



Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			5,408	5,408	8
9	SNF/PED					9
10	ICF	28,615	13,593	907	43,115	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,615	13,593	6,315	48,523	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.05%

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 10/02/191

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 \_\_\_\_\_ and days of care provided 5,408

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER** # **0037358** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	240,190	30,313	8,880	279,383		279,383		279,383		1
2	Food Purchase		246,615		246,615	(38,873)	207,742	(1,804)	205,938		2
3	Housekeeping		21,942	165,684	187,626		187,626		187,626		3
4	Laundry		18,743	111,086	129,829		129,829		129,829		4
5	Heat and Other Utilities			118,430	118,430		118,430	1,210	119,640		5
6	Maintenance	62,778	27,785	23,451	114,014		114,014	17,781	131,795		6
7	Other (specify):*			8,124	8,124		8,124	807	8,931		7
8	<b>TOTAL General Services</b>	<b>302,968</b>	<b>345,398</b>	<b>435,655</b>	<b>1,084,021</b>	<b>(38,873)</b>	<b>1,045,148</b>	<b>17,994</b>	<b>1,063,142</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,100	2,100		2,100		2,100		9
10	Nursing and Medical Records	2,348,509	89,301	38,354	2,476,164		2,476,164	(579)	2,475,585		10
10a	Therapy		1,030	33	1,063		1,063		1,063		10a
11	Activities	282,331	18,110	2,322	302,763		302,763		302,763		11
12	Social Services			1,323	1,323		1,323		1,323		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,630,840</b>	<b>108,441</b>	<b>44,132</b>	<b>2,783,413</b>		<b>2,783,413</b>	<b>(579)</b>	<b>2,782,834</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	99,054		61,000	160,054		160,054	56,625	216,679		17
18	Directors Fees										18
19	Professional Services			89,167	89,167		89,167	1,743	90,910		19
20	Dues, Fees, Subscriptions & Promotions			79,781	79,781		79,781	(61,520)	18,261		20
21	Clerical & General Office Expenses	250,692	36,288	427,892	714,872		714,872	(377,566)	337,306		21
22	Employee Benefits & Payroll Taxes			524,633	524,633	38,873	563,506		563,506		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,039	3,039		3,039	330	3,369		24
25	Other Admin. Staff Transportation			9,200	9,200		9,200	(1,239)	7,961		25
26	Insurance-Prop.Liab.Malpractice			142,273	142,273		142,273	2,485	144,758		26
27	Other (specify):*			31,758	31,758		31,758	2,813	34,571		27
28	<b>TOTAL General Administration</b>	<b>349,746</b>	<b>36,288</b>	<b>1,368,743</b>	<b>1,754,777</b>	<b>38,873</b>	<b>1,793,650</b>	<b>(376,329)</b>	<b>1,417,321</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,283,554</b>	<b>490,127</b>	<b>1,848,530</b>	<b>5,622,211</b>		<b>5,622,211</b>	<b>(358,914)</b>	<b>5,263,297</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	0
		0
		8,880
3	<b>HOUSEKEEPING</b>	
	CONTRACTED HOUSEKEEPING SERVICE	165,684
		0
		165,684
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	626
	CONTRACTED LAUNDRY SERVICES	110,460
		0
		111,086
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	55,375
	ELECTRICITY	37,303
	WATER	25,752
	CABLE TV - LOBBY	0
		0
		118,430
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	11,353
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,119
	ELEVATOR MAINTENANCE & REPAIR	7,055
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,924
	FIRE SERVICE	0
		0
		0
		0
		0
		23,451
7	<b>OTHER</b>	
	SCAVENGER	8,124
	SECURITY SERVICE	0
		0
		0
		8,124
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	30,315
	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	4,835
	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	3,204
		0
		38,354
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	33
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		33
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,322
		0
		2,322
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,323
		0
		1,323
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	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	61,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	4,926
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	84,241
		0
		89,167
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	60,588
	EMPLOYEE WANT ADS XIX F	3,394
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	9,635
	LICENSES & PERMITS XIX F	3,303
	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	1,861
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,000
	PATIENT BACKGROUND CHECKS XIX F	0
		79,781
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,321
	EQUIPMENT REPAIR & MAINTENANCE	15,008
	OUTSIDE CLERICAL SERVICES	389,140
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	22,423
	MESSENGER SERVICE	0
		0
		427,892

