

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819 Report Period Beginning: July 1, 2008 Ending: June 30, 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	<u>222</u>	Skilled (SNF)	<u>222</u>	<u>81,030</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>81,030</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>31,560</u>	<u>12,279</u>	<u>14,863</u>	<u>58,702</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>31,560</u>	<u>12,279</u>	<u>14,863</u>	<u>58,702</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.44%

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 residents

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 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 13,944

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2008 Ending: June 30, 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
	A. General Services										
1	Dietary	472,415	7,043	240,106	719,564		719,564		719,564		1
2	Food Purchase		592,355		592,355		592,355	(2,395)	589,960		2
3	Housekeeping	248,595	34,134	207,985	490,714		490,714		490,714		3
4	Laundry		356		356		356		356		4
5	Heat and Other Utilities			425,637	425,637		425,637	20,384	446,021		5
6	Maintenance	223,861	12,018	191,093	426,972		426,972	(7,933)	419,039		6
7	Other (specify):*			34,802	34,802		34,802		34,802		7
8	TOTAL General Services	944,871	645,906	1,099,623	2,690,400		2,690,400	10,056	2,700,456		8
	B. Health Care and Programs										
9	Medical Director			53,604	53,604		53,604		53,604		9
10	Nursing and Medical Records	4,748,917	811,079	39,522	5,599,518	(521,433)	5,078,085	(17,380)	5,060,705		10
10a	Therapy			1,488,285	1,488,285		1,488,285		1,488,285		10a
11	Activities	155,492			155,492		155,492		155,492		11
12	Social Services	223,303	20,786	12,589	256,678		256,678		256,678		12
13	CNA Training										13
14	Program Transportation			1,055	1,055		1,055	(1,055)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,127,712	831,865	1,595,055	7,554,632	(521,433)	7,033,199	(18,435)	7,014,764		16
	C. General Administration										
17	Administrative	131,367		903,828	1,035,195		1,035,195	(771,900)	263,295		17
18	Directors Fees										18
19	Professional Services			67,236	67,236		67,236	60,904	128,140		19
20	Dues, Fees, Subscriptions & Promotions			57,491	57,491		57,491		57,491		20
21	Clerical & General Office Expenses	270,688	26,557	149,418	446,663		446,663	297,512	744,175		21
22	Employee Benefits & Payroll Taxes			1,014,544	1,014,544		1,014,544	56,374	1,070,918		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,157	14,157		14,157	25,910	40,067		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,718	91,718		91,718	(26,969)	64,749		26
27	Other (specify):*	133,361	6,831	16,870	157,062		157,062	(157,062)			27
28	TOTAL General Administration	535,416	33,388	2,315,262	2,884,066		2,884,066	(515,231)	2,368,835		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,607,999	1,511,159	5,009,940	13,129,098	(521,433)	12,607,665	(523,610)	12,084,055		29

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

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

#0048819

Report Period Beginning: July 1, 2008 Ending: June 30, 2009

Page 4
June 30, 2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			377,778	377,778		377,778	(54,888)	322,890			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			515,471	515,471		515,471	(146,491)	368,980			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			97,190	97,190		97,190		97,190			35
36	Other (specify):*											36
37	TOTAL Ownership			990,439	990,439		990,439	(201,379)	789,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			137,297	137,297	521,433	658,730		658,730			39
40	Barber and Beauty Shops		99		99		99		99			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		99	258,842	258,941	521,433	780,374		780,374			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,607,999	1,511,258	6,259,221	14,378,478		14,378,478	(724,989)	13,653,489			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	(2,395)	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	(42,323)	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	2,740	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	(25,951)	21		24
25	Fund Raising, Advertising and Promotional	(157,062)	27		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	(307,350)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (532,341)		\$	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)	(192,648)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (192,648)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (724,989)		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		521,433	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 521,433	47

BHF USE ONLY

48		49		50		51		52
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Bridgeway Christian Village Rehab & SNF

ID# 0048819

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Miscellaneous	\$ (17,380)	10	1
2	Late Fees, Finance Charges	(29)	21	2
3	Transportation	(1,055)	14	3
4	Office Space Rental - Interest Expense	(108,000)	32	4
5	Office Space Rental - Insurance	(30,000)	26	5
6	Office Space Rental - Depreciation	(90,398)	30	6
7	Charity Care	(47,525)	21	7
8	Cable TV	(12,963)	6	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	Total	(307,350)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

July 1, 2008

Ending:

June 30, 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	(2,395)	0	0	0	0	0	0	0	0	0	0	(2,395)	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	20,384	0	0	0	0	0	0	0	0	0	20,384	5
6	Maintenance	(12,963)	5,030	0	0	0	0	0	0	0	0	0	(7,933)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(15,358)	25,414	0	10,056	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	(17,380)	0	0	0	0	0	0	0	0	0	0	(17,380)	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	(1,055)	0	0	0	0	0	0	0	0	0	0	(1,055)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(18,435)	0	0	0	0	0	0	0	0	0	0	(18,435)	16
	C. General Administration													
17	Administrative	0	(771,900)	0	0	0	0	0	0	0	0	0	(771,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	60,904	0	0	0	0	0	0	0	0	0	60,904	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(70,765)	368,277	0	0	0	0	0	0	0	0	0	297,512	21
22	Employee Benefits & Payroll Taxes	0	56,374	0	0	0	0	0	0	0	0	0	56,374	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	25,910	0	0	0	0	0	0	0	0	0	25,910	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(30,000)	3,031	0	0	0	0	0	0	0	0	0	(26,969)	26
27	Other (specify):*	(157,062)	0	0	0	0	0	0	0	0	0	0	(157,062)	27
28	TOTAL General Administration	(257,827)	(257,404)	0	(515,231)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(291,620)	(231,990)	0	(523,610)	29								

STATE OF ILLINOIS

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

Report Period Beginning:

July 1, 2008 Ending:

Summary B

June 30, 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)	
	D. Ownership													
30	Depreciation	(90,398)	35,510	0	0	0	0	0	0	0	0	0	(54,888)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(150,323)	3,832	0	0	0	0	0	0	0	0	0	(146,491)	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	(240,721)	39,342	0	(201,379)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(532,341)	(192,648)	0	0	0	0	0	0	0	0	0	(724,989)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 Utilities	\$	Christian Homes, Inc.	100.00%	\$ 20,384	\$ 20,384	1
2	V	6 Maintenance				5,030	5,030	2
3	V	17 Administration	903,828			131,928	(771,900)	3
4	V	19 Professional Services				60,904	60,904	4
5	V	21 Clerical				368,277	368,277	5
6	V	22 Employee Benefits				56,374	56,374	6
7	V	24 Travel and Seminar				25,910	25,910	7
8	V	26 Insurance				3,031	3,031	8
9	V	30 Depreciation				35,510	35,510	9
10	V	32 Interest				3,832	3,832	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 903,828			\$ 711,180	\$ * (192,648)	14

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

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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	This workpaper is not applicable										1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13							TOTAL	\$			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 Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2008 Ending: ne 30, 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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number

Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2008 Ending:

June 30, 2009

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			
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	\$ 515,471	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			\$ 515,471	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			\$ 515,471	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.)

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2008 Ending:

June 30, 2009

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Home Office Allocation</u>			\$ <u>10,917</u>	1
2					2
3	TOTALS			\$ 10,917	3

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	222		2007	1975	\$ 5,013,500	\$ 200,540	25	\$ 200,540	\$	\$ 501,350	4
5											5
6											6
7											7
8		Home Office Allocation			103,695	7,593		7,593		195,312	8
		Improvement Type**									
9		Floors for coolers & freezers	3/28/2008		4,873	487	10	487		650	9
10		Eldercare Interiors Project	6/1/2008		4,678	234	20	234		253	10
11		Oxygen storage room	6/1/2008		1,389	69	20	69		75	11
12		Professional architectural services	6/1/2008		32,518	1,626	20	1,626		1,761	12
13		Prep walls for painting southeast wing	6/1/2008		13,275	664	20	664		719	13
14		(12) 9500 BTU cooling units	6/1/2008		16,680	1,668	10	1,668		1,807	14
15		B-Wing and Therapy Renovations - Carpentry	6/1/2008		2,907	144	20	144		156	15
16		Engineer consulting services	6/1/2008		48,790	2,440	20	2,440		2,643	16
17		MTR universal fusion tilt wall mount	6/1/2008		2,071	207	10	207		224	17
18		(29) Duett standard toilet tissue holders	6/1/2008		559	56	10	56		61	18
19		2 Cisco IP telephone 48 port voice system	6/1/2008		20,505	2,050	10	2,050		2,221	19
20		Countertops, cabinets, & shelves	6/1/2008		20,848	1,042	20	1,042		1,129	20
21		Nurse call system	6/1/2008		16,842	842	20	842		912	21
22		Install 10 cable lines	6/1/2008		5,243	524	10	524		568	22
23		Site survey, hydraulic calculations	6/1/2008		925	93	10	93		100	23
24		Install new windows and reglaze windows	6/1/2008		2,200	220	10	220		238	24
25		Fitting - outdoor water main parking lot	6/1/2008		6,866	343	20	343		372	25
26		Resurface doors	6/1/2008		9,800	980	10	980		1,062	26
27		Surface mounted cabinets	6/1/2008		1,840	92	20	92		100	27
28		Carpet and installation	6/1/2008		158,638	15,864	10	15,864		17,186	28
29		Sentronics device & room signs	6/1/2008		1,543	154	10	154		167	29
30		(60) replacement escutcheon	6/1/2008		1,174	59	20	59		64	30
31		Snackshop ceiling & countertop	6/1/2008		3,121	156	20	156		169	31
32		Cabinets and set of tops	6/1/2008		930	46	20	46		50	32
33		Tracing all resident cables to main closet	6/1/2008		9,702	970	10	970		1,051	33
34		Programming and schematic phase	6/1/2008		7,467	373	20	373		404	34
35		Install 2 new sidewalks	4/1/2007		2,238	149	15	149		335	35
36		Install 350 sq. ft. sidewalk	1/1/2007		933	187	5	187		467	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, 2008 Ending: June 30, 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	
	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		\$ 1,821	\$	\$ 4,552	37
38	Landscaping	1/1/2007	2,462	492		492		1,231	38
39	Asphalt parking lot, patch pot holes	9/13/2007	2,000	400		400		733	39
40	Landscaping, lay new sod	6/1/2008	1,727	173		173		187	40
41	Office Space Rental			(90,398)		(90,398)			41
42	B-Wing and Therapy Renovations - Carpentry	6/1/2008	69,670	3,480		3,480		3,770	42
43	B-Wing and Therapy Renovations - Mobilization	6/1/2008	5,000	252		252		273	43
44	B-Wing and Therapy Renovations - Demo & Concrete Patching	6/1/2008	28,139	1,404		1,404		1,521	44
45	B-Wing and Therapy Renovations - Carpentry	6/1/2008	77,060	3,852		3,852		4,173	45
46	B-Wing and Therapy Renovations - Casework	6/1/2008	8,530	432		432		468	46
47	B-Wing and Therapy Renovations - Doors/Frames/Hardware	6/1/2008	7,065	348		348		377	47
48	B-Wing and Therapy Renovations - Gypsum Bd. Partitions & AC	6/1/2008	78,950	3,948		3,948		4,277	48
49	B-Wing and Therapy Renovations - Flooring	6/1/2008	89,870	4,488		4,488		4,862	49
50	B-Wing and Therapy Renovations - Painting	6/1/2008	71,000	3,552		3,552		3,848	50
51	B-Wing and Therapy Renovations - Accessories	6/1/2008	9,840	492		492		533	51
52	B-Wing and Therapy Renovations - Fire Protection	6/1/2008	10,885	540		540		585	52
53	B-Wing and Therapy Renovations - Plumbing	6/1/2008	53,240	2,664		2,664		2,886	53
54	B-Wing and Therapy Renovations - HVAC & Temp Control	6/1/2008	58,372	2,916		2,916		3,159	54
55	B-Wing and Therapy Renovations - Electrical	6/1/2008	128,000	6,396		6,396		6,929	55
56	B-Wing and Therapy Renovations - Insurance	6/1/2008	7,330	372		372		403	56
57	B-Wing and Therapy Renovations - Fee	6/1/2008	41,552	2,076		2,076		2,249	57
58	B-Wing and Therapy Renovations - Special Needs Shower/Toilet	6/1/2008	9,880	492		492		533	58
59	B-Wing and Therapy Renovations - Storm Drain	6/1/2008	1,625	84		84		91	59
60	B-Wing and Therapy Renovations - Bi-Fold Doors for Painting	6/1/2008	2,320	120		120		130	60
61	B-Wing and Therapy Renovations - Corridor Doors	6/1/2008	3,520	180		180		195	61
62	B-Wing and Therapy Renovations - Appliances	6/1/2008	8,000	396		396		429	62
63	B-Wing and Therapy Renovations - Fire Caulk Corridor	6/1/2008	2,430	120		120		130	63
64	B-Wing and Therapy Renovations - Gap over Short Closet Doors	6/1/2008	775	36		36		39	64
65	B-Wing and Therapy Renovations - Remove, Replace and Tape Ba	6/1/2008	1,271	60		60		65	65
66	B-Wing and Therapy Renovations - Rework Non-Closing Toilet R	6/1/2008	968	48		48		52	66
67	B-Wing and Therapy Renovations - Toilet Room Doors	6/1/2008	2,280	120		120		130	67
68	B-Wing and Therapy Renovations - Upgrade Therapy Corridors	6/1/2008	11,800	588		588		637	68
69	B-Wing and Therapy Renovations - Exit Lights	6/1/2008	4,630	228		228		247	69
70	TOTAL (lines 4 thru 69)		\$ 6,325,045	\$ 192,044		\$ 192,044	\$	\$ 781,301	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,325,045	\$ 192,044		\$ 192,044	\$	\$ 781,301	1
2	B-Wing and Therapy Renovations - Private Dining Room	6/1/2008	1,520	72		72		78	2
3	B-Wing and Therapy Renovations - Fire Alarm, Security, Speaker	6/1/2008	3,750	192		192		208	3
4	B-Wing and Therapy Renovations - Ceiling	6/1/2008	3,720	192		192		208	4
5	B-Wing and Therapy Renovations - Add & Disconnect Outlet	6/1/2008	1,455	72		72		78	5
6	B-Wing and Therapy Renovations - Outlets	6/1/2008	2,210	108		108		117	6
7	B-Wing and Therapy Renovations - Trim Plates	6/1/2008	845	48		48		52	7
8	B-Wing and Therapy Renovations - Ceiling and Wall Repair	6/1/2008	2,520	132		132		143	8
9	B-Wing and Therapy Renovations - Shower Sprinkler	6/1/2008	740	36		36		39	9
10	B-Wing and Therapy Renovations - Meds Frig	6/1/2008	1,420	72		72		78	10
11	B-Wing and Therapy Renovations - Casework	6/1/2008	825	36		36		39	11
12	B-Wing and Therapy Renovations - Remove Switch Fan	6/1/2008	425	24		24		26	12
13	B-Wing and Therapy Renovations - Exhaust Fan	6/1/2008	3,840	192		192		208	13
14	B-Wing and Therapy Renovations - HVAC Adjustments	6/1/2008	24,850	1,248		1,248		1,352	14
15	B-Wing and Therapy Renovations - IDPH Review	6/1/2008	1,387	72		72		78	15
16	Exterior Lights	7/1/2008	12,440	1,244		1,244		1,244	16
17	Courtyard Wallpacks Work	8/1/2008	5,400	495		495		495	17
18	Roof- Downpayment & North End	9/30/2008	97,254	4,052		4,052		4,052	18
19	Blower Assembly - Lobby	11/11/2008	6,799	453		453		453	19
20	A Wing - Exterior Wall Repairs	11/14/2008	6,950	463		463		463	20
21	Ejector Pump	1/23/2009	9,100	455		455		455	21
22	Cabling - C Wing	3/23/2009	2,423	81		81		81	22
23	Heat Exchange for Boiler	6/11/2009	11,586	97		97		97	23
24	Watermain	4/1/2009	4,595	115		115		115	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)		\$ 6,531,099	\$ 201,995		\$ 201,995	\$	\$ 791,460	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 562,672	\$ 89,384	\$ 89,384	\$	Various	\$ 145,473	71
72	Current Year Purchases	30,799	3,595	3,595		Various	3,595	72
73	Fully Depreciated Assets							73
74	Home Office Allocation	341,663	25,019	25,019			50,643	74
75	TOTALS	\$ 935,134	\$ 117,997	\$ 117,997	\$		\$ 199,710	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			\$ 39,572	\$ 2,898	\$ 2,898	\$		\$ 17,633	76
77										77
78										78
79										79
80	TOTALS			\$ 39,572	\$ 2,898	\$ 2,898	\$		\$ 17,633	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)	\$ 7,516,722	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 322,890	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,890	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)	\$ 1,008,803	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	\$ 17,257	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 20,708	\$ 6,903	\$ 17,257	91

