

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF# 0048819 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>222</u>	Skilled (SNF)	<u>222</u>	<u>81,252</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>222</u>	TOTALS	<u>222</u>	<u>81,252</u>	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	<u>30,045</u>	<u>10,759</u>	<u>12,420</u>	<u>53,224</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,045</u>	<u>10,759</u>	<u>12,420</u>	<u>53,224</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 65.50%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Emergency maint. and Chaplain services provided for independent living residentsF. Does the facility maintain a daily midnight census? YesG. 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 7/1/2007

J. Was the facility purchased or leased after January 1, 1978?

YES Date 6/30/07 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified 222 and days of care provided 11,423Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	507,368	6,314	281,096	794,778		794,778		794,778		1
2	Food Purchase		452,286		452,286		452,286	(26,587)	425,699		2
3	Housekeeping	242,842	28,904	154,328	426,074		426,074		426,074		3
4	Laundry		2,004		2,004		2,004		2,004		4
5	Heat and Other Utilities			395,847	395,847		395,847	19,300	415,147		5
6	Maintenance	198,858	11,339	192,930	403,127		403,127	5,965	409,092		6
7	Other (specify):* Trash Removal			19,648	19,648		19,648		19,648		7
8	TOTAL General Services	949,068	500,847	1,043,849	2,493,764		2,493,764	(1,322)	2,492,442		8
	B. Health Care and Programs										
9	Medical Director			50,703	50,703		50,703		50,703		9
10	Nursing and Medical Records	3,994,857	597,026	65,050	4,656,933	(342,698)	4,314,235	(25,228)	4,289,007		10
10a	Therapy			1,153,405	1,153,405		1,153,405		1,153,405		10a
11	Activities	1,177			1,177		1,177		1,177		11
12	Social Services	342,676	19,333	7,119	369,128		369,128		369,128		12
13	CNA Training										13
14	Program Transportation			4,613	4,613		4,613	(4,613)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,338,710	616,359	1,280,890	6,235,959	(342,698)	5,893,261	(29,841)	5,863,420		16
	C. General Administration										
17	Administrative	121,617		684,888	806,505		806,505	(561,985)	244,520		17
18	Directors Fees										18
19	Professional Services			134,735	134,735		134,735	77,410	212,145		19
20	Dues, Fees, Subscriptions & Promotions			90,162	90,162		90,162	(34,533)	55,629		20
21	Clerical & General Office Expenses	336,870	15,275	256,573	608,718		608,718	59,102	667,820		21
22	Employee Benefits & Payroll Taxes			750,655	750,655		750,655	29,074	779,729		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,872	17,872		17,872	29,873	47,745		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			105,082	105,082		105,082	(17,972)	87,110		26
27	Other (specify):*										27
28	TOTAL General Administration	458,487	15,275	2,039,967	2,513,729		2,513,729	(419,031)	2,094,698		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,746,265	1,132,481	4,364,706	11,243,452	(342,698)	10,900,754	(450,194)	10,450,560		29

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

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

STATE OF ILLINOIS

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Facility Name & ID Number Bridgeway Christian Village Rehab & SNF #0048819 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			267,513	267,513		267,513	(62,797)	204,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			467,808	467,808		467,808	(202,906)	264,902			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			78,211	78,211		78,211		78,211			35
36	Other (specify):*											36
37	TOTAL Ownership			813,532	813,532		813,532	(265,703)	547,829			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			99,902	99,902	342,698	442,600		442,600			39
40	Barber and Beauty Shops			2,429	2,429		2,429		2,429			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,611	119,611		119,611		119,611			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			221,942	221,942	342,698	564,640		564,640			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,746,265	1,132,481	5,400,180	12,278,926		12,278,926	(715,897)	11,563,029			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,587)	2		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				9
10	Interest and Other Investment Income	(27,310)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,560)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,817)	21		24
25	Fund Raising, Advertising and Promotional	(34,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(453,090)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (652,897)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(63,000)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,000)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (715,897)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		342,698	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 342,698		47