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	246,112
	UNEMPLOYMENT COMPENSATION XIX D	45,302
	WORKERS COMPENSATION INSURANC XIX D	102,889
	HOSPITALIZATION INSURANCE XIX D	114,955
	EMPLOYEE BENEFITS - OTHER XIX D	15,375
	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
		524,633
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	3,039
	TRAVEL XIX G	0
		3,039
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	9,200
		9,200
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	142,273
		142,273
27	<b>OTHER</b>	
	BAD DEBTS VI 24	31,758
		31,758

GRAND TOTAL COLUMN 3 OTHER

1,848,530

**BRIDGEVIEW HEALTH CARE CENTER  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	246,615
LESS SALES TAX	<u>(1,804)</u>
NET FOOD	244,811

TOTAL PATIENT CENSUS	48,523
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	145,569

ADD # EMPLOYEE MEALS/DAY	75
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	27,375

PATIENT MEALS	145,569
ADD EMPLOYEE MEALS	<u>27,375</u>
TOTAL MEALS/YEAR	172,944

NET FOOD	244,811
DIVIDE TOTAL MEALS/YEAR	<u>172,944</u>

COST PER MEAL	1.42
TIME EMPLOYEE MEALS	<u>27,375</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>38,873</b>

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

#0037358

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	
	<b>D. Ownership</b>											
30	Depreciation			57,691	57,691		57,691	158,401	216,092			30
31	Amortization of Pre-Op. & Org.							1,865	1,865			31
32	Interest			81,709	81,709		81,709	317,493	399,202			32
33	Real Estate Taxes			196,214	196,214		196,214	4,277	200,491			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			5,968	5,968		5,968	9,207	15,175			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			830,822	830,822		830,822	2,003	832,825			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,684	467,558	612,242		612,242	(217)	612,025			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		144,684	547,493	692,177		692,177	(217)	691,960			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,283,554	634,811	3,226,845	7,145,210		7,145,210	(357,128)	6,788,082			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>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,174)	30		9
10	Interest and Other Investment Income	(102)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,804)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,861)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,758)	27		24
25	Fund Raising, Advertising and Promotional	(60,588)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(63,960)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (177,247)</b>		<b>\$</b>	<b>30</b>

<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)	(179,881)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (179,881)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (357,128)</b>		<b>37</b>

**\*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>			<b>\$</b>	<b>47</b>

ID# 0037358

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING TRAVEL ALLOWANCE	\$ (3,000)	25	1
2	LEGAL - COLLECTION FEES	(1,683)	19	2
3	MARKETING SALARY	(59,277)	21	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>	(63,960)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER# 0037358

