



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

# **0037358** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,646	3,101	7,352	19,099	8
9	SNF/PED					9
10	ICF	20,483	8,692	150	29,325	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,129	11,793	7,502	48,424	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.87%**

**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 10/02/91

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

YES  Date 10/02/91 NO

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

YES  NO  If YES, enter number

of beds certified 97 and days of care provided 6,243

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	254,721	25,509	10,913	291,143		291,143		291,143		1
2	Food Purchase		268,269		268,269		268,269	(1,966)	266,303		2
3	Housekeeping		23,928	177,660	201,588		201,588		201,588		3
4	Laundry		24,464	120,811	145,275		145,275		145,275		4
5	Heat and Other Utilities			118,367	118,367		118,367	1,639	120,006		5
6	Maintenance	86,399	52,355	27,260	166,014		166,014	17,165	183,179		6
7	Other (specify):*			13,830	13,830		13,830	866	14,696		7
8	<b>TOTAL General Services</b>	341,120	394,525	468,841	1,204,486		1,204,486	17,704	1,222,190		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,100	2,100		2,100		2,100		9
10	Nursing and Medical Records	2,333,910	102,756	7,978	2,444,644		2,444,644	(1,291)	2,443,353		10
10a	Therapy	491,197	8,348		499,545		499,545		499,545		10a
11	Activities	282,241	22,105	800	305,146		305,146		305,146		11
12	Social Services			2,424	2,424		2,424		2,424		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,107,348	133,209	13,302	3,253,859		3,253,859	(1,291)	3,252,568		16
	<b>C. General Administration</b>										
17	Administrative	141,223		156,768	297,991		297,991	(6,875)	291,116		17
18	Directors Fees										18
19	Professional Services			113,907	113,907		113,907	1,194	115,101		19
20	Dues, Fees, Subscriptions & Promotions			68,831	68,831		68,831	(41,373)	27,458		20
21	Clerical & General Office Expenses	250,904	33,257	486,633	770,794		770,794	(407,663)	363,131		21
22	Employee Benefits & Payroll Taxes			624,735	624,735		624,735		624,735		22
23	Inservice Training & Education			8,008	8,008		8,008		8,008		23
24	Travel and Seminar							715	715		24
25	Other Admin. Staff Transportation			14,313	14,313		14,313	671	14,984		25
26	Insurance-Prop.Liab.Malpractice			179,322	179,322		179,322	1,883	181,205		26
27	Other (specify):*			34,570	34,570		34,570	5,970	40,540		27
28	<b>TOTAL General Administration</b>	392,127	33,257	1,687,087	2,112,471		2,112,471	(445,478)	1,666,993		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,840,595	560,991	2,169,230	6,570,816		6,570,816	(429,065)	6,141,751		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.



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	156,768
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,181
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	100,726
		0
		113,907
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	37,288
	EMPLOYEE WANT ADS XIX F	11,252
	CONTRIBUTIONS VI 20 XIX F	100
	DUES & SUBSCRIPTIONS XIX F	10,676
	LICENSES & PERMITS XIX F	4,682
	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	4,623
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	100
	PATIENT BACKGROUND CHECKS XIX F	110
		68,831
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,032
	EQUIPMENT REPAIR & MAINTENANCE	23,090
	OUTSIDE CLERICAL SERVICES	416,240
	PENALTIES / OVERDRAFT CHARGES VI 18	28,925
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,346
	MESSENGER SERVICE	0
		0
		486,633

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	290,219
	UNEMPLOYMENT COMPENSATION XIX D	57,368
	WORKERS COMPENSATION INSURANCE XIX D	86,291
	HOSPITALIZATION INSURANCE XIX D	164,086
	EMPLOYEE BENEFITS - OTHER XIX D	26,771
	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
		624,735
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	8,008
		8,008
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	14,313
		14,313
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	179,322
		179,322
27	<b>OTHER</b>	
	BAD DEBTS VI 24	34,570
		34,570

GRAND TOTAL COLUMN 3 OTHER

2,169,230

**BRIDGEVIEW HEALTH CARE CENTER  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	268,269
LESS SALES TAX	<u>(1,966)</u>
NET FOOD	266,303

TOTAL PATIENT CENSUS	48,424
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	145,272

