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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CTR

Address: 8100 S 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: SANFORD BOKOR **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 01/01/2013 to 12/31/2013 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) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	8,348	2,353	6,037	16,738	8
9	SNF/PED					9
10	ICF	21,786	6,493	916	29,195	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,134	8,846	6,953	45,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.19%

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 10/2/91

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

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 5,021

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		7,157	613,353	620,510		620,510		620,510			1
2	Food Purchase		3,041		3,041		3,041	(1,526)	1,515			2
3	Housekeeping		1,684	207,039	208,723		208,723		208,723			3
4	Laundry		11,212	133,080	144,292		144,292		144,292			4
5	Heat and Other Utilities			120,349	120,349		120,349	1,216	121,565			5
6	Maintenance	103,473	63,584	38,257	205,314		205,314	18,110	223,424			6
7	Other (specify):*			11,224	11,224		11,224	1,092	12,316			7
8	TOTAL General Services	103,473	86,678	1,123,302	1,313,453		1,313,453	18,892	1,332,345			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	2,580,532	95,687	16,984	2,693,203		2,693,203		2,693,203			10
10a	Therapy	494,153	8,596		502,749		502,749		502,749			10a
11	Activities	339,795	18,450	816	359,061		359,061		359,061			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			7,538	7,538		7,538		7,538			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,414,480	122,733	27,438	3,564,651		3,564,651		3,564,651			16
	C. General Administration											
17	Administrative	129,282		186,000	315,282		315,282	(26,544)	288,738			17
18	Directors Fees											18
19	Professional Services			80,175	80,175		80,175	(12,123)	68,052			19
20	Dues, Fees, Subscriptions & Promotions			115,444	115,444		115,444	(87,512)	27,932			20
21	Clerical & General Office Expenses	265,405	30,303	559,316	855,024		855,024	(421,717)	433,307			21
22	Employee Benefits & Payroll Taxes			710,467	710,467		710,467		710,467			22
23	Inservice Training & Education			15,952	15,952		15,952		15,952			23
24	Travel and Seminar							969	969			24
25	Other Admin. Staff Transportation			25,027	25,027		25,027	2,117	27,144			25
26	Insurance-Prop.Liab.Malpractice			260,985	260,985		260,985	8,468	269,453			26
27	Other (specify):*			145,000	145,000		145,000	(100,832)	44,168			27
28	TOTAL General Administration	394,687	30,303	2,098,366	2,523,356		2,523,356	(637,174)	1,886,182			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,912,640	239,714	3,249,106	7,401,460		7,401,460	(618,282)	6,783,178			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 CTR #0037358 **Report Period Beginning: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		200	
	CONTRACTED DIETARY SERVICES		613,153	613,353
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING		207,039	
			0	207,039
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,902	
	CONTRACTED LAUNDRY SERVICES		129,178	133,080
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		38,936	
	ELECTRICITY		47,873	
	WATER		33,540	
	CABLE TV - LOBBY		0	
			0	120,349
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,219	
	PAINTING & DECORATING		2,560	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		14,045	
	ELEVATOR MAINTENANCE & REPAIR		7,763	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,670	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	38,257
7	**OTHER**			
	SCAVENGER		11,224	
	SECURITY SERVICE		0	
			0	
			0	11,224
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		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	9,199	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	SPECIAL CARE UNIT		7,785	
			0	16,984
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	816	
			0	816
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR **#0037358** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		7,538	7,538
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	186,000	186,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	38,153	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	42,022	
			0	80,175
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	83,165	
	EMPLOYEE WANT ADS	XIX F	8,950	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	12,782	
	LICENSES & PERMITS	XIX F	3,952	
	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	5,615	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	980	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				115,444
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		11,095	
	EQUIPMENT REPAIR & MAINTENANCE		28,207	
	OUTSIDE CLERICAL SERVICES		497,700	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,314	
	MESSENGER SERVICE		0	
			0	559,316

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	294,558	
	UNEMPLOYMENT COMPENSATION	XIX D	84,500	
	WORKERS COMPENSATION INSURANC	XIX D	102,871	
	HOSPITALIZATION INSURANCE	XIX D	192,381	
	EMPLOYEE BENEFITS - OTHER	XIX D	36,157	
	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	710,467
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		15,952	
				15,952
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		25,027	
				25,027
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		260,985	
				260,985
27	**OTHER**			
	BAD DEBTS	VI 24	145,000	
				145,000

GRAND TOTAL COLUMN 3 OTHER **3,249,106**

BRIDGEVIEW HEALTH CARE CTR
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	3,041
LESS SALES TAX	(1,526)
NET FOOD	1,515
TOTAL PATIENT CENSUS	45,933
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	137,799
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	137,799
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	137,799
NET FOOD	1,515
DIVIDE TOTAL MEALS/YEAR	137,799
COST PER MEAL	0.01
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR #0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			104,101	104,101		104,101	159,974	264,075			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,676	21,676		21,676	297,049	318,725			32
33	Real Estate Taxes			391,663	391,663		391,663	4,694	396,357			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			8,328	8,328		8,328	10,821	19,149			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,015,008	1,015,008		1,015,008	(16,702)	998,306			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,787	1,870	140,657		140,657		140,657			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,070	328,070		328,070		328,070			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		138,787	329,940	468,727		468,727		468,727			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,912,640	378,501	4,594,054	8,885,195		8,885,195	(634,984)	8,250,211			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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	10,504	30		9
10	Interest and Other Investment Income	(708)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,526)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(5,615)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(14,731)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,000)	27		24
25	Fund Raising, Advertising and Promotional	(83,165)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		10		28
29	Other-Attach Schedule	(10,560)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (250,801)		$	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)	(384,183)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (384,183)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (634,984)		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

BRIDGEVIEW HEALTH CARE CTR

ID# 0037358

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (10,160)	21	1
2	MARKETING TRAVEL	(400)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,560)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	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	1,216	0	0	0	0	0	0	0	0	1,216	5
6	Maintenance	0	0	10,094	8,016	0	0	0	0	0	0	0	18,110	6
7	Other (specify):*	0	0	245	0	847	0	0	0	0	0	0	1,092	7
8	**TOTAL General Services**	(1,526)	0	11,555	8,016	847	0	0	0	0	0	0	18,892	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	(186,000)	0	159,456	0	0	0	0	0	0	0	(26,544)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,731)	0	2,608	0	0	0	0	0	0	0	0	(12,123)	19
20	Fees, Subscriptions & Promotions	(88,780)	0	1,268	0	0	0	0	0	0	0	0	(87,512)	20
21	Clerical & General Office Expenses	(10,160)	(497,700)	75,249	10,894	0	0	0	0	0	0	0	(421,717)	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	969	0	0	0	0	0	0	0	0	969	24
25	Other Admin. Staff Transportation	(400)	0	2,517	0	0	0	0	0	0	0	0	2,117	25
26	Insurance-Prop.Liab.Malpractice	0	7,421	1,047	0	0	0	0	0	0	0	0	8,468	26
27	Other (specify):*	(145,000)	0	14,057	0	30,111	0	0	0	0	0	0	(100,832)	27
28	**TOTAL General Administration**	(259,071)	(676,279)	97,715	170,350	30,111	0	0	0	0	0	0	(637,174)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(260,597)	(676,279)	109,270	178,366	30,958	0	0	0	0	0	0	(618,282)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	10,504	147,113	2,357	0	0	0	0	0	0	0	0	159,974	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(708)	294,024	3,733	0	0	0	0	0	0	0	0	297,049	32
33	Real Estate Taxes	0	0	4,694	0	0	0	0	0	0	0	0	4,694	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	10,821	0	0	0	0	0	0	0	0	10,821	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,796	(48,103)	21,605	0	0	0	0	0	0	0	0	(16,702)	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)	(250,801)	(724,382)	130,875	178,366	30,958	0	0	0	0	0	0	(634,984)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 186,000	DYNAMIC HEALTHCARE		$	$ (186,000)	1
2	V	21	BOOKKEEPING SERVICES	497,700	" "			(497,700)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240	BRIDGEVIEW ASSOCIATES LLC			(489,240)	7
8	V	30	DEPRECIATION		" "		147,113	147,113	8
9	V	32	AMORTIZATION		" "		1,865	1,865	9
10	V	32	INTEREST		" "		292,159	292,159	10
11	V	26	PROPERTY/BOILER INSURANCE		" "		7,421	7,421	11
12	V								12
13	V								13
14	Total			$ 1,172,940			$ 448,558	$ * (724,382)	14

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 1,216	$ 1,216	15
16	V	6	REPAIR & MAINT.		" "		10,094	10,094	16
17	V	7	EMP BEN-GEN SERV		" "		245	245	17
18	V	19	PROFESSIONAL FEES		" "		2,608	2,608	18
19	V	20	DUES AND SUBSCRIPTION		" "		1,268	1,268	19
20	V	21	CLERICAL & GENERAL		" "		75,249	75,249	20
21	V	24	SEMINARS AND TRAVEL		" "		969	969	21
22	V	25	AUTO EXPENSE		" "		2,517	2,517	22
23	V	26	INSURANCE		" "		1,047	1,047	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" "		14,057	14,057	24
25	V	30	DEPRECIATION		" "		2,357	2,357	25
26	V	32	INTEREST		" "		3,733	3,733	26
27	V	33	REAL ESTATE TAXES		" "		4,694	4,694	27
28	V	35	EQUIPMENT RENTAL		" "		10,734	10,734	28
29	V	35	EQUIPMENT RENTAL		" "		87	87	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			$			$ 130,875	$ * 130,875	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 8,016	$ 8,016	15
16	V	17	ADMIN COMP - M MAUER		" "		23,765	23,765	16
17	V	17	ADMIN COMP - M AARON		" "		26,936	26,936	17
18	V	17	ADMIN COMP - F AARON		" "		2,500	2,500	18
19	V	17	ADMIN COMP - D AARON		" "		22,291	22,291	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "				20
21	V	17	ADMIN COMP - S HARAMARAS		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		21,272	21,272	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		14,038	14,038	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		24,461	24,461	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		24,193	24,193	26
27	V	21	CLERICAL COMP - S AARON		" "		10,293	10,293	27
28	V	21	CLERICAL COMP - E MARYLES				601	601	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			$			$ 178,366	$ * 178,366	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 847	$ 847	15
16	V	27	EMP BEN - M MAUER		" "		1,303	1,303	16
17	V	27	EMP BEN - M AARON		" "		1,896	1,896	17
18	V	27	EMP BEN - F AARON		" "		7,537	7,537	18
19	V	27	EMP BEN - D AARON		" "		1,806	1,806	19
20	V	27	EMP BEN - S GOLDSTEIN		" "				20
21	V	27	EMP BEN - S HARAMARAS		" "				21
22	V	27	EMP BEN - D KUFTA		" "		1,498	1,498	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "		3,615	3,615	24
25	V	27	EMP BEN - NON OWNER		" "		7,424	7,424	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,937	2,937	26
27	V	27	EMP BEN - S AARON		" "		2,046	2,046	27
28	V	27	EMP BEN - E MARYLES				49	49	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			$			$ 30,958	$ * 30,958	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	RAJCHENBACH FAMILY TRUST	18.75	BRADLEY	BRADLEY	BRIDGEVIEW ASSOCIATES LLC		BUILDING CO	1
2	MAURICE AARON	19.74	GROSS POINTE MANOR LLC	NILES	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	MARSHALL MAUER	12.83	OTTAWA PAVILION LTD	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	FRED AARON	7.89	PARK RIDGE CARE CENTER LTD	PARK RIDGE				4
5	SHIMON GOLDSTEIN	3.94	STERLING PAVILION LTD	STERLING				5
6	SHARON AARON	.41	WARREN PARK HEALTH AND LIVING CEN	CHICAGO				6
7	CHANA MAUER-RAY	4.44	WATERFRONT TERRACE INC	CHICAGO				7
8	DENNIS NEHMER	.41	WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				8
9	DIANA KUFTA	.41	WOODBRIDGE NURSING PAVILION LTD	CHICAGO				9
10	ESTHER MARYLES	4.44	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11	HOWIE & SUSIE ALTER	.82	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12	SUE KOPLIN HARAMARAS	.41	WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				12
13	SYLVIA AARON	.16						13
14	FRANCES MAUER	6.58						14
15	MARK HOLLANDER DISCRETIONARY	6.25						15
16	SHARON HOLLANDER DISCRETIONA	6.25						16
17	FEIGE KNOBEL DISCRETIONARY TR	6.25						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	SHAREHOLDER	ADMINISTRATIVE			4.75	11.88	SALARY	$ 23,765	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIVE			5.39	10.77	SALARY	26,936	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL			4.75	11.88	SALARY	10,293	21-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE			9		SALARY	37,500	17-1	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIVE					SALARY	2,500	17-7	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIVE			6.73	13.47	SALARY	21,272	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			5.39	13.47	SALARY	8,016	6-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.33	1.19	SALARY	601	21-7	8
9	DANIEL AARON		ADMINISTRATIVE			14.79	36.99	SALARY	22,291	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 153,174		13

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 STREET
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	PATIENT DAYS	407,371	12	$ 10,786	$	45,933	$ 1,216	1
2	6	REPAIR & MAINT.	PATIENT DAYS	407,371	12	89,523	37,553	45,933	10,094	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	407,371	12	2,175		45,933	245	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,371	12	23,130		45,933	2,608	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	407,371	12	11,247		45,933	1,268	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,371	12	667,372	493,233	45,933	75,249	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,371	12	8,593		45,933	969	7
8	25	AUTO EXPENSE	PATIENT DAYS	407,371	12	22,321		45,933	2,517	8
9	26	INSURANCE	PATIENT DAYS	407,371	12	9,284		45,933	1,047	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	407,371	12	124,673		45,933	14,057	10
11	30	DEPRECIATION	PATIENT DAYS	407,371	12	20,906		45,933	2,357	11
12	32	INTEREST	PATIENT DAYS	407,371	12	33,103		45,933	3,733	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,371	12	41,631		45,933	4,694	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	12	95,202		45,933	10,734	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	12	770		45,933	87	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,160,716	$ 530,786		$ 130,875	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 STREET
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	9	$ 59,522	$ 59,522	5	$ 8,016	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	23,765	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	5	26,936	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	12,500	12,500	9	2,500	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271	15	22,291	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	90,400	90,400			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	75,864	75,862			7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	158,070	158,070	7	21,272	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V I	WGHTD AVG HOURS	40	11	118,147	118,147	5	14,038	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	181,559	181,559	6	24,461	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	40	11	203,618	203,618	5	24,193	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	86,700	86,700	5	10,293	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	50,541	50,541	0	601	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,509,192	$ 1,509,190		$ 178,366	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 STREET
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	9	$ 6,291	$	5	$ 847	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	10,970		5	1,303	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,077		5	1,896	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	37,685		9	7,537	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,884		15	1,806	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	41,051				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	25,938				7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	9	11,132		7	1,498	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,080				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	11	30,426		5	3,615	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	9	55,102		6	7,424	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	11	24,720		5	2,937	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	11	17,233		5	2,046	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	4,119		0	49	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 284,708	$		$ 30,958	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 5,722,000	$ 5,257,117	10/41	5.8500	$ 292,159	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL				750,000			17,673	6
7	PHARMACY		X	AP FINANCING				46,932			4,003	7
8												8
9	TOTAL Facility Related				$49,218.18		$ 5,722,000	$ 6,054,049			$ 313,835	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,722,000	$ 6,054,049			$ 313,835	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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 345,000	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.)		$ 364,663	2
3. Under or (over) accrual (line 2 minus line 1).		$ 19,663	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 372,000	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.		$ 391,663	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	204,234	8
	2009	239,768	9
	2010	257,629	10
	2011	338,246	11
	2012	364,663	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 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 364,662.68	$ 364,662.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 364,662.68	$ 364,662.68

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$	$ 2,420,952	4
5											5
6											6
7	RELATED PARTY				50,018	1,282	35	1,429	147	29,058	7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		711	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		59,571	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		1,056	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		4,079	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		585	14
15	CARPET INSTALL			1995	1,303	33	39	33		601	15
16	RAIL BUMPER			1995	917	24	39	24		433	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		2,406	17
18	PAINTING WORK			1996	8,400	215	39	215		3,736	18
19	WALL COVERING			1996	1,435	37	39	37		640	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		1,056	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		1,143	21
22	CONDENCING UNIT			1999	3,824	98	39	98		1,436	22
23	DRAPES			1999	5,369	138	39	138		1,986	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		3,171	24
25	DOOR WORK			1999	10,490	269	39	269		3,858	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		2,160	26
27	TILES			2000	8,855	322	27.5	322		4,322	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		1,968	28
29	ROD MAIN SEWER			2000	1,100	41	27.5	41		547	29
30	DRAPERIES			2001	2,118		7			2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		3,817	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		4,478	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		16,612	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		3,696	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		2,970	35
36				2003	4,023	134	15	134		3,419	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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$	$ 669	37
38	COIL	2003	806	29	27.5	29		303	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,518	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		638	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		2,551	41
42	FLOOR COVERING	2004	888	32	27.5	32		303	42
43	CABINETS	2004	2,594	95	27.5	95		898	43
44	BOILER	2004	2,574	93	27.5	93		880	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		407	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		2,727	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		21,831	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		3,062	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		423	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		6,496	50
51	NETWORK CABLING	2006	855	31	27.5	31		231	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		969	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		597	53
54	FANS	2006	1,108	40	27.5	40		298	54
55	DOORS	2006	1,711	62	27.5	62		463	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		11,835	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		865	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		6,575	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		788	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		4,695	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		7,059	61
62	CONDENSER	2007	1,712	62	27.5	62		401	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		453	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		3,614	64
65	DOORS	2008	1,645	60	27.5	60		327	65
66	BOILER	2008	5,104	185	27.5	185		1,010	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		254	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		2,229	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		7,374	69
70	TOTAL (lines 4 thru 69)		$ 5,700,555	$ 152,746		$ 152,893	$ 147	$ 2,678,043	70

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 5,700,555	$ 152,746		$ 152,893	$ 147	$ 2,678,043	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		17,428	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		718	3
4	HEATING WORK	2009	9,475	345	27.5	345		1,538	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		1,748	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	608	27.5	608		2,103	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		667	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		2,199	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		795	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		4,288	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	621	27.5	621		2,148	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		2,110	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		387	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	233	27.5	233		806	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		519	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TILE	2010	5,691	207	27.5	207		716	16
17	CEILING PIPING	2010	2,825	103	27.5	103		356	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		1,591	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		536	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		315	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		363	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	125	27.5	125		432	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	67	27.5	67		232	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	56	27.5	56		194	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		789	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	96	27.5	96		332	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	63	27.5	63		218	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		1,177	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		1,718	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	368	27.5	368		905	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		2,045	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		1,074	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS	2011	65,023	2,364	27.5	2,364		5,812	33
34	TOTAL (lines 1 thru 33)		$ 6,150,928	$ 169,121		$ 169,268	$ 147	$ 2,734,302	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 6,150,928	$ 169,121		$ 169,268	$ 147	$ 2,734,302	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		460	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		2,766	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		529	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		745	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		1,672	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		3,181	7
8	FLOORING/TACKBOARD/LIGHT fixtures	2011	2,809	102	27.5	102		252	8
9									9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		39,774	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		34,409	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		76,921	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		24,047	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		23,384	18
19	NURSE STATION	2002	17,320	229	39	229		10,600	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		50,704	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		12,732	21
22	NURSE STATION	2004	27,559	707	39	707		6,687	22
23	CARPET, TILE, WALLCOVERING	2004	42,388		39			42,388	23
24	MODERNIZE ELEVATORS	2007	175,828	4,508	39	4,508		29,114	24
25	WINDOWS	2006	83,000	2,128	39	2,128		12,679	25
26									26
27	DOORS & WINDOWS	2012	4,075	153	27.5	153		221	27
28	PLUMBING WORK	2012	11,639	433	27.5	433		627	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	968	27.5	968		1,408	29
30	FLOORING	2012	8,640	306	27.5	306		450	30
31	SECURITY SYSTEM WORK	2012	5,130	178	27.5	178		264	31
32	ROOF REPAIR	2012	1,595	51	27.5	51		77	32
33	NURSE CALL SYSTEM WORK	2012	1,488	51	27.5	51		76	33
34	TOTAL (lines 1 thru 33)		$ 7,066,329	$ 191,716		$ 191,863	$ 147	$ 3,110,469	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,066,329	$ 191,716		$ 191,863	$ 147	$ 3,110,469	1
2	CEILING REPAIR	2012	2,145	76	27.5	76		112	2
3	ELECTRIC WORK	2012	2,825	102	27.5	102		149	3
4	HANDRAIL SPACERS	2012	2,800	102	27.5	102		149	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	127	27.5	127		181	5
6	SPRINKLER & SECURITY SYSTEM	2013	13,953	236	27.5	236		236	6
7	DOORS & HARDWARE	2013	6,459	112	27.5	112		112	7
8	BATHROOM SINKS, FAUCETS & DRYWALL	2013	15,179	249	27.5	249		249	8
9	OFFICE WALL REPAIR	2013	4,383	75	27.5	75		75	9
10	AC REPAIR & ROOF FAN INSTALL	2013	8,750	149	27.5	149		149	10
11	COMPRESSORS, BREAKERS HEAT COIL	2013	21,983	360	27.5	360		360	11
12	WALK IN FREEZER REPAIR	2013	1,055	12	27.5	12		12	12
13	FENCE INSTALL	2013	2,800	53	27.5	53		50	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,151,869	$ 193,369		$ 193,516	$ 147	$ 3,112,303	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 564,555	$ 15,689	$ 56,455	$ 40,766	10 YRS	$ 319,791	71
72	Current Year Purchases	75,718	43,438	7,572	(35,866)	10 YRS	7,572	72
73	Fully Depreciated Assets	224,113					224,113	73
74	RELATED PARTY	26,530	266	845	579		24,078	74
75	TOTALS	$ 890,916	$ 59,393	$ 64,872	$ 5,479		$ 575,554	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			$ 26,575	$ 809	$ 5,687	$ 4,878		$ 12,381	76
77										77
78										78
79										79
80	TOTALS			$ 26,575	$ 809	$ 5,687	$ 4,878		$ 12,381	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)	$ 8,373,360	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 253,571	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 264,075	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,504	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,700,238	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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,915 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	$ 6,824	17
18	PAYROLL ADJ			(5,411)	18
19					19
20					20
21	TOTAL		$ 600.00	$ 1,413	21

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,870			1,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				113,193		113,193	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Supplies, Lab, Radiology,Other						25,594		25,594	13
14	TOTAL			$		$ 1,870	$ 138,787		$ 140,657	14

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 218,509	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (335,000))	1,790,237		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,208		6
7	Other Prepaid Expenses	49,136		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	313,507		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,527,597	$	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	1,260,965		15
16	Equipment, at Historical Cost	864,385		16
17	Accumulated Depreciation (book methods)	(1,113,467)		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): Deposit	556,627		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,568,510	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,096,107	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 537,451	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	321,332		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,359		31
32	Accrued Real Estate Taxes(Sch.IX-B)	372,000		32
33	Accrued Interest Payable	2,388		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO BANK LEUMI	750,000		36
37	LOAN PAYABLE	46,932		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,062,462	$	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)**	$ 2,062,462	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,033,645	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,096,107	$	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,966,218	1	
2	Restatements (describe):		2	
3	ILLINOIS REPLACEMENT TAX	(8,263)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,957,955	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	258,090	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)**	$ 75,690	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)**	$ 2,033,645	24	*

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,817,212	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,817,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	314,031	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 314,031	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***	708	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 708	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)**	$ 9,131,951	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,313,453	31
32	Health Care	3,564,651	32
33	General Administration	2,523,356	33
	B. Capital Expense		
34	Ownership	1,015,008	34
	C. Ancillary Expense		
35	Special Cost Centers	140,657	35
36	Provider Participation Fee	328,070	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(11,334)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,873,861	40
41	**Income before Income Taxes (line 30 minus line 40)****	258,090	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 258,090	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,490,112	44
45	Private Pay - Net Inpatient Revenue	1,480,964	45
46	Medicare - Net Inpatient Revenue	2,552,823	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	293,313	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,817,212	49

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

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

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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
2	Assistant Director of Nursing	1,965	2,243	82,825	36.93	2
3	Registered Nurses	10,074	11,572	372,838	32.22	3
4	Licensed Practical Nurses	31,680	36,162	996,606	27.56	4
5	CNAs & Orderlies	89,556	103,089	1,080,032	10.48	5
6	CNA Trainees					6
7	Licensed Therapist	10,890	11,545	494,153	42.80	7
8	Rehab/Therapy Aides					8
9	Activity Director	5,202	6,057	121,077	19.99	9
10	Activity Assistants	16,627	18,374	218,718	11.90	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,543	5,863	103,473	17.65	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,037	2,437	129,282	53.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,864	13,741	265,405	19.31	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	1,999	2,465	48,231	19.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,437	213,548	$ 3,912,640 *	$ 18.32	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		$ 0	1-3	35
36	Medical Director	48	2,100	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	96	9,199	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	17	816	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify) SPECIAL CARE UNI	104	7,785	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	265	$ 19,900		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 CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR		$ 91,782
FRED AARON	ADMINISTRATIVE		37,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 129,282

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 186,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 186,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		80,175
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 80,175

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,871
Unemployment Compensation Insurance	84,500
FICA Taxes	294,558
Employee Health Insurance	192,381
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	36,157
TOTAL (agree to Schedule V, line 22, col.8)	$ 710,467

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	$ 2,690
Advertising: Employee Recruitment	8,950
Health Care Worker Background Check	980
(Indicate # of checks performed 90)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	5,615
MARKETING/ADV/PROMO	83,165
LICENSES/DUES/SUBSCRIPTIONS	14,044
MGMT CO ALLOC	1,268
TRUST/FRANCHISE/CONTRIB/ETC	(5,615)
Less: Public Relations Expense	(0)
Non-allowable advertising	(83,165)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,932

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	969
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 969

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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													
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Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 $ 9,965**

(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. $ **8,802** 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. $ **328,070**
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 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.