BHF USE ONLY						
48		49		50		51
						52

Bridgeway Christian Village Rehab & SNF

ID# 0048819

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous	\$ (25,228)	10	1
2	Marketing Salaries	(117,991)	21	2
3	Marketing Supplies	(1,358)	21	3
4	Marketing Other	(15,221)	21	4
5	Late Fees, Finance Charges	(2,859)	21	5
6	Transportation	(4,613)	14	6
7	Office Space Rental - Interest Expense	(175,596)	32	7
8	Office Space Rental - Insurance	(20,073)	26	8
9	Office Space Rental - Depreciation	(90,151)	30	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	Total	(453,090)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF# 0048819

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(26,587)	0	0	0	0	0	0	0	0	0	0	(26,587)	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	19,300	0	0	0	0	0	0	0	0	0	19,300	5
6	Maintenance	0	5,965	0	0	0	0	0	0	0	0	0	5,965	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(26,587)	25,265	0	(1,322)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(25,228)	0	0	0	0	0	0	0	0	0	0	(25,228)	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	(4,613)	0	0	0	0	0	0	0	0	0	0	(4,613)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(29,841)	0	0	0	0	0	0	0	0	0	0	(29,841)	16
	C. General Administration													
17	Administrative	0	(561,985)	0	0	0	0	0	0	0	0	0	(561,985)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	77,410	0	0	0	0	0	0	0	0	0	77,410	19
20	Fees, Subscriptions & Promotions	(34,533)	0	0	0	0	0	0	0	0	0	0	(34,533)	20
21	Clerical & General Office Expenses	(248,806)	307,908	0	0	0	0	0	0	0	0	0	59,102	21
22	Employee Benefits & Payroll Taxes	0	29,074	0	0	0	0	0	0	0	0	0	29,074	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	29,873	0	0	0	0	0	0	0	0	0	29,873	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(20,073)	2,101	0	0	0	0	0	0	0	0	0	(17,972)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(303,412)	(115,619)	0	(419,031)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(359,840)	(90,354)	0	(450,194)	29								

STATE OF ILLINOIS

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2007 Ending:

Summary B

June 30, 2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(90,151)	27,354	0	0	0	0	0	0	0	0	0	(62,797)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(202,906)	0	0	0	0	0	0	0	0	0	0	(202,906)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(293,057)	27,354	0	(265,703)	37								
	Ancillary Expense													
	E. Special Cost Centers													
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	0	0	0	0	0	0	0	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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(652,897)	(63,000)	0	(715,897)	45								

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
See attached listing of Board of Directors						

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	5 Utilities	\$	Christian Homes, Inc.	100.00%	\$ 19,300	\$ 19,300
2	V	6 Maintenance				5,965	5,965
3	V	17 Administration	684,888			122,903	(561,985)
4	V	19 Professional Services				77,410	77,410
5	V	21 Clerical				307,908	307,908
6	V	22 Employee Benefits				29,074	29,074
7	V	24 Travel and Seminar				29,873	29,873
8	V	26 Insurance				2,101	2,101
9	V	30 Depreciation				27,354	27,354
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 684,888			\$ 621,888	\$ * (63,000)

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	This workpaper is not applicable									
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13								TOTAL	\$	

* 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 Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2007 Ending: ne 30, 2008

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Series 2007 Bonds	X		Purchase Facility		6/30/07	\$ 9,355,030	\$ 9,355,030	5/15/2031	0.0567	\$ 467,808	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 9,355,030	\$ 9,355,030			\$ 467,808	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 9,355,030	\$ 9,355,030			\$ 467,808	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bridgeway Christian Village Rehab & SNF COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0048819

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>N/A</u>	<u>N/A</u>	<u>\$ N/A</u>	<u>\$</u>
2. _____	_____	<u>\$</u>	<u>\$</u>
3. _____	_____	<u>\$</u>	<u>\$</u>
4. _____	_____	<u>\$</u>	<u>\$</u>
5. _____	_____	<u>\$</u>	<u>\$</u>
6. _____	_____	<u>\$</u>	<u>\$</u>
7. _____	_____	<u>\$</u>	<u>\$</u>
8. _____	_____	<u>\$</u>	<u>\$</u>
9. _____	_____	<u>\$</u>	<u>\$</u>
10. _____	_____	<u>\$</u>	<u>\$</u>
TOTALS		<u>\$</u>	<u>\$</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,352 B. General Construction Type: Exterior Brick Frame Steel & Wood Number of Stories 1

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).