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	145,272
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	145,272

NET FOOD	266,303
DIVIDE TOTAL MEALS/YEAR	<u>145,272</u>

COST PER MEAL	1.83
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

BRIDGEVIEW HEALTH CARE CENTER

#0037358

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			73,041	73,041		73,041	170,437	243,478			30
31	Amortization of Pre-Op. & Org.							1,865	1,865			31
32	Interest			54,987	54,987		54,987	295,952	350,939			32
33	Real Estate Taxes			216,234	216,234		216,234	4,921	221,155			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			6,040	6,040		6,040	9,172	15,212			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			839,542	839,542		839,542	(6,893)	832,649			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,607	97,087	285,694		285,694	(759)	284,935			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>		188,607	177,022	365,629		365,629	(759)	364,870			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,840,595	749,598	3,185,794	7,775,987		7,775,987	(436,717)	7,339,270			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				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	2,687	30		9
10	Interest and Other Investment Income	(15,591)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,966)	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	(28,925)	21		18
19	Entertainment		20		19
20	Contributions	(4,723)	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	(34,570)	27		24
25	Fund Raising, Advertising and Promotional	(37,288)	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	(41,193)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (161,569)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(275,148)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (275,148)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (436,717)		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.		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0037358  
Report Period Beginning: 01/01/2009  
Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARIES	\$ -41193	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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>	(41,193)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CENTER**# **0037358**

Report Period Beginning:

**01/01/2009**

Ending:

**12/31/2009**

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	(1,966)	0	0	0	0	0	0	0	0	0	0	(1,966)	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	1,639	0	0	0	0	0	0	0	0	1,639	5
6	Maintenance	0	0	8,354	8,811	0	0	0	0	0	0	0	17,165	6
7	Other (specify):*	0	0	0	0	866	0	0	0	0	0	0	866	7
8	<b>TOTAL General Services</b>	<b>(1,966)</b>	<b>0</b>	<b>9,993</b>	<b>8,811</b>	<b>866</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17,704</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	(1,291)	0	0	0	0	0	(1,291)	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>(1,291)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,291)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(156,768)	0	149,893	0	0	0	0	0	0	0	(6,875)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,194	0	0	0	0	0	0	0	0	1,194	19
20	Fees, Subscriptions & Promotions	(42,011)	0	638	0	0	0	0	0	0	0	0	(41,373)	20
21	Clerical & General Office Expenses	(70,118)	(416,240)	67,810	10,885	0	0	0	0	0	0	0	(407,663)	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	715	0	0	0	0	0	0	0	0	715	24
25	Other Admin. Staff Transportation	0	0	671	0	0	0	0	0	0	0	0	671	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,883	0	0	0	0	0	0	0	0	1,883	26
27	Other (specify):*	(34,570)	0	13,168	0	27,372	0	0	0	0	0	0	5,970	27
28	<b>TOTAL General Administration</b>	<b>(146,699)</b>	<b>(573,008)</b>	<b>86,079</b>	<b>160,778</b>	<b>27,372</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(445,478)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(148,665)</b>	<b>(573,008)</b>	<b>96,072</b>	<b>169,589</b>	<b>28,238</b>	<b>(1,291)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(429,065)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER# 0037358