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,804)	0	0	0	0	0	0	0	0	0	0	(1,804)	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	1,210	0	0	0	0	0	0	0	0	1,210	5
6	Maintenance	0	0	9,484	8,297	0	0	0	0	0	0	0	17,781	6
7	Other (specify):*	0	0	0	0	807	0	0	0	0	0	0	807	7
8	<b>TOTAL General Services</b>	<b>(1,804)</b>	<b>0</b>	<b>10,694</b>	<b>8,297</b>	<b>807</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17,994</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	(579)	0	0	0	0	0	(579)	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>(579)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(579)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(61,000)	0	117,625	0	0	0	0	0	0	0	56,625	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,683)	0	3,426	0	0	0	0	0	0	0	0	1,743	19
20	Fees, Subscriptions & Promotions	(62,449)	0	929	0	0	0	0	0	0	0	0	(61,520)	20
21	Clerical & General Office Expenses	(59,277)	(389,140)	61,762	9,089	0	0	0	0	0	0	0	(377,566)	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	330	0	0	0	0	0	0	0	0	330	24
25	Other Admin. Staff Transportation	(3,000)	0	1,761	0	0	0	0	0	0	0	0	(1,239)	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,485	0	0	0	0	0	0	0	0	2,485	26
27	Other (specify):*	(31,758)	0	12,649	0	21,922	0	0	0	0	0	0	2,813	27
28	<b>TOTAL General Administration</b>	<b>(158,167)</b>	<b>(450,140)</b>	<b>83,342</b>	<b>126,714</b>	<b>21,922</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(376,329)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(159,971)</b>	<b>(450,140)</b>	<b>94,036</b>	<b>135,011</b>	<b>22,729</b>	<b>(579)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(358,914)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	(17,174)	172,402	3,173	0	0	0	0	0	0	0	0	158,401	30
31	Amortization of Pre-Op. & Org.	0	1,865	0	0	0	0	0	0	0	0	0	1,865	31
32	Interest	(102)	313,964	3,631	0	0	0	0	0	0	0	0	317,493	32
33	Real Estate Taxes	0	0	4,277	0	0	0	0	0	0	0	0	4,277	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	9,207	0	0	0	0	0	0	0	0	9,207	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(17,276)</b>	<b>(1,009)</b>	<b>20,288</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>2,003</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	(217)	0	0	0	0	0	(217)	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>(217)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(217)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(177,247)</b>	<b>(451,149)</b>	<b>114,324</b>	<b>135,011</b>	<b>22,729</b>	<b>(796)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(357,128)</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>SCHEDULED ATTACHED</b>		<b>SCHEDULED 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	17	MANAGEMENT FEE	\$ 61,000	DYNAMIC HEALTHCARE CONSULTANTS		\$	\$ (61,000)	1
2	V	21	BOOKKEEPING SERVICES	389,140				(389,140)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240	BRIDGEVIEW ASSOCIATES			(489,240)	7
8	V	30	DEPRECIATION			172,402		172,402	8
9	V	31	AMORTIZATION			1,865		1,865	9
10	V	32	INTEREST			313,964		313,964	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 939,380			\$ 488,231	\$ *	(451,149)	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	100.00%	\$ 1,210	\$	1,210	15
16	V	6 REPAIR & MAINT.		" " "		9,484		9,484	16
17	V	19 PROFESSIONAL FEES		" " "		3,426		3,426	17
18	V	20 DUES AND SUBSCRIPTION		" " "		929		929	18
19	V	21 CLERICAL & GENERAL		" " "		61,762		61,762	19
20	V	24 SEMINARS AND TRAVEL		" " "		330		330	20
21	V	25 AUTO EXPENSE		" " "		1,761		1,761	21
22	V	26 INSURANCE		" " "		2,485		2,485	22
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		12,649		12,649	23
24	V	30 DEPRECIATION		" " "		3,173		3,173	24
25	V	32 INTEREST		" " "		3,631		3,631	25
26	V	33 REAL ESTATE TAXES		" " "		4,277		4,277	26
27	V	35 EQUIPMENT RENTAL		" " "		9,207		9,207	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		\$			\$ 114,324	\$ *	114,324	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		\$ 8,297	\$ 8,297
16	V	10 DON SALARY - NON OWNER		" " "			
17	V	17 ADMIN. CMP. - M. MAUER		" " "		22,518	22,518
18	V	17 ADMIN. CMP. - M. AARON		" " "		25,745	25,745
19	V	17 ADMIN. CMP. - F. AARON		" " "		19,050	19,050
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "			
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "			
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "		15,110	15,110
23	V	17 ADMIN. CMP. - HOWARD ALTER		" " "			
24	V	17 ADMIN. CMP. - NON OWNER		" " "		14,000	14,000
25	V	17 ADMIN. CMP. - CFO NON-OWNER		" " "		21,202	21,202
26	V	21 CLERICAL. CMP. - S. AARON		" " "		9,089	9,089
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	<b>Total</b>		\$			\$ 135,011	\$ * 135,011

\* 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		\$ 807	\$	807	15
16	V	15 EMP. BEN. - DON NON OWNER		" " "					16
17	V	27 EMP. BEN. - M. MAUER		" " "		1,643		1,643	17
18	V	27 EMP. BEN. - M. AARON		" " "		2,160		2,160	18
19	V	27 EMP. BEN. - F. AARON		" " "		8,779		8,779	19
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "					20
21	V	27 EMP. BEN. - S. KOPLIN		" " "					21
22	V	27 EMP. BEN. - D. MAGAFAS		" " "		1,259		1,259	22
23	V	27 EMP. BEN. - HOWARD ALTER		" " "					23
24	V	27 EMP. BEN. - NON OWNER		" " "		3,428		3,428	24
25	V	27 EMP. BEN. - CFO NON-OWNER		" " "		2,741		2,741	25
26	V	27 EMP. BEN. - S. AARON		" " "		1,912		1,912	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>		\$			\$ 22,729	\$ *	22,729	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	\$ 19,842	LINCOLN MEDICAL SUPPLIES, INC.		\$ 19,263	\$ (579)
16	V	39 ANCILLARY EXPENSE	7,452	" " "		7,235	(217)
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	<b>Total</b>		\$ 27,294			\$ 26,498	\$ * (796)