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>Home Office Allocation</u>			\$ <u>9,850</u>	1
2					2
3	TOTALS			\$ 9,850	3

Facility Name & ID Number **Bridgeway Christian Village Rehab & SNF**# **0048819**

Report Period Beginning:

July 1, 2007 Ending: **June 30, 2008****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	222		2007	1975	\$ 5,013,500	\$ 200,540	25	\$ 200,540	\$	\$ 300,810	4
5											5
6											6
7											7
8		Home Office Allocation			91,701	6,421		6,421		152,451	8
		Improvement Type**									
9		Floors for coolers & freezers		3/28/2008	4,873	162	10	162		162	9
10		Eldercare Interiors Project		6/1/2008	4,678	19	20	19		19	10
11		Oxygen storage room		6/1/2008	1,389	6	20	6		6	11
12		Professional architectural services		6/1/2008	32,518	135	20	135		135	12
13		Prep walls for painting southeast wing		6/1/2008	13,275	55	20	55		55	13
14		(12) 9500 BTU cooling units		6/1/2008	16,680	139	10	139		139	14
15		B-wing and therapy renovations		6/1/2008	846,416	3,527	20	3,527		3,527	15
16		Engineer consulting services		6/1/2008	48,790	203	20	203		203	16
17		MTR universal fusion tilt wall mount		6/1/2008	2,071	17	10	17		17	17
18		(29) Duett standard toilet tissue holders		6/1/2008	559	5	10	5		5	18
19		2 Cisco IP telephone 48 port voice system		6/1/2008	20,505	171	10	171		171	19
20		Countertops, cabinets, & shelves		6/1/2008	20,848	87	20	87		87	20
21		Nurse call system		6/1/2008	16,842	70	20	70		70	21
22		Install 10 cable lines		6/1/2008	5,243	44	10	44		44	22
23		Site survey, hydraulic calculations		6/1/2008	925	8	10	8		8	23
24		Install new windows and reglaze windows		6/1/2008	2,200	18	10	18		18	24
25		Fitting - outdoor water main parking lot		6/1/2008	6,866	29	20	29		29	25
26		Resurface doors		6/1/2008	9,800	82	10	82		82	26
27		Surface mounted cabinets		6/1/2008	1,840	8	20	8		8	27
28		Carpet and installation		6/1/2008	158,638	1,322	10	1,322		1,322	28
29		Sentronics device & room signs		6/1/2008	1,543	13	10	13		13	29
30		(60) replacement escutcheon		6/1/2008	1,174	5	20	5		5	30
31		Snackshop ceiling & countertop		6/1/2008	3,121	13	20	13		13	31
32		Cabinets and set of tops		6/1/2008	930	4	20	4		4	32
33		Tracing all resident cables to main closet		6/1/2008	9,702	81	10	81		81	33
34		Programming and schematic phase		6/1/2008	7,467	31	20	31		31	34
35		Install 2 new sidewalks		4/1/2007	2,238	149	15	149		186	35
36		Install 350 sq. ft. sidewalk		1/1/2007	933	187	5	187		280	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **Bridgeway Christian Village Rehab & SNF**

0048819

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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	Install 3 sidewalks	1/1/2007	\$ 9,104	\$ 1,821	5	\$ 1,821	\$	\$ 2,731	37
38	Landscaping	1/1/2007	2,462	492	5	492		739	38
39	Asphalt parking lot, patch pot holes	9/13/2007	2,000	333	5	333		333	39
40	Landscaping, lay new sod	6/1/2008	1,727	15	10	15		15	40
41	Office Space Rental			(90,151)		(90,151)			41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,362,558	\$ 126,061		\$ 126,061	\$	\$ 463,799	70

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	\$ 248,850	\$ 49,453	\$ 49,453	\$	Various	\$ 59,493	71
72	Current Year Purchases	313,822	8,269	8,269		Various	8,269	72
73	Fully Depreciated Assets							73
74	Home Office Allocation	269,179	18,849	18,849			42,314	74
75	TOTALS	\$ 831,851	\$ 76,571	\$ 76,571	\$		\$ 110,076	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	Home Office Allocation			\$ 29,756	\$ 2,084	\$ 2,084	\$		\$ 11,317	76
77										77
78										78
79										79
80	TOTALS			\$ 29,756	\$ 2,084	\$ 2,084	\$		\$ 11,317	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)	\$ 7,234,015	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 204,716	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 204,716	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 585,192	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	2005 Chevy Silverado, acquired in 2007	\$ 20,708	\$ 6,903	\$ 10,354	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 20,708	\$ 6,903	\$ 10,354	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 10,402	92
93			93
94			94
95		\$ 10,402	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:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 78,211 Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units	5 Cost				
					hrs	\$				
1	Licensed Occupational Therapist		hrs	\$	6,187	\$ 369,058	\$	6,187	\$ 369,058	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs		1,600	106,484		1,600	106,484	3
4	Licensed Physical Therapist		hrs		11,111	677,864		11,111	677,864	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	18,898	\$ 1,153,406	\$	18,898	\$ 1,153,406	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 Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (1,512,220)	\$	1
2	Cash-Patient Deposits	51,309		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 119,823)	2,437,274		3
4	Supply Inventory (priced at <u>FIFO</u>)	39,426		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,139		6
7	Other Prepaid Expenses	8,199		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corp., and other</u>	2,264,703		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,290,830	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,252,393		14
15	Leasehold Improvements, at Historical Cost	18,464		15
16	Equipment, at Historical Cost	583,380		16
17	Accumulated Depreciation (book methods)	(389,464)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	54,692		21
22	Other Long-Term Assets (spe <u>Deferred Financing C</u>)	50,039		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,569,504	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,860,334	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 316,244	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,309		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	537,657		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	54,692		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Other Accrued Liabilities</u>	36,565		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 996,467	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,355,030		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,355,030	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,351,497	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (491,163)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,860,334	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,282,674)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,282,674)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	791,511	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 791,511	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (491,163)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF# 0048819Report Period Beginning: July 1, 2007Ending: June 30, 2008**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,635,617	1
2	Discounts and Allowances for all Levels	(3,446,731)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,188,886	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,108,445	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,108,445	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,830	13
14	Non-Patient Meals	26,587	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,128	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,657	19
20	Radiology and X-Ray	16,215	20
21	Other Medical Services	98,791	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,208	23
D. Non-Operating Revenue			
24	Contributions	9,402	24
25	Interest and Other Investment Income***	27,310	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,712	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	543,186	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 543,186	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,070,437	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,493,764	31
32	Health Care	6,235,959	32
33	General Administration	2,513,729	33
B. Capital Expense			
34	Ownership	813,532	34
C. Ancillary Expense			
35	Special Cost Centers	102,331	35
36	Provider Participation Fee	119,611	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,278,926	40
41	Income before Income Taxes (line 30 minus line 40)**	791,511	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 791,511	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning: July 1, 2007

Ending:

June 30, 2008

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	1,966	1,995	\$ 87,101	\$ 43.66	1
2	Assistant Director of Nursing	704	736	34,448	46.80	2
3	Registered Nurses	33,896	36,615	1,255,719	34.30	3
4	Licensed Practical Nurses	25,734	27,939	743,485	26.61	4
5	CNAs & Orderlies	105,947	114,368	1,505,637	13.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,844	6,261	94,575	15.11	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	18,648	20,543	343,853	16.74	11
12	Dietician					12
13	Food Service Supervisor	4,054	4,624	61,745	13.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	40,661	44,208	445,625	10.08	15
16	Dishwashers					16
17	Maintenance Workers	11,167	12,656	198,858	15.71	17
18	Housekeepers	22,202	24,267	242,843	10.01	18
19	Laundry					19
20	Administrator	2,151	2,179	133,431	61.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,983	2,019	45,287	22.43	23
24	Clerical	7,013	7,535	103,383	13.72	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					31
32	Other Health Care Ward Clerk	9,555	10,394	132,097	12.71	32
33	Other(specify) <u>Comm. Liaison, M</u>	10,063	11,155	318,178	28.52	33
34	TOTAL (lines 1 - 33)	301,588	327,494	\$ 5,746,265 *	\$ 17.55	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	776	\$ 25,511	In 1, col 3	35
36	Medical Director	720	50,703	In 9, col 3	36
37	Medical Records Consultant	24	1,470	In 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	240	5,773	In 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	71	5,542	In 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,831	\$ 88,999		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 344	In 10, col 3	50
51	Licensed Practical Nurses	9	297	In 10, col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	17	\$ 641		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$6,620
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,585 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. \$ 119,611
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 26,587
- (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? _____
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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.