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	2,687	163,237	4,513	0	0	0	0	0	0	0	0	170,437	30
31	Amortization of Pre-Op. & Org.	0	1,865	0	0	0	0	0	0	0	0	0	1,865	31
32	Interest	(15,591)	307,482	4,061	0	0	0	0	0	0	0	0	295,952	32
33	Real Estate Taxes	0	0	4,921	0	0	0	0	0	0	0	0	4,921	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	9,172	0	0	0	0	0	0	0	0	9,172	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(12,904)</b>	<b>(16,656)</b>	<b>22,667</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>(6,893)</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	(759)	0	0	0	0	0	(759)	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>(759)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(759)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(161,569)</b>	<b>(589,664)</b>	<b>118,739</b>	<b>169,589</b>	<b>28,238</b>	<b>(2,050)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(436,717)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	<b>MANAGEMENT FEES</b>	\$ 156,768	<b>DYNAMIC HEALTHCARE</b>		\$	(156,768)	1
2	V	21	<b>BOOKKEEPING SERVICES</b>	416,240				(416,240)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	<b>RENT</b>	489,240	<b>BRIDGEVIEW ASSOCIATES LLC</b>			(489,240)	7
8	V	30	<b>DEPRECIATION</b>			163,237		163,237	8
9	V	31	<b>AMORTIZATION</b>			1,865		1,865	9
10	V	32	<b>INTEREST</b>			307,482		307,482	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,062,248			\$ 472,584	\$ *	(589,664)	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%	\$ 1,639	\$ 1,639	15
16	V	6	REPAIR & MAINT.		"	"	"		8,354	8,354	16
17	V	19	PROFESSIONAL FEES		"	"	"		1,194	1,194	17
18	V	20	DUES AND SUBSCRIPTION		"	"	"		638	638	18
19	V	21	CLERICAL & GENERAL		"	"	"		67,810	67,810	19
20	V	24	SEMINARS AND TRAVEL		"	"	"		715	715	20
21	V	25	AUTO EXPENSE		"	"	"		671	671	21
22	V	26	INSURANCE		"	"	"		1,883	1,883	22
23	V	27	EMP. BEN. - GEN, ADMIN.		"	"	"		13,168	13,168	23
24	V	30	DEPRECIATION		"	"	"		4,513	4,513	24
25	V	32	INTEREST		"	"	"		4,061	4,061	25
26	V	33	REAL ESTATE TAXES		"	"	"		4,921	4,921	26
27	V	35	EQUIPMENT RENTAL		"	"	"		9,172	9,172	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			\$					\$ 118,739	\$ * 118,739	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 COMP - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 8,811	\$ 8,811
16	V	17 ADMIN COMP - M MAUER		" " "		24,038	24,038
17	V	17 ADMIN COMP - M AARON		" " "		27,259	27,259
18	V	17 ADMIN COMP - F AARON		" " "		21,200	21,200
19	V	17 ADMIN COMP - S GOLDSTEIN		" " "			
20	V	17 ADMIN COMP - J AARON		" " "			
21	V	17 ADMIN COMP - S KOPLIN		" " "			
22	V	17 ADMIN COMP - D MAGAFAS		" " "		22,427	22,427
23	V	17 ADMIN COMP - HOWARD ALTER		" " "			
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		" " "			
25	V	17 ADMIN COMP - NON OWNER - VAR		" " "		30,248	30,248
26	V	17 ADMIN COMP - NON OWNER - CFO		" " "		24,721	24,721
27	V	21 CLERICAL COMP - S AARON		" " "		10,885	10,885
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 169,589	\$ * 169,589

\* 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	100.00%	\$ 866	\$ 866
16	V	27 EMP BEN - M MAUER		" " "		1,725	1,725
17	V	27 EMP BEN - M AARON		" " "		2,250	2,250
18	V	27 EMP BEN - F AARON		" " "		8,736	8,736
19	V	27 EMP BEN - S GOLDSTEIN		" " "			
20	V	27 EMP BEN - J AARON		" " "			
21	V	27 EMP BEN - S KOPLIN		" " "			
22	V	27 EMP BEN - D MAGAFAS		" " "		1,453	1,453
23	V	27 EMP BEN - HOWARD ALTER		" " "			
24	V	27 EMP BEN - V DAVIS		" " "			
25	V	27 EMP BEN - NON OWNER		" " "		8,536	8,536
26	V	27 EMP BEN - NON OWNER - CFO		" " "		2,735	2,735
27	V	27 EMP BEN - S AARON		" " "		1,937	1,937
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 28,238	\$ * 28,238

\* 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	\$ 11,959	LINCOLN MEDICAL SUPPLIES INC	100.00%	\$ 10,668	\$ (1,291)	15
16	V	39	ANCILLARY EXPENSE	7,029			6,270	(759)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 18,988			\$ 16,938	\$ * (2,050)	39

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

Facility Name &amp; ID Number

BRIDGEVIEW HEALTH CARE CENTER

#

0037358

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	\$ 24,038	17-7	1
2	MAURY AARON	ADMINISTRATIVE			" "			SALARY	27,259	17-7	2
3	SHARON AARON	CLERICAL			" "			SALARY	10,885	21-7	3
4	FRED AARON	ADMINISTRATIVE			" "			SALARY	21,200	17-7	4
5	FRED AARON	ADMINISTRATIVE			" "			SALARY	36,000	17-1	5
6	DIANA MAGAFAS	ADMINISTRATIVE			" "			SALARY	22,427	17-7	6
7	DENNIS NEHMER	MAINTENANCE			" "			SALARY	8,811	6-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 150,620		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:

**01/01/2009**

Ending: **2/31/2009**

**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 HEALTH CARE CONSULTANTS  
 Street Address 3359 W MAIN ST  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-8219  
 Fax Number ( 847 ) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	393,498	11	\$ 13,322	\$ 48,424	\$ 1,639	1
2	6	REPAIR & MAINT.	" "	393,498	11	67,883	48,424	8,354	2
3	19	PROFESSIONAL FEES	" "	393,498	11	9,699	48,424	1,194	3
4	20	DUES AND SUBSCRIPTION	" "	393,498	11	5,183	48,424	638	4
5	21	CLERICAL & GENERAL	" "	393,498	11	551,031	404,350	67,810	5
6	24	SEMINARS AND TRAVEL	" "	393,498	11	5,810	48,424	715	6
7	25	AUTO EXPENSE	" "	393,498	11	5,452	48,424	671	7
8	26	INSURANCE	" "	393,498	11	15,305	48,424	1,883	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	393,498	11	107,005	48,424	13,168	9
10	30	DEPRECIATION	" "	393,498	11	36,672	48,424	4,513	10
11	32	INTEREST	" "	393,498	11	33,003	48,424	4,061	11
12	33	REAL ESTATE TAXES	" "	393,498	11	39,991	48,424	4,921	12
13	35	EQUIPMENT RENTAL	" "	393,498	11	74,530	48,424	9,172	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					\$ 964,886	\$ 404,350	\$ 118,739	25

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

# **0037358**

Report Period Beginning:

**01/01/2009**

Ending: **2/31/2009**

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 HEALTH CARE CONSULTANTS  
 Street Address 3359 W MAIN ST  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-8219  
 Fax Number ( 847 ) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	\$ 63,031	\$ 63,031	6	\$ 8,811	1
2	17	ADMIN COMP - M MAUER	" "	40	10	195,000	195,000	5	24,038	2
3	17	ADMIN COMP - M AARON	" "	40	8	195,000	195,000	6	27,259	3
4	17	ADMIN COMP - F AARON	" "	45	5	106,000	106,000	9	21,200	4
5	17	ADMIN COMP - S GOLDSTEIN	" "	40	2	94,542	94,542			5
6	17	ADMIN COMP - J AARON	" "	40	1	2,657	2,657			6
7	17	ADMIN COMP - S KOPLIN	" "	30	3	73,196	73,196			7
8	17	ADMIN COMP - D MAGAFAS	" "	50	8	160,425	160,425	7	22,427	8
9	17	ADMIN COMP - HOWARD ALTER	" "	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V	" "	40	1	74,152	74,152			10
11	17	ADMIN COMP - NON OWNER - V	" "	45	8	216,303	216,303	6	30,248	11
12	17	ADMIN COMP - NON OWNER - C	" "	45	10	200,543	200,543	6	24,721	12
13	21	CLERICAL COMP - S AARON	" "	40	10	88,338	88,338	5	10,885	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					\$ 1,481,187	\$ 1,481,187		\$ 169,589	25

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

# **0037358**

Report Period Beginning:

**01/01/2009**

Ending: **2/31/2009**

**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 HEALTH CARE CONSULTANTS  
 Street Address 3359 W MAIN ST  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-8219  
 Fax Number ( 847 ) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	\$ 6,197	6	\$ 866	1
2	27	EMP BEN - M MAUER	" "	40	10	13,995	5	1,725	2
3	27	EMP BEN - M AARON	" "	40	8	16,097	6	2,250	3
4	27	EMP BEN - F AARON	" "	45	5	43,678	9	8,736	4
5	27	EMP BEN - S GOLDSTEIN	" "	40	2	37,728			5
6	27	EMP BEN - J AARON	" "	40	1				6
7	27	EMP BEN - S KOPLIN	" "	30	3	25,540			7
8	27	EMP BEN - D MAGAFAS	" "	50	8	10,394	7	1,453	8
9	27	EMP BEN - HOWARD ALTER	" "	40	1	1,079			9
10	27	EMP BEN - V DAVIS	" "	40	1	17,756			10
11	27	EMP BEN - NON OWNER	" "	45	8	61,038	6	8,536	11
12	27	EMP BEN - NON OWNER - CFO	" "	45	10	22,185	6	2,735	12
13	27	EMP BEN - S AARON	" "	40	10	15,719	5	1,937	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					\$ 271,406	\$	\$ 28,238	25