\* 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: **01/01/2007** Ending: **12/31/2007**

## 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	\$ 22,518	17-7	1
2	MAURY AARON	ADMINISTRATIVE			" "			SALARY	25,745	17-7	2
3	SHARON AARON	CLERICAL			" "			SALARY	9,089	21-7	3
4	FRED AARON	ADMINISTRATIVE			" "			SALARY	19,050	17-7	4
5	DIANA MAGAFAS	ADMINISTRATIVE			" "			SALARY	15,110	17-7	5
6	DENNIS NEHMER	MAINTENANCE			" "			SALARY	8,297	6-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 99,809		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:

**01/01/2007**

Ending: **2/31/2007**

**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	5	UTILITIES	TOTAL PATIENT DAYS	388,610	11	\$ 9,690	\$ 48,523	\$ 1,210	1
2	6	REPAIR & MAINT.	" "	388,610	11	75,959	48,523	9,484	2
3	19	PROFESSIONAL FEES	" "	388,610	11	27,437	48,523	3,426	3
4	20	DUES AND SUBSCRIPTION	" "	388,610	11	7,442	48,523	929	4
5	21	CLERICAL & GENERAL	" "	388,610	11	494,636	380,513	61,762	5
6	24	SEMINARS AND TRAVEL	" "	388,610	11	2,640	48,523	330	6
7	25	AUTO EXPENSE	" "	388,610	11	14,104	48,523	1,761	7
8	26	INSURANCE	" "	388,610	11	19,903	48,523	2,485	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	388,610	11	101,305	48,523	12,649	9
10	30	DEPRECIATION	" "	388,610	11	25,409	48,523	3,173	10
11	32	INTEREST	" "	388,610	11	29,080	48,523	3,631	11
12	33	REAL ESTATE TAXES	" "	388,610	11	34,252	48,523	4,277	12
13	35	EQUIPMENT RENTAL	" "	388,610	11	73,733	48,523	9,207	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					\$ 915,590	\$ 380,513	\$ 114,324	25

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

# **0037358**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**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  
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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	11	\$ 58,010	\$ 58,020	6	\$ 8,297	1
2	10	DON SALARY - NON OWNER	" "	40	11	73,306	73,306			2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	180,000	180,000	5	22,518	3
4	17	ADMIN. CMP. - M. AARON	" "	40	11	180,000	180,000	6	25,745	4
5	17	ADMIN. CMP. - F. AARON	" "	45	11	95,250	95,250	9	19,050	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	11	37,505	37,505			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	30	11	71,549	71,549			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	50	11	105,666	105,666	7	15,110	8
9	17	ADMIN. CMP. - S. LEVY	" "	40	11	12,000	12,000			9
10	17	ADMIN. CMP. - H. ALTER	" "	45	11	97,823	97,823	6	14,000	10
11	17	ADMIN. CMP. - NON-OWNER	" "	45	11	169,480	169,480	6	21,202	11
12	21	CLERICAL. CMP. - S. AARON	" "	40	11	72,716	72,716	5	9,089	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					\$ 1,153,305	\$ 1,153,315		\$ 135,011	25

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

# **0037358**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**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	11	\$ 5,643	6	\$ 807	1
2	17	EMP.BEN. - DON NON OWNER	" "	40	11	19,251			2
3	27	EMP.BEN. - M. MAUER	" "	40	11	13,131	5	1,643	3
4	27	EMP. BEN. - M. AARON	" "	40	11	15,105	6	2,160	4
5	27	EMP. BEN. - F. AARON	" "	45	11	43,896	9	8,779	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	11	34,284			6
7	27	EMP. BEN. - S. KOPLIN	" "	30	11	25,887			7
8	27	EMP. BEN. - D. MAGAFAS	" "	50	11	8,807	7	1,259	8
9	27	EMP. BEN. - H. ALTER	" "	40	11	1,120			9
10	27	EMP. BEN. - NON-OWNER	" "	45	11	23,953	6	3,428	10
11	27	EMP. BEN. - CFO NON-OWNER	" "	45	11	21,910	6	2,741	11
12	27	EMP. BEN. - S. AARON	" "	40	11	15,300	5	1,912	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					\$ 228,287	\$	\$ 22,729	25