G. Construction-in-Progress

	Description	Cost	
92	Facility	\$ 362,130	92
93	Home Office Allocation	10,105	93
94			94
95		\$ 372,235	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

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: \$ 95,240 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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	10,002	\$ 614,448	\$	10,002	\$ 614,448	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs		2,360	149,127		2,360	149,127	3
4	Licensed Physical Therapist		hrs		11,686	724,710		11,686	724,710	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			\$	24,048	\$ 1,488,285	\$	24,048	\$ 1,488,285	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, 2008**Ending: **June 30, 2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **June 30, 2009** (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	\$ 2,018,471	\$	1
2	Cash-Patient Deposits	72,661		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>71,590</u>)	1,609,032		3
4	Supply Inventory (priced at <u>FIFO</u>)	19,513		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,305		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corp., and other</u>	(134,778)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,596,204	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,404,345		14
15	Leasehold Improvements, at Historical Cost	23,059		15
16	Equipment, at Historical Cost	604,277		16
17	Accumulated Depreciation (book methods)	(762,470)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	32,117		21
22	Other Long-Term Assets (spe <u>Deferred Financing Co</u>)	410,084		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,711,412	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,307,616	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 309,136	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	72,661		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	601,187		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	40,200		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Other Accrued Liabilities</u>	43,636		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,066,820	\$	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)	\$ 10,421,850	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (114,234)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,307,616	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (491,163)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (491,163)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	376,930	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) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 376,929	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)	\$ (114,234)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,881,054	1
2	Discounts and Allowances for all Levels	(5,699,381)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,181,673	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,215,352	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,215,352	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	3,600	13
14	Non-Patient Meals	2,395	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	80,233	17
18	Sale of Supplies to Non-Patients	131	18
19	Laboratory	39,096	19
20	Radiology and X-Ray	34,642	20
21	Other Medical Services	92,735	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 252,832	23
D. Non-Operating Revenue			
24	Contributions	50,978	24
25	Interest and Other Investment Income***	42,323	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 93,301	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	12,250	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,250	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,755,408	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,690,400	31
32	Health Care	7,554,632	32
33	General Administration	2,884,066	33
B. Capital Expense			
34	Ownership	990,439	34
C. Ancillary Expense			
35	Special Cost Centers	137,396	35
36	Provider Participation Fee	121,545	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,378,478	40
41	Income before Income Taxes (line 30 minus line 40)**	376,930	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 376,930	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, 2008**

Ending:

June 30, 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	2,471	2,631	\$ 118,028	\$ 44.86	1
2	Assistant Director of Nursing	1,385	2,073	88,882	42.88	2
3	Registered Nurses	43,659	47,581	1,675,051	35.20	3
4	Licensed Practical Nurses	26,655	29,140	677,558	23.25	4
5	CNAs & Orderlies	127,780	136,793	1,752,934	12.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,015	5,590	84,383	15.10	8
9	Activity Director	1,903	2,159	45,227	20.95	9
10	Activity Assistants	9,220	9,787	110,060	11.25	10
11	Social Service Workers	5,737	6,463	117,657	18.20	11
12	Dietician					12
13	Food Service Supervisor	2,725	3,295	48,063	14.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,990	44,058	424,352	9.63	15
16	Dishwashers					16
17	Maintenance Workers	11,355	12,574	223,861	17.80	17
18	Housekeepers	22,452	24,341	248,595	10.21	18
19	Laundry					19
20	Administrator	2,568	2,800	131,367	46.92	20
21	Assistant Administrator					21
22	Other Administrative	2,600	2,800	76,829	27.44	22
23	Office Manager	3,979	4,195	45,177	10.77	23
24	Clerical	8,398	9,029	149,051	16.51	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 C: Ward Clerk	7,476	8,181	138,359	16.91	32
33	Other(specify) <u>Comm. Liaison, M</u>	14,056	15,598	452,565	29.01	33
34	TOTAL (lines 1 - 33)	339,424	369,088	\$ 6,607,999 *	\$ 17.90	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	2,592	\$ 53,135	ln 1, col 3	35
36	Medical Director	720	53,604	ln 9, col 3	36
37	Medical Records Consultant	30	1,800	ln 10, col 3	37
38	Nurse Consultant	6	468	ln 10, col 3	38
39	Pharmacist Consultant	216	5,583	ln 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	127	7,202	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,691	\$ 121,792		49

C. CONTRACT NURSES

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF# 0048819Report Period Beginning: July 1, 2008 Ending: June 30, 2008**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 - \$10,285
- (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. \$ 62,275 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. \$ 121,545
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. \$ 2,395
- (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
- (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.