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

# **0037358**

Report Period Beginning:

**01/01/2009**

Ending: **2/31/2009**

**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 LINCOLN MEDICAL SUPPLIES INC  
 Street Address 3359 W MAIN ST  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-8219  
 Fax Number ( 847 ) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 10,668	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					6,270	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				\$	\$		\$ 16,938	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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	<b>CAMBRIDGE</b>		<b>X</b>	<b>MORTGAGE</b>	<b>\$49,218.18</b>	<b>11/1/06</b>	<b>\$ 5,722,000</b>	<b>\$ 5,541,673</b>	<b>10/1/41</b>	<b>5.8500</b>	<b>\$ 307,482</b>	<b>1</b>							
2												<b>2</b>							
3												<b>3</b>							
4												<b>4</b>							
5	<b>RELATED PARTY</b>	<b>X</b>									<b>4,061</b>	<b>5</b>							
<b>Working Capital</b>																			
6	<b>BANK LEUMI</b>		<b>X</b>	<b>WORKING CAPITAL</b>				<b>679,250</b>		<b>4.5000</b>	<b>51,386</b>	<b>6</b>							
7			<b>X</b>	<b>INSURANCE FINANCING</b>							<b>3,601</b>	<b>7</b>							
8												<b>8</b>							
9	<b>TOTAL Facility Related</b>				<b>\$49,218.18</b>		<b>\$ 5,722,000</b>	<b>\$ 6,220,923</b>			<b>\$ 366,530</b>	<b>9</b>							
<b>B. Non-Facility Related*</b>																			
10	<b>IRS, IDR, ETC</b>		<b>X</b>	<b>LATE FEES</b>								<b>10</b>							
11												<b>11</b>							
12												<b>12</b>							
13												<b>13</b>							
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>							
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 5,722,000</b>	<b>\$ 6,220,923</b>			<b>\$ 366,530</b>	<b>15</b>							

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>196,000</b>	<b>1</b>
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>204,234</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>8,234</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>208,000</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>216,234</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>187,467</b>	<b>8</b>
	2005	<b>183,926</b>	<b>9</b>
	2006	<b>190,214</b>	<b>10</b>
	2007	<b>192,639</b>	<b>11</b>
	2008	<b>204,234</b>	<b>12</b>

**REAL ESTATE TAX ACCRUAL BASED ON 102% OF THE 2008 REAL ESTATE TAX BILL**

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-36-214-061-0000</u>	<u>NURSING HOME</u>	\$ <u>204,233.63</u>	\$ <u>204,233.63</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>204,233.63</u>	\$ <u>204,233.63</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 53,650 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

