FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CENTER

Address: 8100 SOUTH HARLEM AVENUE (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 10/02/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,492	2,468	5,844	18,804	8
9	SNF/PED					9
10	ICF	21,884	7,517		29,401	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,376	9,985	5,844	48,205	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.46%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/02/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/02/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 5,844

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	263,048	20,492	11,836	295,376		295,376		295,376			1
2	Food Purchase		283,010		283,010	(44,895)	238,115	(1,715)	236,400			2
3	Housekeeping		29,393	178,256	207,649		207,649		207,649			3
4	Laundry		17,355	124,120	141,475		141,475		141,475			4
5	Heat and Other Utilities			125,339	125,339		125,339	1,649	126,988			5
6	Maintenance	105,245	78,576	28,084	211,905		211,905	13,820	225,725			6
7	Other (specify):*			16,140	16,140		16,140	826	16,966			7
8	**TOTAL General Services**	368,293	428,826	483,775	1,280,894	(44,895)	1,235,999	14,580	1,250,579			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	2,447,820	120,460	8,576	2,576,856		2,576,856	(2,762)	2,574,094			10
10a	Therapy	513,960	5,272		519,232		519,232		519,232			10a
11	Activities	316,349	24,577	816	341,742		341,742		341,742			11
12	Social Services			1,134	1,134		1,134		1,134			12
13	CNA Training											13
14	Program Transportation			246	246		246		246			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,278,129	150,309	12,872	3,441,310		3,441,310	(2,762)	3,438,548			16
	C. General Administration											
17	Administrative	136,426		187,000	323,426		323,426	(39,762)	283,664			17
18	Directors Fees											18
19	Professional Services			84,033	84,033		84,033	(2,111)	81,922			19
20	Dues, Fees, Subscriptions & Promotions			103,747	103,747		103,747	(75,199)	28,548			20
21	Clerical & General Office Expenses	227,904	40,258	514,311	782,473		782,473	(420,515)	361,958			21
22	Employee Benefits & Payroll Taxes			672,255	672,255	44,895	717,150		717,150			22
23	Inservice Training & Education			7,168	7,168		7,168		7,168			23
24	Travel and Seminar							431	431			24
25	Other Admin. Staff Transportation			12,310	12,310		12,310	955	13,265			25
26	Insurance-Prop.Liab.Malpractice			196,106	196,106		196,106	8,761	204,867			26
27	Other (specify):*			60,000	60,000		60,000	(22,476)	37,524			27
28	**TOTAL General Administration**	364,330	40,258	1,836,930	2,241,518	44,895	2,286,413	(549,916)	1,736,497			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,010,752	619,393	2,333,577	6,963,722		6,963,722	(538,098)	6,425,624			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#: BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,780	
	REPAIRS & MAINTENANCE		2,056	
			0	11,836
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICE		178,256	
			0	178,256
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,279	
	CONTRACTED LAUNDRY SERVICES		118,841	124,120
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		39,762	
	ELECTRICITY		54,503	
	WATER		31,074	
	CABLE TV - LOBBY		0	
			0	125,339
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,847	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,817	
	ELEVATOR MAINTENANCE & REPAIR		4,520	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,900	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	28,084
7	**OTHER**			
	SCAVENGER		16,140	
	SECURITY SERVICE		0	
			0	
			0	16,140
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,100	2,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	361	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	8,215	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	8,576
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	816	
			0	816
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,134	
			0	1,134
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER **#0037358** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		246	246
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	187,000	187,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,961	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	70,072	
			0	84,033
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	68,467	
	EMPLOYEE WANT ADS	XIX F	10,922	
	CONTRIBUTIONS	VI 20 XIX F	100	
	DUES & SUBSCRIPTIONS	XIX F	11,149	
	LICENSES & PERMITS	XIX F	3,746	
	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	7,523	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,840	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				103,747
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,824	
	EQUIPMENT REPAIR & MAINTENANCE		21,112	
	OUTSIDE CLERICAL SERVICES		469,623	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,752	
	MESSENGER SERVICE		0	
			0	514,311

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	293,482	
	UNEMPLOYMENT COMPENSATION	XIX D	71,618	
	WORKERS COMPENSATION INSURANC	XIX D	88,905	
	HOSPITALIZATION INSURANCE	XIX D	197,905	
	EMPLOYEE BENEFITS - OTHER	XIX D	20,345	
	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	672,255
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		7,168	
				7,168
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,310	
				12,310
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		196,106	
				196,106
27	**OTHER**			
	BAD DEBTS	VI 24	60,000	
				60,000

GRAND TOTAL COLUMN 3 OTHER **2,333,577**

BRIDGEVIEW HEALTH CARE CENTER
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	283,010
LESS SALES TAX	(1,715)
NET FOOD	281,295
TOTAL PATIENT CENSUS	48,205
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	144,615
ADD # EMPLOYEE MEALS/DAY	75
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	27,375
PATIENT MEALS	144,615
ADD EMPLOYEE MEALS	27,375
TOTAL MEALS/YEAR	171,990
NET FOOD	281,295
DIVIDE TOTAL MEALS/YEAR	171,990
COST PER MEAL	1.64
TIME EMPLOYEE MEALS	27,375
EMPLOYEE MEAL RECLASSIFICATION	**44,895**
	========

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			107,224	107,224		107,224	143,932	251,156			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,608	42,608		42,608	296,395	339,003			32
33	Real Estate Taxes			276,768	276,768		276,768	2,811	279,579			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			14,397	14,397		14,397	8,370	22,767			35
36	Other (specify):*											36
37	**TOTAL Ownership**			930,237	930,237		930,237	(37,732)	892,505			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,748	127,532	316,280		316,280	(565)	315,715			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		188,748	207,467	396,215		396,215	(565)	395,650			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,010,752	808,141	3,471,281	8,290,174		8,290,174	(576,395)	7,713,779			45

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,761)	30		9
10	Interest and Other Investment Income	(14,050)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,715)	2		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				18
19	Entertainment				19
20	Contributions	(7,623)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,109)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(68,467)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(26,566)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (192,291)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(384,104)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (384,104)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (576,395)		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 Yes	2 No	3 Amount	4 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					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BRIDGEVIEW HEALTH CARE CENTER

ID# 0037358

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ -26566	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,566)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,715)	0	0	0	0	0	0	0	0	0	0	(1,715)	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	1,649	0	0	0	0	0	0	0	0	1,649	5
6	Maintenance	0	0	5,388	8,432	0	0	0	0	0	0	0	13,820	6
7	Other (specify):*	0	0	0	0	826	0	0	0	0	0	0	826	7
8	**TOTAL General Services**	(1,715)	0	7,037	8,432	826	0	0	0	0	0	0	14,580	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	0	0	0	0	0	(2,762)	0	0	0	0	0	(2,762)	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	**TOTAL Health Care and Programs**	0	0	0	0	0	(2,762)	0	0	0	0	0	(2,762)	16
	C. General Administration													
17	Administrative	0	(187,000)	0	147,238	0	0	0	0	0	0	0	(39,762)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,109)	0	998	0	0	0	0	0	0	0	0	(2,111)	19
20	Fees, Subscriptions & Promotions	(76,090)	0	891	0	0	0	0	0	0	0	0	(75,199)	20
21	Clerical & General Office Expenses	(26,566)	(469,623)	65,276	10,398	0	0	0	0	0	0	0	(420,515)	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	431	0	0	0	0	0	0	0	0	431	24
25	Other Admin. Staff Transportation	0	0	955	0	0	0	0	0	0	0	0	955	25
26	Insurance-Prop.Liab.Malpractice	0	7,279	1,482	0	0	0	0	0	0	0	0	8,761	26
27	Other (specify):*	(60,000)	0	12,666	0	24,858	0	0	0	0	0	0	(22,476)	27
28	**TOTAL General Administration**	(165,765)	(649,344)	82,699	157,636	24,858	0	0	0	0	0	0	(549,916)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(167,480)	(649,344)	89,736	166,068	25,684	(2,762)	0	0	0	0	0	(538,098)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,761)	151,099	3,594	0	0	0	0	0	0	0	0	143,932	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,050)	305,827	4,618	0	0	0	0	0	0	0	0	296,395	32
33	Real Estate Taxes	0	0	2,811	0	0	0	0	0	0	0	0	2,811	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	8,370	0	0	0	0	0	0	0	0	8,370	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,811)	(32,314)	19,393	0	0	0	0	0	0	0	0	(37,732)	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	(565)	0	0	0	0	0	(565)	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	(565)	0	0	0	0	0	(565)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(192,291)	(681,658)	109,129	166,068	25,684	(3,327)	0	0	0	0	0	(576,395)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SHCEDULE ATTACHED		

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. [X] 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	$ 187,000	DYNAMIC HEALTHCARE	100.00%	$	$ (187,000)	1
2	V	21	BOOKKEEPING SERVICES	469,623	" "			(469,623)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240	BRIDGEVIEW ASSOCIATES LLC	100.00%		(489,240)	7
8	V	30	DEPRECIATION		" "		151,099	151,099	8
9	V	32	AMORTIZATION		" "		1,865	1,865	9
10	V	32	INTEREST		" "		303,962	303,962	10
11	V	26	PROPERTY/BOILER INSURANCE		" "		7,279	7,279	11
12	V								12
13	V								13
14	Total			$ 1,145,863			$ 464,205	$ * (681,658)	14

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,649	$ 1,649	15
16	V	6	REPAIR & MAINT.		" "		5,388	5,388	16
17	V	19	PROFESSIONAL FEES		" "		998	998	17
18	V	20	DUES AND SUBSCRIPTION		" "		891	891	18
19	V	21	CLERICAL & GENERAL		" "		65,276	65,276	19
20	V	24	SEMINARS AND TRAVEL		" "		431	431	20
21	V	25	AUTO EXPENSE		" "		955	955	21
22	V	26	INSURANCE		" "		1,482	1,482	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" "		12,666	12,666	23
24	V	30	DEPRECIATION		" "		3,594	3,594	24
25	V	32	INTEREST		" "		4,618	4,618	25
26	V	33	REAL ESTATE TAXES		" "		2,811	2,811	26
27	V	35	EQUIPMENT RENTAL		" "		8,370	8,370	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 109,129	$ * 109,129	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 8,432	$ 8,432	15
16	V	17	ADMIN COMP - M MAUER		" "		24,336	24,336	16
17	V	17	ADMIN COMP - M AARON		" "		27,595	27,595	17
18	V	17	ADMIN COMP - F AARON		" "		17,200	17,200	18
19	V	17	ADMIN COMP - S GOLDSTEIN		" "				19
20	V	17	ADMIN COMP - J AARON		" "				20
21	V	17	ADMIN COMP - S KOPLIN		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		22,304	22,304	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "				24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		31,464	31,464	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		24,339	24,339	26
27	V	21	CLERICAL COMP - S AARON		" "		10,398	10,398	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 166,068	$ * 166,068	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 826	$ 826	15
16	V	27	EMP BEN - M MAUER		" "		1,324	1,324	16
17	V	27	EMP BEN - M AARON		" "		1,538	1,538	17
18	V	27	EMP BEN - F AARON		" "		7,113	7,113	18
19	V	27	EMP BEN - S GOLDSTEIN		" "				19
20	V	27	EMP BEN - J AARON		" "				20
21	V	27	EMP BEN - S KOPLIN		" "				21
22	V	27	EMP BEN - D KUFTA		" "		1,475	1,475	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "				24
25	V	27	EMP BEN - NON OWNER		" "		8,977	8,977	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,614	2,614	26
27	V	27	EMP BEN - S AARON		" "		1,817	1,817	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 25,684	$ * 25,684	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	10	MEDICAL SUPPLIES	$ 23,872	LINCOLN MEDICAL SUPPLIES INC	100.00%	$ 21,110	$ (2,762)	15
16	V	39	ANCILLARY EXPENSE	4,882	" "		4,317	(565)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,754			$ 25,427	$ * (3,327)	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MARSHALL MAUER	ADMINISTRATIVE			SEE ATTACHED SCHEDULE			SALARY	$ 24,336	17-7	1
2	MAURY AARON	ADMINISTRATIVE						SALARY	27,595	17-7	2
3	SHARON AARON	CLERICAL						SALARY	10,398	21-7	3
4	FRED AARON	ADMINISTRATIVE						SALARY	17,200	17-7	4
5	FRED AARON	ADMINISTRATIVE						SALARY	33,000	17-1	5
6	DIANIA KUFTA	ADMINISTRATIVE						SALARY	22,304	17-7	6
7	DENNIS NEHMER	MAINTENANCE						SALARY	8,432	6-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,265		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	400,612	11	$ 13,707	$	48,205	$ 1,649	1
2	6	REPAIR & MAINT.	" "	400,612	11	44,776		48,205	5,388	2
3	19	PROFESSIONAL FEES	" "	400,612	11	8,291		48,205	998	3
4	20	DUES AND SUBSCRIPTION	" "	400,612	11	7,402		48,205	891	4
5	21	CLERICAL & GENERAL	" "	400,612	11	542,482	382,381	48,205	65,276	5
6	24	SEMINARS AND TRAVEL	" "	400,612	11	3,581		48,205	431	6
7	25	AUTO EXPENSE	" "	400,612	11	7,935		48,205	955	7
8	26	INSURANCE	" "	400,612	11	12,320		48,205	1,482	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	400,612	11	105,262		48,205	12,666	9
10	30	DEPRECIATION	" "	400,612	11	29,871		48,205	3,594	10
11	32	INTEREST	" "	400,612	11	38,376		48,205	4,618	11
12	33	REAL ESTATE TAXES	" "	400,612	11	23,364		48,205	2,811	12
13	35	EQUIPMENT RENTAL	" "	400,612	11	69,556		48,205	8,370	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					$ 906,923	$ 382,381		$ 109,129	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	$ 61,112	$ 61,112	6	$ 8,432	1
2	17	ADMIN COMP - M MAUER	" "	40	10	200,000	200,000	5	24,336	2
3	17	ADMIN COMP - M AARON	" "	40	8	200,000	200,000	6	27,595	3
4	17	ADMIN COMP - F AARON	" "	45	5	86,000	86,000	9	17,200	4
5	17	ADMIN COMP - S GOLDSTEIN	" "	40	2	89,700	89,700			5
6	17	ADMIN COMP - J AARON	" "	40	1	3,386	3,386			6
7	17	ADMIN COMP - S KOPLIN	" "	30	3	73,516	73,516			7
8	17	ADMIN COMP - D MAGAFAS	" "	50	8	161,659	161,659	7	22,304	8
9	17	ADMIN COMP - HOWARD ALTER	" "	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V	" "	40	1	74,483	74,483			10
11	17	ADMIN COMP - NON OWNER - VA	" "	45	8	228,000	228,000	6	31,464	11
12	17	ADMIN COMP - NON OWNER - CE	" "	45	10	200,022	200,022	5	24,339	12
13	21	CLERICAL COMP - S AARON	" "	40	10	85,429	85,429	5	10,398	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,475,307	$ 1,475,307		$ 166,068	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	$ 5,988	$	6	$ 826	1
2	27	EMP BEN - M MAUER	" "	40	10	10,884		5	1,324	2
3	27	EMP BEN - M AARON	" "	40	8	11,145		6	1,538	3
4	27	EMP BEN - F AARON	" "	45	5	35,563		9	7,113	4
5	27	EMP BEN - S GOLDSTEIN	" "	40	2	35,796				5
6	27	EMP BEN - J AARON	" "	40	1					6
7	27	EMP BEN - S KOPLIN	" "	30	3	25,120				7
8	27	EMP BEN - D MAGAFAS	" "	50	8	10,687		7	1,475	8
9	27	EMP BEN - HOWARD ALTER	" "	40	1	1,083				9
10	27	EMP BEN - V DAVIS	" "	40	1	16,762				10
11	27	EMP BEN - NON OWNER	" "	45	8	65,051		6	8,977	11
12	27	EMP BEN - NON OWNER - CFO	" "	45	10	21,483		5	2,614	12
13	27	EMP BEN - S AARON	" "	40	10	14,927		5	1,817	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					$ 254,489	$		$ 25,684	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 21,110	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						4,317	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					$	$		$ 25,427	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$49,218.18	11/06	$ 5,722,000	$ 5,476,298	10/41	5.8500	$ 303,962	1
2	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		65,118	57,347			1,865	2
3												3
4												4
5	RELATED PARTY										4,618	5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL				529,250		PRIME+	38,666	6
7	IMPERIAL CREDIT CORP.		X	INSURANCE FINANCING							3,942	7
8												8
9	TOTAL Facility Related				$49,218.18		$ 5,787,118	$ 6,062,895			$ 353,053	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,787,118	$ 6,062,895			$ 353,053	15

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.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 208,000	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.)		$ 239,768	2
3. Under or (over) accrual (line 2 minus line 1).		$ 31,768	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 245,000	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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 276,768	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	183,926	8
	2006	190,214	9
	2007	192,639	10
	2008	204,234	11
	2009	239,768	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 239,767.81	$ 239,767.81
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 239,767.81	$ 239,767.81

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 304,000	1
2					2
3	TOTALS			$ 304,000	3

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1995		$ 5,092,000	$ 130,564	39	$ 130,564	$	$ 2,029,260	4
5					748,886	20,334	39	20,334		311,901	5
6											6
7											7
8	RELATED PARTY				53,378	1,369	35	1,525	156	26,434	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		615	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		51,417	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		903	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		3,452	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		489	14
15	CARPET INSTALL			1995	1,303	33	39	33		502	15
16	RAIL BUMPER			1995	917	24	39	24		361	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		1,995	17
18	PAINTING WORK			1996	8,400	215	39	215		3,091	18
19	WALL COVERING			1996	1,435	37	39	37		529	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		864	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		927	21
22	CONDENCING UNIT			1999	3,824	98	39	98		1,142	22
23	DRAPES			1999	5,369	138	39	138		1,572	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		2,514	24
25	DOOR WORK			1999	10,490	269	39	269		3,051	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		1,713	26
27	TILES			2000	8,855	322	27.5	322		3,356	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		1,509	28
29	ROD MAIN SEWER			2000	1,100	41	27.5	41		424	29
30	DRAPERIES			2001	2,118		7			2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		2,776	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		3,257	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		12,022	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		2,688	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		2,118	35
36	FENCES & CONCRETE			2003	4,023	134	15	134		3,017	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 BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	ORIENTATION BOARDS	2003	$ 1,752	$ 64	27.5	$ 64	$	$ 477	37
38	COIL	2003	806	29	27.5	29		216	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,083	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		455	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		1,819	41
42	FLOOR COVERING	2004	888	32	27.5	32		207	42
43	CABINETS	2004	2,594	95	27.5	95		613	43
44	BOILER	2004	2,574	93	27.5	93		601	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		278	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		1,866	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		14,937	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		1,976	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		273	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		4,192	50
51	NETWORK CABLING	2006	855	31	27.5	31		138	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		579	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		357	53
54	FANS	2006	1,108	40	27.5	40		178	54
55	DOORS	2006	1,711	62	27.5	62		277	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		7,101	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		463	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		3,521	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		422	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		2,514	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		3,780	61
62	CONDENSER	2007	1,712	62	27.5	62		215	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		204	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		1,628	64
65	DOORS	2008	1,645	60	27.5	60		147	65
66	BOILER	2008	5,104	185	27.5	185		455	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		83	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		729	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		2,412	69
70	TOTAL (lines 4 thru 69)		$ 6,452,801	$ 173,167		$ 173,323	$ 156	$ 2,532,928	70

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 6,452,801	$ 173,167		$ 173,323	$ 156	$ 2,532,928	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		5,701	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		235	3
4	HEATING WORK	2009	9,475	345	27.5	345		503	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		572	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	279	27.5	279		279	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	88	27.5	88		88	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	291	27.5	291		291	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	105	27.5	105		105	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	568	27.5	568		568	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	285	27.5	285		285	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	280	27.5	280		280	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	51	27.5	51		51	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	107	27.5	107		107	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	69	27.5	69		69	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TIL	2010	5,691	95	27.5	95		95	16
17	CEILING PIPING	2010	2,825	47	27.5	47		47	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	211	27.5	211		211	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	71	27.5	71		71	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	42	27.5	42		42	20
21	BRICK WALL REPAIR	2010	2,900	48	27.5	48		48	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	57	27.5	57		57	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	31	27.5	31		31	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	26	27.5	26		26	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	105	27.5	105		105	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	44	27.5	44		44	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	29	27.5	29		29	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,760,745	$ 180,903		$ 181,059	$ 156	$ 2,542,868	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 358,325	$ 25,803	$ 35,355	$ 9,552	10 YRS	$ 180,269	71
72	Current Year Purchases	79,318	52,785	3,966	(48,819)	10 YRS	3,966	72
73	Fully Depreciated Assets	204,243					204,243	73
74	RELATED PARTY	585,419	201	24,876	24,675		395,362	74
75	TOTALS	$ 1,227,305	$ 78,789	$ 64,197	$ (14,592)		$ 783,840	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				$	$	$	$		$	76
77	RELATED PARTY			27,698	2,225	5,900	3,675		8,498	77
78										78
79										79
80	TOTALS			$ 27,698	$ 2,225	$ 5,900	$ 3,675		$ 8,498	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)	$ 8,319,748	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 261,917	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 251,156	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,761)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,335,206	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.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.		$
13.		$
14.		$

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: $ 13,106 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	ADMINISTRATIVE	2010 LEXUS	$ 600.00	$ 1,291	17
18					18
19					19
20					20
21	TOTAL		$ 600.00	$ 1,291	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 CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			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.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,625			5,625	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			121,907			121,907	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				165,792		165,792	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Medical Supplies	39-2					12,340		12,340	12
13	Other (specify): Radiology,Laboratory	39-2					10,616		10,616	13
14	TOTAL			$		$ 127,532	$ 188,748		$ 316,280	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.

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 710,239	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 250,000)	588,935		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,511		6
7	Other Prepaid Expenses	17,473		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Tax Escrow	112,216		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,550,374	$	10
	B. Long-Term Assets			
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	866,481		15
16	Equipment, at Historical Cost	641,885		16
17	Accumulated Depreciation (book methods)	(764,771)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	533,800		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,277,395	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,827,769	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 594,771	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	529,250		29
30	Accrued Salaries Payable	291,865		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,033		31
32	Accrued Real Estate Taxes(Sch.IX-B)	245,000		32
33	Accrued Interest Payable	2,313		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,687,232	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,687,232	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,140,537	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,827,769	$	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,044,049	1
2	Restatements (describe):		2
3	2009 IL Replacement Tax	(8,357)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,035,692	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	287,245	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)**	$ 104,845	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)**	$ 1,140,537	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,274,339	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,274,339	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	429,538	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 429,538	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		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	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,050	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,050	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,717,927	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,280,894	31
32	Health Care	3,441,310	32
33	General Administration	2,241,518	33
	B. Capital Expense		
34	Ownership	930,237	34
	C. Ancillary Expense		
35	Special Cost Centers	316,280	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	140,508	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,430,682	40
41	**Income before Income Taxes (line 30 minus line 40)****	287,245	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 287,245	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,939	2,279	$ 111,906	$ 49.10	1
2	Assistant Director of Nursing	2,022	2,190	71,484	32.64	2
3	Registered Nurses	3,985	4,482	146,142	32.61	3
4	Licensed Practical Nurses	33,751	38,009	974,498	25.64	4
5	CNAs & Orderlies	92,915	103,337	1,103,295	10.68	5
6	CNA Trainees					6
7	Licensed Therapist	11,755	12,460	513,960	41.25	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,684	3,985	65,621	16.47	9
10	Activity Assistants	16,210	17,979	250,728	13.95	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,173	3,697	68,468	18.52	13
14	Head Cook	5,092	5,859	63,001	10.75	14
15	Cook Helpers/Assistants	12,612	13,826	131,579	9.52	15
16	Dishwashers					16
17	Maintenance Workers	6,328	6,602	105,245	15.94	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,981	2,300	136,426	59.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,219	12,865	227,904	17.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,934	2,173	40,495	18.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,600	232,043	$ 4,010,752 *	$ 17.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	239	$ 9,780	1-3	35
36	Medical Director	Monthly fee	2,100	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly fee	8,215	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	20	816	11-3	44
45	Social Service Consultant	Monthly fee	1,134	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	259	$ 22,045		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	10	361	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10	$ 361		53

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR	0	$ 103,426
FRED AARON	OTHER ADMIN	0	33,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,426

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 187,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 187,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		84,033
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 84,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,905
Unemployment Compensation Insurance	71,618
FICA Taxes	293,482
Employee Health Insurance	197,905
Employee Meals	44,895
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	20,345
	0
	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 717,150

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,922
Health Care Worker Background Check	1,840
(Indicate # of checks performed 60)	
Patient Background Checks 124	0
TRUST/FRANCHISE/CONTRIB/ETC	7,623
MARKETING/ADV/PROMO	68,467
LICENSES/DUES/SUBSCRIPTIONS	14,895
MGMT CO ALLOC	891
TRUST/FRANCHISE/CONTRIB/ETC	(7,623)
Less: Public Relations Expense	(0)
Non-allowable advertising	(68,467)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,548

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	431
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 431

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10								N/A					
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $7,507 IL ASSOC OF HC FAC $1,752**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,997** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **44,895** 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.