Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. #00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			156,676	156,676		156,676	82,119	238,795			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,206	25,206		25,206	305,193	330,399			32
33	Real Estate Taxes			275,629	275,629		275,629	5,446	281,075			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			7,631	7,631		7,631	10,482	18,113			35
36	Other (specify):*											36
37	**TOTAL Ownership**			954,382	954,382		954,382	(86,000)	868,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		244,851	108,502	353,353		353,353		353,353			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**		244,851	188,437	433,288		433,288		433,288			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,928,169	693,854	3,763,494	8,385,517		8,385,517	(611,842)	7,773,675			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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Refer-ence	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	(69,374)	30		9
10	Interest and Other Investment Income	(1,316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,328)	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	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(472)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,107)	27		24
25	Fund Raising, Advertising and Promotional	(77,035)	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	(27,305)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (188,437)		$	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)	(423,405)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (423,405)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (611,842)		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.		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	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BRIDGEVIEW HEALTH CARE CENTER LTD.

ID# 00037358

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ -27305	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**	(27,305)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,328)	0	0	0	0	0	0	0	0	0	0	(1,328)	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	1,238	0	0	0	0	0	0	0	0	1,238	5
6	Maintenance	0	0	7,646	8,285	0	0	0	0	0	0	0	15,931	6
7	Other (specify):*	0	0	116	0	820	0	0	0	0	0	0	936	7
8	**TOTAL General Services**	(1,328)	0	9,000	8,285	820	0	0	0	0	0	0	16,777	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	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	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(209,000)	0	140,917	0	0	0	0	0	0	0	(68,083)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(472)	0	764	0	0	0	0	0	0	0	0	292	19
20	Fees, Subscriptions & Promotions	(77,535)	0	837	0	0	0	0	0	0	0	0	(76,698)	20
21	Clerical & General Office Expenses	(27,305)	(482,700)	61,837	9,838	0	0	0	0	0	0	0	(438,330)	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	896	0	0	0	0	0	0	0	0	896	24
25	Other Admin. Staff Transportation	0	0	1,561	0	0	0	0	0	0	0	0	1,561	25
26	Insurance-Prop.Liab.Malpractice	0	7,889	524	0	0	0	0	0	0	0	0	8,413	26
27	Other (specify):*	(11,107)	0	12,906	0	27,531	0	0	0	0	0	0	29,330	27
28	**TOTAL General Administration**	(116,419)	(683,811)	79,325	150,755	27,531	0	0	0	0	0	0	(542,619)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(117,747)	(683,811)	88,325	159,040	28,351	0	0	0	0	0	0	(525,842)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(69,374)	149,003	2,490	0	0	0	0	0	0	0	0	82,119	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,316)	302,109	4,400	0	0	0	0	0	0	0	0	305,193	32
33	Real Estate Taxes	0	0	5,446	0	0	0	0	0	0	0	0	5,446	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	10,482	0	0	0	0	0	0	0	0	10,482	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(70,690)	(38,128)	22,818	0	0	0	0	0	0	0	0	(86,000)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(188,437)	(721,939)	111,143	159,040	28,351	0	0	0	0	0	0	(611,842)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
SCHEDULED ATTACHED		SCHEDULED ATTACHED		SCHEDULED 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	$ 209,000	DYNAMIC HEALTHCARE	100.00%	$	$ (209,000)	1
2	V	21	BOOKKEEPING SERVICES	482,700	" "			(482,700)	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		" "		149,003	149,003	8
9	V	32	AMORTIZATION		" "		1,865	1,865	9
10	V	32	INTEREST		" "		300,244	300,244	10
11	V	26	PROPERTY/BOILER INSURANCE		" "		7,889	7,889	11
12	V								12
13	V								13
14	Total			$ 1,180,940			$ 459,001	$ * (721,939)	14

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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%	$ 1,238	$ 1,238	15
16	V	6	REPAIR & MAINT.		" "		7,646	7,646	16
17	V	7	EMP BEN-GEN SERV		" "		116	116	17
18	V	19	PROFESSIONAL FEES		" "		764	764	18
19	V	20	DUES AND SUBSCRIPTION		" "		837	837	19
20	V	21	CLERICAL & GENERAL		" "		61,837	61,837	20
21	V	24	SEMINARS AND TRAVEL		" "		896	896	21
22	V	25	AUTO EXPENSE		" "		1,561	1,561	22
23	V	26	INSURANCE		" "		524	524	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" "		12,906	12,906	24
25	V	30	DEPRECIATION		" "		2,490	2,490	25
26	V	32	INTEREST		" "		4,400	4,400	26
27	V	33	REAL ESTATE TAXES		" "		4,631	4,631	27
28	V	33	RE TAX PROTEST FEES		" "		815	815	28
29	V	35	EQUIPMENT RENTAL		" "		10,482	10,482	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	39	LABORATORY SERVICE	7,520	LABPRO INC		7,520		35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,520			$ 118,663	$ * 111,143	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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%	$ 8,285	$ 8,285	15
16	V	17	ADMIN COMP - M MAUER		" "		23,494	23,494	16
17	V	17	ADMIN COMP - M AARON		" "		26,626	26,626	17
18	V	17	ADMIN COMP - F AARON		" "		13,600	13,600	18
19	V	17	ADMIN COMP - S GOLDSTEIN		" "				19
20	V	17	ADMIN COMP - J AARON		" "				20
21	V	17	ADMIN COMP - S HARAMARAS		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		20,312	20,312	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		4,992	4,992	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		26,465	26,465	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		25,428	25,428	26
27	V	21	CLERICAL COMP - S AARON		" "		9,838	9,838	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			$			$ 159,040	$ * 159,040	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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%	$ 820	$ 820	15
16	V	27	EMP BEN - M MAUER		" "		1,290	1,290	16
17	V	27	EMP BEN - M AARON		" "		1,494	1,494	17
18	V	27	EMP BEN - F AARON		" "		8,783	8,783	18
19	V	27	EMP BEN - S GOLDSTEIN		" "				19
20	V	27	EMP BEN - J AARON		" "				20
21	V	27	EMP BEN - S HARAMARAS		" "				21
22	V	27	EMP BEN - D KUFTA		" "		1,427	1,427	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "		1,210	1,210	24
25	V	27	EMP BEN - NON OWNER		" "		8,347	8,347	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,939	2,939	26
27	V	27	EMP BEN - S AARON		" "		2,041	2,041	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			$			$ 28,351	$ * 28,351	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	ADMINISTRATIVE						SALARY	$ 23,494	17-7	1
2	MAURY AARON	ADMINISTRATIVE						SALARY	26,626	17-7	2
3	SHARON AARON	CLERICAL	SEE ATTACHED SCHEDULE					SALARY	9,838	21-7	3
4	FRED AARON	ADMINISTRATIVE						SALARY	24,000	17-1	4
5	FRED AARON	ADMINISTRATIVE						SALARY	13,600	17-7	5
6	DIANIA KUFTA	ADMINISTRATIVE						SALARY	20,312	17-7	6
7	DENNIS NEHMER	MAINTENANCE						SALARY	8,285	6-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 126,155		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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	416,329	14	$ 11,113	$	46,386	$ 1,238	1
2	6	REPAIR & MAINT.	" "	416,329	14	68,628	12,499	46,386	7,646	2
3	7	EMP BEN-GEN SERV.	" "	416,329	14	1,044		46,386	116	3
4	19	PROFESSIONAL FEES	" "	416,329	14	6,858		46,386	764	4
5	20	DUES AND SUBSCRIPTION	" "	416,329	14	7,513		46,386	837	5
6	21	CLERICAL & GENERAL	" "	416,329	14	555,005	401,070	46,386	61,837	6
7	24	SEMINARS AND TRAVEL	" "	416,329	14	8,041		46,386	896	7
8	25	AUTO EXPENSE	" "	416,329	14	14,007		46,386	1,561	8
9	26	INSURANCE	" "	416,329	14	4,707		46,386	524	9
10	27	EMP. BEN. - GEN, ADMIN.	" "	416,329	14	115,833		46,386	12,906	10
11	30	DEPRECIATION	" "	416,329	14	22,348		46,386	2,490	11
12	32	INTEREST	" "	416,329	14	39,492		46,386	4,400	12
13	33	REAL ESTATE TAXES	" "	416,329	14	41,569		46,386	4,631	13
14	33	RE TAX PROTEST FEES	" "	416,329	14	7,315		46,386	815	14
15	35	EQUIPMENT RENTAL	" "	416,329	14	94,081		46,386	10,482	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 997,554	$ 413,569		$ 111,143	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	$ 62,231	$ 62,231	5	$ 8,285	1
2	17	ADMIN COMP - M MAUER	" "	40	10	200,000	200,000	5	23,494	2
3	17	ADMIN COMP - M AARON	" "	40	8	200,000	200,000	5	26,626	3
4	17	ADMIN COMP - F AARON	" "	45	5	68,000	68,000	9	13,600	4
5	17	ADMIN COMP - S GOLDSTEIN	" "	40	2	121,602	121,602			5
6	17	ADMIN COMP - S HARAMARAS	" "	40	4	74,106	74,106			6
7	17	ADMIN COMP - D KUFTA	" "	50	8	152,525	152,525	7	20,312	7
8	17	ADMIN COMP - HOWARD ALTER	" "	50	1	12,000	12,000			8
9	17	ADMIN COMP - NON OWNER - V	" "	40	8	74,874	74,874	3	4,992	9
10	17	ADMIN COMP - NON OWNER - VA	" "	45	8	198,817	198,817	6	26,465	10
11	17	ADMIN COMP - NON OWNER - CF	" "	45	10	216,469	216,469	5	25,428	11
12	21	CLERICAL COMP - S AARON	" "	40	10	83,751	83,751	5	9,838	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					$ 1,464,375	$ 1,464,375		$ 159,040	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	$ 6,161	$	5	$ 820	1
2	27	EMP BEN - M MAUER	" "	40	10	10,982		5	1,290	2
3	27	EMP BEN - M AARON	" "	40	8	11,224		5	1,494	3
4	27	EMP BEN - F AARON	" "	45	5	43,917		9	8,783	4
5	27	EMP BEN - S GOLDSTEIN	" "	40	2	44,352				5
6	27	EMP BEN - S KOPLIN	" "	40	4	30,190				6
7	27	EMP BEN - D MAGAFAS	" "	50	8	10,718		7	1,427	7
8	27	EMP BEN - HOWARD ALTER	" "	50	1	1,101				8
9	27	EMP BEN - V DAVIS	" "	40	8	18,154		3	1,210	9
10	27	EMP BEN - NON OWNER	" "	45	8	62,705		6	8,347	10
11	27	EMP BEN - NON OWNER - CFO	" "	45	10	25,019		5	2,939	11
12	27	EMP BEN - S AARON	" "	40	10	17,376		5	2,041	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					$ 281,899	$		$ 28,351	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: LABPRO 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	39	LABORATORY SERVICE	DIRECT ALLOCATION			$ 7,520	$		$ 7,520	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,520	$		$ 7,520	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER L # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 5,407,223	10/41	5.8500	$ 300,244	1
2	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		65,118	55,482			1,865	2
3												3
4												4
5	RELATED PARTY										4,400	5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL							21,450	6
7	IMPERIAL CREDIT CORP.		X	INSURANCE FINANCING							3,756	7
8												8
9	TOTAL Facility Related				$49,218.18		$ 5,787,118	$ 5,462,705			$ 331,715	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	$ 5,462,705			$ 331,715	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 LTD. # 00037358 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 245,000	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.)		$ 257,629	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,629	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 263,000	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.		$ 275,629	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	190,214	8
2007	192,639	9
2008	204,234	10
2009	239,768	11
2010	257,629	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% 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 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 00037358

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 257,628.89	$ 257,628.89
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 257,628.89	$ 257,628.89

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 2,159,824	4
5											5
6											6
7											7
8	RELATED PARTY				49,424	1,267	35	1,412	145	25,889	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		647	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		54,135	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		954	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		3,661	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		521	14
15	CARPET INSTALL			1995	1,303	33	39	33		535	15
16	RAIL BUMPER			1995	917	24	39	24		385	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		2,132	17
18	PAINTING WORK			1996	8,400	215	39	215		3,306	18
19	WALL COVERING			1996	1,435	37	39	37		566	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		928	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		999	21
22	CONDENCING UNIT			1999	3,824	98	39	98		1,240	22
23	DRAPES			1999	5,369	138	39	138		1,710	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		2,733	24
25	DOOR WORK			1999	10,490	269	39	269		3,320	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		1,862	26
27	TILES			2000	8,855	322	27.5	322		3,678	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		1,662	28
29	ROD MAIN SEWER			2000	1,100	41	27.5	41		465	29
30	DRAPERIES			2001	2,118		7			2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		3,123	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		3,664	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		13,552	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		3,024	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		2,402	35
36	FENCES & CONCRETE			2003	4,023	134	15	134		3,151	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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
37	ORIENTATION BOARDS	2003	$ 1,752	$ 64	27.5	$ 64	$	$ 541	37
38	COIL	2003	806	29	27.5	29		245	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,228	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		516	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		2,063	41
42	FLOOR COVERING	2004	888	32	27.5	32		239	42
43	CABINETS	2004	2,594	95	27.5	95		708	43
44	BOILER	2004	2,574	93	27.5	93		694	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		321	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		2,153	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		17,235	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		2,338	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		323	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		4,960	50
51	NETWORK CABLING	2006	855	31	27.5	31		169	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		709	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		437	53
54	FANS	2006	1,108	40	27.5	40		218	54
55	DOORS	2006	1,711	62	27.5	62		339	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		8,679	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		597	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		4,539	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		544	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		3,241	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		4,873	61
62	CONDENSER	2007	1,712	62	27.5	62		277	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		287	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		2,290	64
65	DOORS	2008	1,645	60	27.5	60		207	65
66	BOILER	2008	5,104	185	27.5	185		640	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		140	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		1,229	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		4,066	69
70	TOTAL (lines 4 thru 69)		$ 5,699,961	$ 152,731		$ 152,876	$ 145	$ 2,371,946	70

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 12A, Carried Forward		$ 5,699,961	$ 152,731		$ 152,876	$ 145	$ 2,371,946	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		9,610	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		396	3
4	HEATING WORK	2009	9,475	345	27.5	345		848	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		964	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	608	27.5	608		887	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		281	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		927	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		335	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		1,808	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	621	27.5	621		906	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		890	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		163	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	233	27.5	233		340	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		219	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TIL	2010	5,691	207	27.5	207		302	16
17	CEILING PIPING	2010	2,825	103	27.5	103		150	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		671	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		226	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		133	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		153	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	125	27.5	125		182	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	67	27.5	67		98	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	56	27.5	56		82	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		333	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	96	27.5	96		140	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	63	27.5	63		92	27
28	THERAPY ROOM - FLOORING	2011	13,166	219	27.5	219		219	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	320	27.5	320		320	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	169	27.5	169		169	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	381	27.5	381		381	31
32	THERAPY ROOM - DOORS	2011	12,009	200	27.5	200		200	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS	2011	65,023	1,084	27.5	1,084		1,084	33
34	TOTAL (lines 1 thru 33)		$ 6,150,334	$ 166,300		$ 166,445	$ 145	$ 2,395,455	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 12B, Carried Forward		$ 6,150,334	$ 166,300		$ 166,445	$ 145	$ 2,395,455	1
2	ROOF DRAINS	2011	5,150	86	27.5	86		86	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	516	27.5	516		516	3
4	ROOF REPAIR	2011	5,920	99	27.5	99		99	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	139	27.5	139		139	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	312	27.5	312		312	6
7	SCANNER	2011	35,598	593	27.5	593		593	7
8	FLOORING/TACKBOARD/LIGHT fixtures	2011	2,809	48	27.5	48		48	8
9									9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		38,054	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		32,921	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		73,595	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		23,007	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		22,372	18
19	NURSE STATION	2002	17,320	229	39	229		10,142	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		41,886	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		12,182	21
22	NURSE STATION	2004	27,559	707	39	707		5,273	22
23	CARPET, TILE, WALLCOVERING	2004	42,388	1,890	39	1,890		42,386	23
24	MODERNIZE ELEVATORS	2007	175,828	4,508	39	4,508		20,098	24
25	WINDOWS	2006	83,000	2,128	39	2,128		8,423	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,006,664	$ 186,532		$ 186,677	$ 145	$ 2,727,587	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 428,177	$ 25,293	$ 42,302	$ 17,009	10 YRS	$ 217,072	71
72	Current Year Purchases	95,121	95,121	4,756	(90,365)	10 YRS	4,756	72
73	Fully Depreciated Assets	213,709				5-10 YRS	213,709	73
74	RELATED PARTY	25,419		824	824		22,148	74
75	TOTALS	$ 762,426	$ 120,414	$ 47,882	$ (72,532)		$ 457,685	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			$ 25,646	$ 1,223	$ 4,236	$ 3,013		$ 12,104	76
77										77
78										78
79										79
80	TOTALS			$ 25,646	$ 1,223	$ 4,236	$ 3,013		$ 12,104	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)	$ 8,098,736	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 308,169	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 238,795	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (69,374)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,197,376	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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA - 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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 5,728 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			(5,297)	18
19					19
20					20
21	TOTAL		$ 600.00	$ 1,903	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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,120			2,120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			106,382			106,382	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				206,870		206,870	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MED SUP,LAB,XRAY						37,981		37,981	12
13	Other (specify):									13
14	TOTAL			$		$ 108,502	$ 244,851		$ 353,353	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 LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 267,106	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	1,378,925		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,844		6
7	Other Prepaid Expenses	18,199		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	226,587		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,018,661	$	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	1,116,357		15
16	Equipment, at Historical Cost	737,006		16
17	Accumulated Depreciation (book methods)	(921,447)		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	530,800		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,462,716	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,481,377	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 634,347	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,001,374		29
30	Accrued Salaries Payable	283,468		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,272		31
32	Accrued Real Estate Taxes(Sch.IX-B)	263,000		32
33	Accrued Interest Payable	2,594		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)**	$ 2,212,055	$	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)**	$ 2,212,055	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,269,322	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,481,377	$	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,140,537	1
2	Restatements (describe):		2
3	2010 IL REPLACEMENT TAX	(6,462)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,134,075	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	469,647	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	(334,400)	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)**	$ 135,247	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)**	$ 1,269,322	24 *

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 8,489,195	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,489,195	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	364,653	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 364,653	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***	1,316	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,316	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)**	$ 8,855,164	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,295,715	31
32	Health Care	3,488,649	32
33	General Administration	2,213,483	33
	B. Capital Expense		
34	Ownership	954,382	34
	C. Ancillary Expense		
35	Special Cost Centers	353,353	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,385,517	40
41	**Income before Income Taxes (line 30 minus line 40)****	469,647	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 469,647	43

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

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

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,925	2,302	$ 110,473	$ 47.99	1
2	Assistant Director of Nursing	1,932	2,101	71,633	34.09	2
3	Registered Nurses	5,401	6,073	200,955	33.09	3
4	Licensed Practical Nurses	33,152	37,623	992,243	26.37	4
5	CNAs & Orderlies	90,556	100,775	1,079,330	10.71	5
6	CNA Trainees					6
7	Licensed Therapist	11,702	12,266	478,976	39.05	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,682	4,106	74,617	18.17	9
10	Activity Assistants	18,071	19,974	272,643	13.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,533	2,226	36,979	16.61	13
14	Head Cook	3,065	3,493	38,674	11.07	14
15	Cook Helpers/Assistants	5,948	6,450	63,174	9.79	15
16	Dishwashers					16
17	Maintenance Workers	6,695	7,059	116,825	16.55	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,228	2,773	138,042	49.78	20
21	Assistant Administrator	1,743	2,064	58,866	28.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,671	9,935	155,098	15.61	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	1,738	2,008	39,641	19.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,042	221,228	$ 3,928,169 *	$ 17.76	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	M	$ 5,987	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	0	10-3	38
39	Pharmacist Consultant	H	8,498	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	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,401		49

C. CONTRACT NURSES

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR		$ 114,042
CHRISTINE MICHAELS	ASST ADMIN		58,866
FRED AARON	OTHER ADMIN		24,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 196,908

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 209,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 209,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		61,304
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 61,304

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,011
Unemployment Compensation Insurance	91,875
FICA Taxes	297,524
Employee Health Insurance	178,189
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	20,637
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,236

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,493
Advertising: Employee Recruitment	10,370
Health Care Worker Background Check	2,920
(Indicate # of checks performed 292)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	500
MARKETING/ADV/PROMO	77,035
LICENSES/DUES/SUBSCRIPTIONS	20,233
MGMT CO ALLOC	837
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(77,035)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,853

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT ALLCO	896
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 896

**See instructions.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER LTD. # 00037358 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $14,892**

(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. $ **10,609** Line **10-2**

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

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

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

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

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

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.