---



---



---



---



---



---

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**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	\$	\$ 1,898,696	4
5					748,886	25,541	39	25,541		291,567	5
6											6
7											7
8	RELATED PARTY				54,590	1,400	35	1,560	160	25,475	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1991		1,017	32	31.5	32		583	9
10	LEASEHOLD IMPROVEMENTS		1991		2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS		1992		85,574	2,718	31.5	2,718		48,699	11
12	LEASEHOLD IMPROVEMENTS		1993		1,600	51	31.5	51		852	12
13	LEASEHOLD IMPROVEMENTS		1994		8,141	209	39	209		3,243	13
14	1ST FLOOR CENTRAL A/C		1995		1,250	32	39	32		457	14
15	CARPET INSTALL		1995		1,303	33	39	33		469	15
16	RAIL BUMPER		1995		917	24	39	24		337	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM		1996		5,320	137	39	137		1,858	17
18	PAINTING WORK		1996		8,400	215	39	215		2,876	18
19	WALL COVERING		1996		1,435	37	39	37		492	19
20	FRONT LOBBY/WINDOW, DOOR WORK		1997		2,509	64	39	64		800	20
21	ELEVATOR REPAIR		1998		2,800	72	39	72		855	21
22	CONDENCING UNIT		1999		3,824	98	39	98		1,044	22
23	DRAPES		1999		5,369	138	39	138		1,434	23
24	CARPETING AND VINYL FLOORING		1999		8,540	219	39	219		2,295	24
25	DOOR WORK		1999		10,490	269	39	269		2,782	25
26	KITCHEN CABINETS		1999		5,832	149	39	149		1,564	26
27	TILES		2000		8,855	322	27.5	322		3,034	27
28	ELEVATOR REPAIR		2000		4,240	153	27.5	153		1,356	28
29	ROD MAIN SEWER		2000		1,100	41	27.5	41		383	29
30	DRAPERIES		2001		2,118		7			2,118	30
31	RECEPTION DESK/DOOR		2002		9,534	347	27.5	347		2,429	31
32	FLOORING / BUMPER GUARDS		2002		11,198	407	27.5	407		2,850	32
33	WALLPAPER, BORDER, ARTWORK		2002		42,079	1,530	27.5	1,530		10,492	33
34	WIRING, MOTOR		2002		9,224	336	27.5	336		2,352	34
35	HANDRAILS & GUARDS		2003		7,811	284	27.5	284		1,834	35
36	FENCES & CONCRETE		2003		4,023	134	15	134		3,553	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 &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	ORIENTATION BOARDS	2003	\$ 1,752	\$ 64	27.5	\$ 64	\$ 2,136	37	
38	COIL	2003	806	29	27.5	29	980	38	
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145	4,861	39	
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61	2,038	40	
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244	8,165	41	
42	FLOOR COVERING	2004	888	32	27.5	32	175	42	
43	CABINETS	2004	2,594	95	27.5	95	518	43	
44	BOILER	2004	2,574	93	27.5	93	508	44	
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43	235	45	
46	BRICK MOUNT SIGN	2004	4,317	287	15	287	1,579	46	
47	PARKING LOT	2004	34,455	2,298	15	2,298	12,639	47	
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362	1,614	48	
49	SECURITY MONITORS	2005	1,375	50	27.5	50	223	49	
50	CARPET & VINYL	2005	21,130	768	27.5	768	3,424	50	
51	NETWORK CABLING	2006	855	31	27.5	31	107	51	
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130	449	52	
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80	277	53	
54	FANS	2006	1,108	40	27.5	40	138	54	
55	DOORS	2006	1,711	62	27.5	62	215	55	
56	LANDSCAPING	2006	23,665	1,578	15	1,578	5,523	56	
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134	329	57	
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018	2,503	58	
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122	300	59	
60	CABLING OF BUILDING	2007	20,000	727	27.5	727	1,787	60	
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093	2,687	61	
62	CONDENSER	2007	1,712	62	27.5	62	153	62	
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83	121	63	
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662	966	64	
65	DOORS	2008	1,645	60	27.5	60	87	65	
66	BOILER	2008	5,104	185	27.5	185	270	66	
67	DISH TV EQUIPMENT	2009	1,575	26	27.5	26	26	67	
68	PLUMBING WORK	2009	13,761	229	27.5	229	229	68	
69	SHOWER ROOM REMODEL	2009	45,476	758	27.5	758	758	69	
70	TOTAL (lines 4 thru 69)		\$ 6,454,013	\$ 177,207		\$ 177,367	\$ 160	\$ 2,375,514	70

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,454,013	\$ 177,207		\$ 177,367	\$ 160	\$ 2,375,514	1
2	2009	107,498	1,792	27.5	1,792		1,792	2
3	2009	4,434	74	27.5	74		74	3
4	2009	9,475	158	27.5	158		158	4
5	2009	10,786	180	27.5	180		180	5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,586,206	\$ 179,411		\$ 179,571	\$ 160	\$ 2,377,718	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 372,311	\$ 31,759	\$ 34,444	\$ 2,685	10 YRS	\$ 189,578	71
72	Current Year Purchases	32,293	19,376	1,615	(17,761)	10 YRS	1,615	72
73	Fully Depreciated Assets	157,964					157,964	73
74	RELATED PARTY	558,591	7,132	23,861	16,729		349,169	74
75	TOTALS	\$ 1,121,159	\$ 58,267	\$ 59,920	\$ 1,653		\$ 698,326	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	RELATED PARTY			\$ 24,365	\$ 3,113	\$ 3,987	\$ 874		\$ 5,095	76
77										77
78										78
79										79
80	TOTALS			\$ 24,365	\$ 3,113	\$ 3,987	\$ 874		\$ 5,095	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,035,730	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 240,791	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,478	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,687	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,081,139	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