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

# **0037358**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**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						19,263	2
3	39 ANCILLARY EXPENSE	" "						7,235	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				\$	\$		\$ 26,498	25

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

# **0037358**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	CAMBRIDGE		X	MORTGAGE	\$49,812.18	11/1/06	\$ 5,722,000	\$ 5,662,100	10/1/41	5.8500	\$ 313,964	1
2												2
3												3
4												4
5	RELATED PARTY										3,631	5
<b>Working Capital</b>												
6	LASALLE BANK		X	LINE OF CREDIT				777,250			78,161	6
7			X	INSURANCE							3,548	7
8												8
9	TOTAL Facility Related				\$49,812.18		\$ 5,722,000	\$ 6,439,350			\$ 399,304	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,722,000	\$ 6,439,350			\$ 399,304	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 2006 report.	\$	<b>188,000</b>	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.)	\$	<b>190,214</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,214	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>194,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>196,214</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>169,450</b>	8
	2003	<b>179,476</b>	9
	2004	<b>187,467</b>	10
	2005	<b>183,926</b>	11
	2006	<b>190,214</b>	12

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

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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



Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$	\$ 1,637,568	4
5				665,885	27,694	39	27,694		185,277	5
6										6
7										7
8	RELATED PARTY			55,389	1,420	35	1,583	163	22,683	8
	<b>Improvement Type**</b>									
9	LEASEHOLD IMPROVEMENTS		1991	1,017	32	31.5	32		519	9
10	LEASEHOLD IMPROVEMENTS		1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS		1992	85,574	2,718	31.5	2,718		43,263	11
12	LEASEHOLD IMPROVEMENTS		1993	1,600	51	31.5	51		750	12
13	LEASEHOLD IMPROVEMENTS		1994	8,141	209	39	209		2,825	13
14	1ST FLOOR CENTRAL A/C		1995	1,250	32	39	32		393	14
15	CARPET INSTALL		1995	1,303	33	39	33		403	15
16	RAIL BUMPER		1995	917	24	39	24		289	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM		1996	5,320	137	39	137		1,584	17
18	PAINTING WORK		1996	8,400	215	39	215		2,446	18
19	WALL COVERING		1996	1,435	37	39	37		418	19
20	FRONT LOBBY/WINDOW, DOOR WORK		1997	2,509	64	39	64		672	20
21	ELEVATOR REPAIR		1998	2,800	72	39	72		711	21
22	CONDENCING UNIT		1999	3,824	98	39	98		848	22
23	DRAPES		1999	5,369	138	39	138		1,158	23
24	CARPETING AND VINYL FLOORING		1999	8,540	219	39	219		1,857	24
25	DOOR WORK		1999	10,490	269	39	269		2,244	25
26	KITCHEN CABINETS		1999	5,832	149	39	149		1,266	26
27	TILES		2000	8,855	322	27.5	322		2,390	27
28	ELEVATOR REPAIR		2000	4,240	153	27.5	153		1,050	28
29	ROD MAIN SEWER		2000	1,100	41	27.5	41		301	29
30	DRAPERIES		2001	2,118	300	7		(300)	2,118	30
31	RECEPTION DESK/DOOR		2002	9,534	347	27.5	347		1,735	31
32	FLOORING / BUMPER GUARDS		2002	11,198	407	27.5	407		2,036	32
33	WALLPAPER, BORDER, ARTWORK		2002	42,079	1,530	27.5	1,530		7,432	33
34	WIRING, MOTOR		2002	9,224	336	27.5	336		1,680	34
35	HANDRAILS & GUARDS		2003	7,811	284	27.5	284		1,266	35
36	FENCES & CONCRETE		2003	4,023	134	15	268	134	3,017	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:

01/01/2007 Ending: 12/31/2007

## 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	\$	\$ 2,008	37
38	COIL	2003	806	29	27.5	29		922	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		4,571	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		1,916	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		7,677	41
42	FLOOR COVERING	2004	888	32	27.5	32		111	42
43	CABINETS	2004	2,594	95	27.5	95		328	43
44	BOILER	2004	2,574	93	27.5	93		322	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		149	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		1,005	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		8,043	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		890	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		123	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		1,888	50
51	NETWORK CABLING	2006	855	31	27.5	31		45	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		189	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		117	53
54	FANS	2006	1,108	40	27.5	40		58	54
55	DOORS	2006	1,711	62	27.5	62		91	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		2,367	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	61	27.5	61		61	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	467	27.5	467		467	58
59	RETRACTABLE AWNING	2007	3,336	56	27.5	56		56	59
60	CABLING OF BUILDING	2007	20,000	333	27.5	333		333	60
61	VINYL TILE & COVE BASE	2007	30,063	501	27.5	501		501	61
62	CONDENSER	2007	1,712	29	27.5	29		29	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,283,774	\$ 175,968		\$ 175,965	\$ (3)	\$ 1,967,181	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	\$ 322,600	\$ 33,062	\$ 31,383	\$ (1,679)	10 YRS	\$ 176,441	71
72	Current Year Purchases	46,719	8,339	2,336	(6,003)	10 YRS	2,336	72
73	Fully Depreciated Assets	100,427					100,427	73
74	RELATED PARTY	573,164	14,562	3,508	(11,054)		340,557	74
75	TOTALS	\$ 1,042,910	\$ 55,963	\$ 37,227	\$ (18,736)		\$ 619,761	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				\$ 21,530	\$ 1,335	\$ 2,900	\$ 1,565		\$ 14,280	76
77										77
78										78
79										79
80	TOTALS			\$ 21,530	\$ 1,335	\$ 2,900	\$ 1,565		\$ 14,280	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)	\$ 7,652,214	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,266	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 216,092	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,174)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,601,222	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

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: \$ 3,915 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>575.00</u>	\$ <u>2,053</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>575.00</u>	\$ <u>2,053</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. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 207,307	\$		\$ 207,307	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,966			19,966	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			240,285			240,285	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				119,756		119,756	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):						24,928		24,928	13
14	<b>TOTAL</b>			\$		\$ 467,558	\$ 144,684		\$ 612,242	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 391,152	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	828,375		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,791		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	124,189		8
9	Other(specify): RE TAX ESCROW	94,027		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,525,534	\$	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	470,502		15
16	Equipment, at Historical Cost	469,744		16
17	Accumulated Depreciation (book methods)	(495,783)		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	550,787		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 995,250	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,520,784	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 577,754	\$	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	227,530		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,357		31
32	Accrued Real Estate Taxes(Sch.IX-B)	194,000		32
33	Accrued Interest Payable	5,565		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>	\$ 1,794,456	\$	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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,794,456	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 726,328	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,520,784	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):	<b>759,608</b>	<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>759,608</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>149,120</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>(182,400)</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>(33,280)</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>726,328</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	\$ 7,049,864	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,049,864	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,881	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 249,881	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>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	102	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 102	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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,299,847	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,084,021	31
32	Health Care	2,783,413	32
33	General Administration	1,754,777	33
	<b>B. Capital Expense</b>		
34	Ownership	830,822	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	612,242	35
36	Provider Participation Fee	79,935	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,145,210	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	154,637	41
42	<b>Income Taxes</b>	(5,517)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 149,120	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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: **01/01/2007**

Ending:

**12/31/2007**

**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	1,472	1,803	\$ 61,477	\$ 34.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,320	7,212	270,612	37.52	3
4	Licensed Practical Nurses	33,226	36,945	907,689	24.57	4
5	CNAs & Orderlies	90,932	103,526	1,071,343	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,598	4,001	67,418	16.85	9
10	Activity Assistants	16,491	18,687	214,913	11.50	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,852	3,357	58,259	17.35	13
14	Head Cook	3,871	4,362	43,246	9.91	14
15	Cook Helpers/Assistants	13,861	15,499	138,685	8.95	15
16	Dishwashers					16
17	Maintenance Workers	2,892	3,111	62,778	20.18	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,997	2,315	99,054	42.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,704	11,057	250,692	22.67	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	1,945	2,273	37,388	16.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,161	214,148	\$ 3,283,554 *	\$ 15.33	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	M	\$ 8,880	1-3	35
36	Medical Director	O	2,100	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,835	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		33	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,322	11-3	44
45	Social Service Consultant	E	1,323	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,493		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		30,315	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$ 30,315		53





Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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 6023 IAHC 1752
- (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. \$ 16,683 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 \_\_\_\_\_ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees