490	\$ 3,147,401 *	\$ 14.54	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	\$ 8,880	1-3	35
36	Medical Director	2,100	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	4,868	10-3	39
40	Physical Therapy Consultant	114	10a-3	40
41	Occupational Therapy Consultant	13	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	2,080	10a-3	43
44	Activity Consultant	49	11-3	44
45	Social Service Consultant	31	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	80	\$ 22,047	49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$	10-3	50	
51	Licensed Practical Nurses	672	33,059	10-3	51
52	Certified Nurse Assistants/Aides	1,195	27,941	10-3	52
53	TOTAL (lines 50 - 52)	1,867	\$ 61,000	53	





Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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. ICLTC 5227
- (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? \_\_\_\_\_
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,412 Line 10-2
- (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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,935  
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? YES
- (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. \$ 38,873 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees