



Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

**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	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,436	7

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

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			5,765	5,765	8
9	SNF/PED					9
10	ICF	33,207	8,948		42,155	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,207	8,948	5,765	47,920	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.68%**

**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 10/2/91

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

YES  Date \_\_\_\_\_ 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 5,765

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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		7,452	601,767	609,219	609,219		609,219		1	
2	Food Purchase		2,711		2,711	2,711	(1,484)	1,227		2	
3	Housekeeping		23,558	180,591	204,149	204,149		204,149		3	
4	Laundry		10,277	132,355	142,632	142,632		142,632		4	
5	Heat and Other Utilities			123,800	123,800	123,800	1,364	125,164		5	
6	Maintenance	111,801	62,150	35,294	209,245	209,245	19,852	229,097		6	
7	Other (specify):*			10,332	10,332	10,332	1,100	11,432		7	
8	<b>TOTAL General Services</b>	111,801	106,148	1,084,139	1,302,088	1,302,088	20,832	1,322,920		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	2,516,985	121,059	10,515	2,648,559	2,648,559		2,648,559		10	
10a	Therapy	403,146	1,928	92,813	497,887	497,887		497,887		10a	
11	Activities	283,022	16,747	816	300,585	300,585		300,585		11	
12	Social Services			421	421	421		421		12	
13	CNA Training									13	
14	Program Transportation			11,955	11,955	11,955		11,955		14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	3,203,153	139,734	118,620	3,461,507	3,461,507		3,461,507		16	
	<b>C. General Administration</b>										
17	Administrative	137,958		234,000	371,958	371,958	(78,725)	293,233		17	
18	Directors Fees									18	
19	Professional Services			68,688	68,688	68,688	(9,069)	59,619		19	
20	Dues, Fees, Subscriptions & Promotions			94,394	94,394	94,394	(64,297)	30,097		20	
21	Clerical & General Office Expenses	261,414	40,811	552,559	854,784	854,784	(429,018)	425,766		21	
22	Employee Benefits & Payroll Taxes			679,206	679,206	679,206		679,206		22	
23	Inservice Training & Education			11,989	11,989	11,989		11,989		23	
24	Travel and Seminar						3,154	3,154		24	
25	Other Admin. Staff Transportation			18,567	18,567	18,567	(615)	17,952		25	
26	Insurance-Prop.Liab.Malpractice			223,084	223,084	223,084	7,606	230,690		26	
27	Other (specify):*			52,146	52,146	52,146	(12,836)	39,310		27	
28	<b>TOTAL General Administration</b>	399,372	40,811	1,934,633	2,374,816	2,374,816	(583,800)	1,791,016		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,714,326	286,693	3,137,392	7,138,411	7,138,411	(562,968)	6,575,443		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	0
	<b>CONTRACTED DIETARY SERVICES</b>	601,767
<b>3</b>	<b>HOUSEKEEPING</b>	
	<b>CONTRACTED HOUSEKEEPING SERVICES</b>	180,591
		0
		180,591
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	6,270
	<b>CONTRACTED LAUNDRY SERVICES</b>	126,085
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	30,838
	ELECTRICITY	52,778
	WATER	40,184
	CABLE TV - LOBBY	0
		0
		123,800
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,279
	PAINTING & DECORATING	1,679
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,418
	ELEVATOR MAINTENANCE & REPAIR	9,343
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	0
		0
		0
		0
		0
		35,294
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	10,332
	SECURITY SERVICE	0
		0
		0
		10,332
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,100
		2,100

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	9,250
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	125
	<b>SPECIAL CARE UNIT</b>	1,140
		0
		10,515
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	536
	SPEECH THERAPY SERVICES	92,277
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		92,813
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	816
		0
		816
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	421
		421
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	11,955
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	234,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	24,776
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	43,912
		0
		68,688
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	64,147
	EMPLOYEE WANT ADS XIX F	3,367
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	19,872
	LICENSES & PERMITS XIX F	4,498
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,000
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,510
	PATIENT BACKGROUND CHECKS XIX F	0
		94,394
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	13,455
	EQUIPMENT REPAIR & MAINTENANCE	24,580
	OUTSIDE CLERICAL SERVICES	493,700
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,824
	MESSENGER SERVICE	0
		0
		552,559

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	289,093
	UNEMPLOYMENT COMPENSATION XIX D	75,747
	WORKERS COMPENSATION INSURANC XIX D	106,964
	HOSPITALIZATION INSURANCE XIX D	182,525
	EMPLOYEE BENEFITS - OTHER XIX D	24,877
	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
		679,206
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	11,989
		11,989
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	18,567
		18,567
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	223,084
		223,084
27	<b>OTHER</b>	
	BAD DEBTS VI 24	52,146
		52,146

GRAND TOTAL COLUMN 3 OTHER

3,137,392

**BRIDGEVIEW HEALTH CARE CTR  
SCHEDULES  
12/31/2012**

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

TOTAL FOOD PURCHASE	2,711
LESS SALES TAX	<u>(1,484)</u>
NET FOOD	1,227
TOTAL PATIENT CENSUS	47,920
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	143,760
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	143,760
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	143,760
NET FOOD	1,227
DIVIDE TOTAL MEALS/YEAR	<u>143,760</u>
COST PER MEAL	0.01
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

## 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			87,919	87,919		87,919	160,083	248,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,362	38,362		38,362	302,191	340,553			32
33	Real Estate Taxes			420,246	420,246		420,246	4,412	424,658			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			8,765	8,765		8,765	11,293	20,058			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,044,532	1,044,532		1,044,532	(11,261)	1,033,271			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		158,206	795	159,001		159,001		159,001			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			336,411	336,411		336,411		336,411			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		158,206	337,206	495,412		495,412		495,412			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,714,326	444,899	4,519,130	8,678,355		8,678,355	(574,229)	8,104,126			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,526	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,484)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(10,733)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,146)	27		24
25	Fund Raising, Advertising and Promotional	(64,147)	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	(15,253)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (135,267)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(438,962)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (438,962)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (574,229)</b>		<b>37</b>

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

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

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

<b>BHF USE ONLY</b>						
48		49		50		51
						52

STATE OF ILLINOIS  
 BRIDGEVIEW HEALTH CARE CTR

ID# 0037358  
 Report Period Beginning: 01/01/2012  
 Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (14,553)	21	1
2	MARKETING TRAVEL	(700)	25	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>		(15,253)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,484)	0	0	0	0	0	0	0	0	0	0	(1,484)	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	1,364	0	0	0	0	0	0	0	0	1,364	5
6	Maintenance	0	0	11,714	8,138	0	0	0	0	0	0	0	19,852	6
7	Other (specify):*	0	0	251	0	849	0	0	0	0	0	0	1,100	7
8	<b>TOTAL General Services</b>	<b>(1,484)</b>	<b>0</b>	<b>13,329</b>	<b>8,138</b>	<b>849</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>20,832</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	0	0	0	0	0	0	0	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>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(234,000)	0	155,275	0	0	0	0	0	0	0	(78,725)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,733)	0	1,664	0	0	0	0	0	0	0	0	(9,069)	19
20	Fees, Subscriptions & Promotions	(65,147)	0	850	0	0	0	0	0	0	0	0	(64,297)	20
21	Clerical & General Office Expenses	(14,553)	(493,700)	68,627	10,608	0	0	0	0	0	0	0	(429,018)	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	3,154	0	0	0	0	0	0	0	0	3,154	24
25	Other Admin. Staff Transportation	(700)	0	85	0	0	0	0	0	0	0	0	(615)	25
26	Insurance-Prop.Liab.Malpractice	0	7,606	0	0	0	0	0	0	0	0	0	7,606	26
27	Other (specify):*	(52,146)	0	13,238	0	26,072	0	0	0	0	0	0	(12,836)	27
28	<b>TOTAL General Administration</b>	<b>(143,279)</b>	<b>(720,094)</b>	<b>87,618</b>	<b>165,883</b>	<b>26,072</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(583,800)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(144,763)</b>	<b>(720,094)</b>	<b>100,947</b>	<b>174,021</b>	<b>26,921</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(562,968)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

01/01/2012 Ending:

Summary B

12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,526	147,113	3,444	0	0	0	0	0	0	0	0	160,083	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	298,180	4,041	0	0	0	0	0	0	0	0	302,191	32
33	Real Estate Taxes	0	0	4,412	0	0	0	0	0	0	0	0	4,412	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	11,293	0	0	0	0	0	0	0	0	11,293	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>9,496</b>	<b>(43,947)</b>	<b>23,190</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>(11,261)</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	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(135,267)</b>	<b>(764,041)</b>	<b>124,137</b>	<b>174,021</b>	<b>26,921</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(574,229)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

**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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 234,000				(234,000)	1
2	V	21 BOOKKEEPING SERVICES	493,700				(493,700)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	489,240				(489,240)	7
8	V	30 DEPRECIATION				147,113	147,113	8
9	V	32 AMORTIZATION				1,865	1,865	9
10	V	32 INTEREST				296,315	296,315	10
11	V	26 PROPERTY/BOILER INSURANCE				7,606	7,606	11
12	V							12
13	V							13
14	Total		\$ 1,216,940			\$ 452,899	\$ * (764,041)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 1,364	\$	1,364	15
16	V	6 REPAIR & MAINT.		" "		11,714		11,714	16
17	V	7 EMP BEN-GEN SERV		" "		251		251	17
18	V	19 PROFESSIONAL FEES		" "		1,664		1,664	18
19	V	20 DUES AND SUBSCRIPTION		" "		850		850	19
20	V	21 CLERICAL & GENERAL		" "		68,627		68,627	20
21	V	24 SEMINARS AND TRAVEL		" "		3,154		3,154	21
22	V	25 AUTO EXPENSE		" "		85		85	22
23	V	27 EMP. BEN. - GEN, ADMIN.		" "		13,238		13,238	23
24	V	30 DEPRECIATION		" "		3,444		3,444	24
25	V	32 INTEREST		" "		4,041		4,041	25
26	V	33 REAL ESTATE TAXES		" "		4,412		4,412	26
27	V	35 EQUIPMENT RENTAL		" "		10,897		10,897	27
28	V	35 EQUIPMENT RENTAL		" "		396		396	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		\$			\$ 124,137	\$ *	124,137	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		\$ 8,138	\$ 8,138
16	V	17 ADMIN COMP - M MAUER		" "		24,390	24,390
17	V	17 ADMIN COMP - M AARON		" "		27,707	27,707
18	V	17 ADMIN COMP - F AARON		" "		9,400	9,400
19	V	17 ADMIN COMP - D AARON		" "		19,325	19,325
20	V	17 ADMIN COMP - S GOLDSTEIN		" "			
21	V	17 ADMIN COMP - S HARAMARAS		" "			
22	V	17 ADMIN COMP - D KUFTA		" "		21,091	21,091
23	V	17 ADMIN COMP - HOWARD ALTER		" "			
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		" "		5,885	5,885
25	V	17 ADMIN COMP - NON OWNER - VAR		" "		25,522	25,522
26	V	17 ADMIN COMP - NON OWNER - CFO		" "		21,955	21,955
27	V	21 CLERICAL COMP - S AARON		" "		10,414	10,414
28	V	21 CLERICAL COMP - E MARYLES		" "		194	194
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 174,021	\$ * 174,021

\* 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		\$ 849	\$	849	15
16	V	27 EMP BEN - M MAUER		" "		1,323		1,323	16
17	V	27 EMP BEN - M AARON		" "		1,912		1,912	17
18	V	27 EMP BEN - F AARON		" "		7,237		7,237	18
19	V	27 EMP BEN - D AARON		" "		1,567		1,567	19
20	V	27 EMP BEN - S GOLDSTEIN		" "					20
21	V	27 EMP BEN - S HARAMARAS		" "					21
22	V	27 EMP BEN - D KUFTA		" "		1,479		1,479	22
23	V	27 EMP BEN - HOWARD ALTER		" "					23
24	V	27 EMP BEN - V DAVIS		" "		1,011		1,011	24
25	V	27 EMP BEN - NON OWNER		" "		6,841		6,841	25
26	V	27 EMP BEN - NON OWNER - CFO		" "		2,749		2,749	26
27	V	27 EMP BEN - S AARON		" "		1,936		1,936	27
28	V	27 EMP BEN - E MARYLES		" "		17		17	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 26,921	\$ *	26,921	39

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

Facility Name & ID Number

BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	RAJCHENBACH FAMILY TRUST	18.75	GROSS POINTE MANOR LLC	NILES	BRIDGEVIEW ASSOCIATES LLC		BUILDING CO	1
2	MAURICE AARON	19.74	OTTAWA PAVILION LTD	OTTAWA	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	MARSHALL MAUER	12.83	PARK RIDGE CARE CENTER LTD	PARK RIDGE	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	FRED AARON	7.89	STERLING PAVILION LTD	STERLING				4
5	SHIMON GOLDSTEIN	3.94	WARREN PARK HEALTH AND LIVING CEN	CHICAGO				5
6	SHARON AARON	.41	WATERFRONT TERRACE INC	CHICAGO				6
7	CHANA MAUER-RAY	4.44	WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				7
8	DENNIS NEHMER	.41	WOODBRIIDGE NURSING PAVILION LTD	CHICAGO				8
9	DIANA KUFTA	.41	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				9
10	ESTHER MARYLES	4.44	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				10
11	HOWIE & SUSIE ALTER	.82	WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				11
12	SUE KOPLIN HARAMARAS	.41						12
13	SYLVIA AARON	.16						13
14	FRANCES MAUER	6.58						14
15	MARK HOLLANDER DISCRETIONARY	6.25						15
16	SHARON HOLLANDER DISCRETIONA	6.25						16
17	FEIGE KNOBEL DISCRETIONARY TRI	6.25						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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

## 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	SHAREHOLDER	ADMINISTRATIV	12.83	175,610	4.88	9.76	SALARY	\$ 24,390	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIV	19.74	172,293	5.54	11.08	SALARY	27,707	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL	0.41	74,972	4.88	12.20	SALARY	10,414	21-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIV	7.89	37,600	9		SALARY	9,400	17-7	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIV	7.89				SALARY	30,000	17-1	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.41	131,079	6.93	13.85	SALARY	21,091	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.41	50,602	5.54	13.85	SALARY	8,138	6-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL	4.44	15,071	0.36	1.27	SALARY	194	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 131,334		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 CTR

# 0037358

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS  
 Street Address 3359 W MAIN STREET  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	413,728	13	\$ 11,773	\$ 47,920	\$ 1,364	1	
2	6	REPAIR & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	47,920	11,714	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	413,728	13	2,165	47,920	251	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369	47,920	1,664	4	
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	413,728	13	7,338	47,920	850	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	47,920	68,627	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227	47,920	3,154	7	
8	25	AUTO EXPENSE	PATIENT DAYS	413,728	13	736	47,920	85	8	
9	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	413,728	13	114,290	47,920	13,238	9	
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732	47,920	3,444	10	
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887	47,920	4,041	11	
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096	47,920	4,412	12	
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	94,085	47,920	10,897	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415	47,920	396	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 1,071,756	\$ 456,183		\$ 124,137	25	

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS  
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 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	\$ 58,740	\$ 58,740	6	\$ 8,138	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	5	24,390	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	200,000	200,000	6	27,707	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	47,000	47,000	9	9,400	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	52,765	52,765	15	19,325	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	102,086	102,086			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	73,867	73,867			7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	152,170	152,170	7	21,091	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	8	117,701	117,701	2	5,885	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	8	184,393	184,393	6	25,522	11
12	17	ADMIN COMP - NON OWNER - CE	WGHTD AVG HOURS	45	10	180,028	180,028	5	21,955	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	85,386	85,386	5	10,414	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	15,265	15,265	0	194	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,481,401	\$ 1,481,401		\$ 174,021	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS  
 Street Address 3359 W MAIN STREET  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	\$ 6,127	\$ 6	\$ 849	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	10,847	5	1,323	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	13,801	6	1,912	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	36,183	9	7,237	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,278	15	1,567	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,829			6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	23,776			7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,672	7	1,479	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,076			9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	8	20,219	2	1,011	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45.01	8	49,423	6	6,841	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,545	5	2,749	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40.01	10	15,870	5	1,936	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	1,340	0	17	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 253,986	\$	\$ 26,921	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	CAMBRIDGE		X	MORTGAGE	\$49,218.18		\$ 5,722,000	\$ 5,334,236	10/41	5.8500	\$ 296,315						
2																	
3																	
4																	
5	RELATED PARTY																
<b>Working Capital</b>																	
6	BANK LEUMI		X	WORKING CAPITAL				875,000			30,543						
7	IMPERIAL CREDIT CORP.		X	INSURANCE FINANCING							1,077						
8	PHARMACY		X	FINANCING				100,613			6,742						
9	TOTAL Facility Related				\$49,218.18		\$ 5,722,000	\$ 6,309,849			\$ 334,677						
<b>B. Non-Facility Related*</b>																	
10	IRS, IDR, ETC		X	LATE FEES													
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 5,722,000	\$ 6,309,849			\$ 334,677						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2011 report.		\$	<b>263,000</b>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>338,246</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>75,246</b>		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>345,000</b>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>420,246</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<b>192,639</b>	8		
	2008	<b>204,234</b>	9		
	2009	<b>239,768</b>	10		
	2010	<b>257,629</b>	11		
	2011	<b>338,246</b>	12		
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>				<b>FOR BHF USE ONLY</b>	
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.</b>				13	13
				14	14
				15	15
				16	16