\*\*

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

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

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

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

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 5,230 Description:  YES  NO 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			\$	\$ <b>810</b>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <b>810</b>	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<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	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	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			81,646				81,646	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs								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				173,992			173,992	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): <u>SUPPLIES, LAB, XRAY, RENTALS</u>					15,441	14,615			30,056	12
13	Other (specify): _____										13
14	<b>TOTAL</b>			\$		\$ 97,087	\$ 188,607		\$	285,694	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 &amp; ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 337,787	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 190,000 )	1,313,754		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,003		6
7	Other Prepaid Expenses	6,316		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESC/EMP LOANS	78,683		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,846,543	\$	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	690,732		15
16	Equipment, at Historical Cost	562,567		16
17	Accumulated Depreciation (book methods)	(657,547)		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	527,500		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,123,252	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,969,795	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 756,250	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	679,250		29
30	Accrued Salaries Payable	257,009		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,605		31
32	Accrued Real Estate Taxes(Sch.IX-B)	208,000		32
33	Accrued Interest Payable	2,632		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</b> (sum of lines 26 thru 37)	\$ 1,925,746	\$	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</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,925,746	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,044,049	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,969,795	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):	<b>691,724</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>691,724</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>534,725</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>352,325</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>1,044,049</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	\$ 8,113,246	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,113,246	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	382,497	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 382,497	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***	15,591	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,591	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>	\$ 8,511,334	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,204,486	31
32	Health Care	3,253,859	32
33	General Administration	2,112,471	33
<b>B. Capital Expense</b>			
34	Ownership	839,542	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	285,694	35
36	Provider Participation Fee	79,935	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>	200,622	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,976,609	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	534,725	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 534,725	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER

# 0037358

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	2,037	2,340	\$ 111,738	\$ 47.75	1
2	Assistant Director of Nursing	1,738	1,787	58,936	32.98	2
3	Registered Nurses	3,242	3,645	117,271	32.17	3
4	Licensed Practical Nurses	34,271	37,812	968,808	25.62	4
5	CNAs & Orderlies	88,315	98,982	1,039,127	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,313	12,118	491,197	40.53	8
9	Activity Director	3,763	4,125	70,492	17.09	9
10	Activity Assistants	13,592	15,026	211,749	14.09	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,332	3,755	64,403	17.15	13
14	Head Cook	5,137	5,646	59,793	10.59	14
15	Cook Helpers/Assistants	12,433	13,801	130,525	9.46	15
16	Dishwashers					16
17	Maintenance Workers	4,160	4,695	86,399	18.40	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,957	2,224	141,223	63.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,781	12,412	250,904	20.21	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	1,859	2,087	38,030	18.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,930	220,455	\$ 3,840,595 *	\$ 17.42	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	\$ 9,780	1-3	35	
36	Medical Director	2,100	9-3	36	
37	Medical Records Consultant	0	10-3	37	
38	Nurse Consultant	0	10-3	38	
39	Pharmacist Consultant	6,055	10-3	39	
40	Physical Therapy Consultant	0	10a-3	40	
41	Occupational Therapy Consultant	0	10a-3	41	
42	Respiratory Therapy Consultant	0	10a-3	42	
43	Speech Therapy Consultant	0	10a-3	43	
44	Activity Consultant	16	800	11-3	44
45	Social Service Consultant	44	2,424	12-3	45
46	Other(specify)				46
47	SPECIAL CARE UNIT		1,141	10-3	47
48					48
49	TOTAL (lines 35 - 48)	60	\$ 22,300		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	23	\$ 782	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	23	\$ 782		53



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$6,765 IL ASSOC OF HC FAC \$1,752
- (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. \$ 20,223 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,935  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 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: \_\_\_\_\_
- (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.