**NOTES:**

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



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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 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 CTR

# 0037358

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$	\$ 2,290,388	4
5										5
6										6
7										7
8	RELATED PARTY			51,380	1,317	35	1,468	151	28,371	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS	1991		1,017	32	31.5	32		679	9
10	LEASEHOLD IMPROVEMENTS	1991		2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS	1992		85,574	2,718	31.5	2,718		56,853	11
12	LEASEHOLD IMPROVEMENTS	1993		1,600	51	31.5	51		1,005	12
13	LEASEHOLD IMPROVEMENTS	1994		8,141	209	39	209		3,870	13
14	1ST FLOOR CENTRAL A/C	1995		1,250	32	39	32		553	14
15	CARPET INSTALL	1995		1,303	33	39	33		568	15
16	RAIL BUMPER	1995		917	24	39	24		409	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM	1996		5,320	137	39	137		2,269	17
18	PAINTING WORK	1996		8,400	215	39	215		3,521	18
19	WALL COVERING	1996		1,435	37	39	37		603	19
20	FRONT LOBBY/WINDOW, DOOR WORK	1997		2,509	64	39	64		992	20
21	ELEVATOR REPAIR	1998		2,800	72	39	72		1,071	21
22	CONDENCING UNIT	1999		3,824	98	39	98		1,338	22
23	DRAPES	1999		5,369	138	39	138		1,848	23
24	CARPETING AND VINYL FLOORING	1999		8,540	219	39	219		2,952	24
25	DOOR WORK	1999		10,490	269	39	269		3,589	25
26	KITCHEN CABINETS	1999		5,832	149	39	149		2,011	26
27	TILES	2000		8,855	322	27.5	322		4,000	27
28	ELEVATOR REPAIR	2000		4,240	153	27.5	153		1,815	28
29	ROD MAIN SEWER	2000		1,100	41	27.5	41		506	29
30	DRAPERIES	2001		2,118		7			2,118	30
31	RECEPTION DESK/DOOR	2002		9,534	347	27.5	347		3,470	31
32	FLOORING / BUMPER GUARDS	2002		11,198	407	27.5	407		4,071	32
33	WALLPAPER, BORDER, ARTWORK	2002		42,079	1,530	27.5	1,530		15,082	33
34	WIRING, MOTOR	2002		9,224	336	27.5	336		3,360	34
35	HANDRAILS & GUARDS	2003		7,811	284	27.5	284		2,686	35
36		2003		4,023	134	15	134		3,285	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 CTR

# 0037358

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ORIENTATION BOARDS	2003	\$ 1,752	\$ 64	27.5	\$ 64	\$	\$ 605	37
38	COIL	2003	806	29	27.5	29		274	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,373	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		577	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		2,307	41
42	FLOOR COVERING	2004	888	32	27.5	32		271	42
43	CABINETS	2004	2,594	95	27.5	95		803	43
44	BOILER	2004	2,574	93	27.5	93		787	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		364	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		2,440	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		19,533	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		2,700	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		373	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		5,728	50
51	NETWORK CABLING	2006	855	31	27.5	31		200	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		839	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		517	53
54	FANS	2006	1,108	40	27.5	40		258	54
55	DOORS	2006	1,711	62	27.5	62		401	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		10,257	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		731	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		5,557	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		666	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		3,968	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		5,966	61
62	CONDENSER	2007	1,712	62	27.5	62		339	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		370	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		2,952	64
65	DOORS	2008	1,645	60	27.5	60		267	65
66	BOILER	2008	5,104	185	27.5	185		825	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		197	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		1,729	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		5,720	69
70	TOTAL (lines 4 thru 69)		\$ 5,701,917	\$ 152,781		\$ 152,932	\$ 151	\$ 2,525,892	70

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

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,701,917	\$ 152,781		\$ 152,932	\$ 151	\$ 2,525,892	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		13,519	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		557	3
4	HEATING WORK	2009	9,475	345	27.5	345		1,193	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		1,356	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	608	27.5	608		1,495	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		474	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		1,563	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		565	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		3,048	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	621	27.5	621		1,527	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		1,500	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		275	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	233	27.5	233		573	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		369	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TIL	2010	5,691	207	27.5	207		509	16
17	CEILING PIPING	2010	2,825	103	27.5	103		253	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		1,131	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		381	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		224	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		258	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	125	27.5	125		307	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	67	27.5	67		165	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	56	27.5	56		138	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		561	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	96	27.5	96		236	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	63	27.5	63		155	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		698	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		1,019	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	368	27.5	368		537	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		1,213	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		637	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS	2011	65,023	2,364	27.5	2,364		3,448	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,152,290	\$ 169,156		\$ 169,307	\$ 151	\$ 2,565,776	34

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

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,152,290	\$ 169,156		\$ 169,307	\$ 151	\$ 2,565,776	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		273	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		1,641	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		314	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		442	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		992	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		1,887	7
8	FLOORING/TACKBOARD-THERAPY RM/LIGHT FIXTURES	2011	2,809	102	27.5	102		150	8
9	DINING ROOM								9
10									10
11									11
12									12
13	<b>RELATED PARTY - LANDLORD:</b>								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		38,914	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		33,665	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		75,258	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		23,527	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		22,878	18
19	NURSE STATION	2002	17,320	229	39	229		10,371	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		46,295	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		12,457	21
22	NURSE STATION	2004	27,559	707	39	707		5,980	22
23	CARPET, TILE, WALLCOVERING	2004	42,388	1,890	39	1,890		44,276	23
24	MODERNIZE ELEVATORS	2007	175,828	2,621	39	2,621		22,719	24
25	WINDOWS	2006	83,000	2,128	39	2,128		10,551	25
26									26
27	DOORS 2ND, 3RD & 4TH FLOOR	2012	4,075	68	27.5	68		68	27
28	PLUMBING WORK 2,3,4 FL EAST SHOWER, ELEVATOR, LA	2012	11,639	194	27.5	194		194	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	440	27.5	440		440	29
30	FLOORING - LOBBY/CORRIDOR	2012	8,640	144	27.5	144		144	30
31	SECURITY SYSTEM WORK	2012	5,130	86	27.5	86		86	31
32	ROOF REPAIR	2012	1,595	26	27.5	26		26	32
33	NURSE CALL SYSTEM WORK	2012	1,488	25	27.5	25		25	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,067,691	\$ 190,597		\$ 190,748	\$ 151	\$ 2,919,349	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,067,691	\$ 190,597		\$ 190,748	\$ 151	\$ 2,919,349	1
2	CEILING REPAIR - DINING ROOM	2012	2,145	36	27.5	36		36	2
3	ELECTRIC WORK - GENERATOR & FIRE SUPPRESSION SY	2012	2,825	47	27.5	47		47	3
4	HANDRAIL SPACERS	2012	2,800	47	27.5	47		47	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	54	27.5	54		54	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)		\$ 7,078,669	\$ 190,781		\$ 190,932	\$ 151	\$ 2,919,533	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 512,894	\$ 14,571	\$ 49,329	\$ 34,758	10 YRS	\$ 260,753	71
72	Current Year Purchases	51,661	30,997	2,583	(28,414)	10 YRS	2,583	72
73	Fully Depreciated Assets	224,113				10 YRS	224,113	73
74	RELATED PARTY	26,797	373	841	468		23,865	74
75	TOTALS	\$ 815,465	\$ 45,941	\$ 52,753	\$ 6,812		\$ 511,314	75

D. Vehicle Costs. (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			\$ 29,063	\$ 1,754	\$ 4,317	\$ 2,563		\$ 8,200	76
77										77
78										78
79										79
80	TOTALS			\$ 29,063	\$ 1,754	\$ 4,317	\$ 2,563		\$ 8,200	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)	\$ 8,227,197	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 238,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 248,002	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,526	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,439,047	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: NA

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

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. \_\_\_\_\_ /2013                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

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: \$ 6,636 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2010 LEXUS	\$ 600.00	\$ 7,200	17
18	PAYROLL ADJ			(5,071)	18
19					19
20					20
21	<b>TOTAL</b>		\$ 600.00	\$ 2,129	21

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2012 Ending: 12/31/2012  
**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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <b>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>3. <b>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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			795				795	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 prescrpts					132,384		132,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): <b>SUPPLIES, LAB,XRAY,RENTALS</b>							25,822		25,822	13
14	<b>TOTAL</b>			\$		\$ 795	\$	158,206	\$	159,001	14

**NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.**

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CTR**# **0037358**Report Period Beginning: **01/01/2012**

Ending:

**12/31/2012****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2012**

(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	\$ 14,901	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 263,000 )	2,297,958		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,643		6
7	Other Prepaid Expenses	65,301		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>RE TAX ESCROW</b>	306,170		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,845,973	\$	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	1,186,405		15
16	Equipment, at Historical Cost	788,667		16
17	Accumulated Depreciation (book methods)	(1,009,366)		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): <b>DEPOSITS</b>	556,627		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,522,333	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,368,306	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 769,639	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	975,613		29
30	Accrued Salaries Payable	278,741		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,061		31
32	Accrued Real Estate Taxes(Sch.IX-B)	345,000		32
33	Accrued Interest Payable	3,034		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,402,088	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,402,088	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,966,218	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,368,306	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,265,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,265,243	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	883,375	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	(182,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 700,975	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,966,218	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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,265,790	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,265,790	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,910	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 295,910	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***	30	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30	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>	\$ 9,561,730	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,302,088	31
32	Health Care	3,461,507	32
33	General Administration	2,374,816	33
<b>B. Capital Expense</b>			
34	Ownership	1,044,532	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	159,001	35
36	Provider Participation Fee	336,411	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,678,355	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	883,375	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 883,375	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,717,062	44
45	Private Pay - Net Inpatient Revenue	1,340,927	45
46	Medicare - Net Inpatient Revenue	2,827,203	46
47	Other-(specify) <u>HOSPICE</u>	380,598	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,265,790	49

**\*\*TAX RETURN PREPARED ON CASH BASIS**

\* 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 CTR**

# **0037358**

Report Period Beginning: **01/01/2012**

Ending:

**12/31/2012**

**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	989	1,238	\$ 52,653	\$ 42.53	1
2	Assistant Director of Nursing	1,954	2,093	77,421	36.99	2
3	Registered Nurses	7,879	8,699	291,475	33.51	3
4	Licensed Practical Nurses	33,448	38,015	1,007,869	26.51	4
5	CNAs & Orderlies	89,902	100,137	1,042,291	10.41	5
6	CNA Trainees					6
7	Licensed Therapist	11,487	12,105	403,146	33.30	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,743	3,074	58,370	18.99	9
10	Activity Assistants	16,020	17,756	224,652	12.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,141	6,413	111,801	17.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,210	2,627	137,958	52.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,704	13,435	261,414	19.46	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	1,926	2,212	45,276	20.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,403	207,804	\$ 3,714,326 *	\$ 17.87	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	2,100	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	125	10-3	38
39	Pharmacist Consultant	H	9,250	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	816	11-3	44
45	Social Service Consultant	E	421	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,712		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number BRIDGEVIEW HEALTH CARE CTR

# 0037358

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

## 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? YEA  
If YES, give association name and amount. ICLTC \$14,454
- (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. \$ 13,369 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. \$ 336,411  
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.