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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0037358

Facility Name: BRIDGEVIEW HLTH CARE CENTER

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 01/01/2014 to 12/31/2014 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) KBKB, 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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	8,499	1,940	5,917	16,356	8
9	SNF/PED					9
10	ICF	24,657	7,438	1,272	33,367	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,156	9,378	7,189	49,723	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.31%

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 [X] Date 10/2/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 5,917

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		6,460	632,727	639,187		639,187		639,187			1
2	Food Purchase		7,797		7,797		7,797	(1,970)	5,827			2
3	Housekeeping			208,238	208,238		208,238		208,238			3
4	Laundry		15,953	135,545	151,498		151,498		151,498			4
5	Heat and Other Utilities			138,674	138,674		138,674	1,296	139,970			5
6	Maintenance	116,764	56,860	33,268	206,892		206,892	15,423	222,315			6
7	Other (specify):*			11,977	11,977		11,977	1,049	13,026			7
8	TOTAL General Services	116,764	87,070	1,160,429	1,364,263		1,364,263	15,798	1,380,061			8
	B. Health Care and Programs											
9	Medical Director			33,350	33,350		33,350		33,350			9
10	Nursing and Medical Records	2,733,643	146,229	18,587	2,898,459		2,898,459		2,898,459			10
10a	Therapy	583,542	6,868		590,410		590,410		590,410			10a
11	Activities	363,374	21,737	824	385,935		385,935		385,935			11
12	Social Services			679	679		679		679			12
13	CNA Training											13
14	Program Transportation			21,750	21,750		21,750		21,750			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,680,559	174,834	75,190	3,930,583		3,930,583		3,930,583			16
	C. General Administration											
17	Administrative	162,073		283,000	445,073		445,073	(133,337)	311,736			17
18	Directors Fees											18
19	Professional Services			105,205	105,205		105,205	(8,695)	96,510			19
20	Dues, Fees, Subscriptions & Promotions			100,549	100,549		100,549	(50,580)	49,969			20
21	Clerical & General Office Expenses	337,875	48,944	566,506	953,325		953,325	(435,155)	518,170			21
22	Employee Benefits & Payroll Taxes			798,078	798,078		798,078		798,078			22
23	Inservice Training & Education			7,623	7,623		7,623		7,623			23
24	Travel and Seminar							1,183	1,183			24
25	Other Admin. Staff Transportation			19,223	19,223		19,223	4,253	23,476			25
26	Insurance-Prop.Liab.Malpractice			205,017	205,017		205,017	6,034	211,051			26
27	Other (specify):*			206,060	206,060		206,060	(163,359)	42,701			27
28	TOTAL General Administration	499,948	48,944	2,291,261	2,840,153		2,840,153	(779,656)	2,060,497			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,297,271	310,848	3,526,880	8,134,999		8,134,999	(763,858)	7,371,141			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 HLTH CARE CENTER #0037358 **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		1,360	
	CONTRACTED DIETARY SERVICE		631,367	632,727
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICE		208,238	
				208,238
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,592	
	CONTRACTED LAUNDRY SERVICE		130,953	135,545
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		45,943	
	ELECTRICITY		55,399	
	WATER		37,332	
	CABLE TV - LOBBY		0	
				138,674
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,864	
	PAINTING & DECORATING		1,230	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,618	
	ELEVATOR MAINTENANCE & REPAIR		8,596	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,960	
	FIRE SERVICE		0	
				33,268
7	**OTHER**			
	SCAVENGER		11,977	
	SECURITY SERVICE		0	
				11,977
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	33,350	33,350

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	150	
	PHARMACY CONSULTANT	XVIII B 39-2	10,162	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,560	
	SPECIAL CARE UNIT		6,715	
				18,587
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	824	
				824
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	679	
				679
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER **#0037358** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		21,750	
				21,750
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	283,000	283,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	50,410	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	54,795	
				105,205
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	50,274	
	EMPLOYEE WANT ADS	XIX F	14,600	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	19,993	
	LICENSES & PERMITS	XIX F	11,253	
	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	3,099	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	830	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				100,549
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		10,930	
	EQUIPMENT REPAIR & MAINTENANCE		32,246	
	OUTSIDE CLERICAL SERVICES		496,900	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,459	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,971	
	MESSENGER SERVICE		0	
				566,506

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	324,932	
	UNEMPLOYMENT COMPENSATION	XIX D	102,663	
	WORKERS COMPENSATION INSURANC	XIX D	95,026	
	HOSPITALIZATION INSURANCE	XIX D	244,367	
	EMPLOYEE BENEFITS - OTHER	XIX D	31,090	
	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	
				798,078
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		7,623	
				7,623
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		19,223	
				19,223
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		205,017	
				205,017
27	**OTHER**			
	BAD DEBTS	VI 24	206,060	
				206,060

GRAND TOTAL COLUMN 3 OTHER **3,526,880**

BRIDGEVIEW HLTH CARE CENTER
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	7,797
LESS SALES TAX	(1,970)
NET FOOD	5,827
TOTAL PATIENT CENSUS	49,723
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	149,169
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	149,169
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	149,169
NET FOOD	5,827
DIVIDE TOTAL MEALS/YEAR	149,169
COST PER MEAL	0.04
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER #0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			105,096	105,096		105,096	156,172	261,268			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,821	43,821		43,821	291,192	335,013			32
33	Real Estate Taxes			386,476	386,476		386,476	4,437	390,913			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			8,228	8,228		8,228	11,978	20,206			35
36	Other (specify):*											36
37	TOTAL Ownership			1,032,861	1,032,861		1,032,861	(25,461)	1,007,400			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,018	14,693	156,711		156,711		156,711			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			346,487	346,487		346,487		346,487			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		142,018	361,180	503,198		503,198		503,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,297,271	452,866	4,920,921	9,671,058		9,671,058	(789,319)	8,881,739			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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	6,479	30		9
10	Interest and Other Investment Income	(670)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,970)	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	(2,459)	21		18
19	Entertainment		20		19
20	Contributions	(3,599)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(10,354)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(206,060)	27		24
25	Fund Raising, Advertising and Promotional	(50,274)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(28,539)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (297,446)		$	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)	(491,873)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (491,873)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (789,319)		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 HLTH CARE CENTER

ID# 0037358

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (28,539)	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**	(28,539)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(1,970)	0	0	0	0	0	0	0	0	0	0	(1,970)	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	1,296	0	0	0	0	0	0	0	0	1,296	5
6	Maintenance	0	0	7,710	7,713	0	0	0	0	0	0	0	15,423	6
7	Other (specify):*	0	0	249	0	800	0	0	0	0	0	0	1,049	7
8	**TOTAL General Services**	(1,970)	0	9,255	7,713	800	0	0	0	0	0	0	15,798	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	(283,000)	0	149,663	0	0	0	0	0	0	0	(133,337)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,354)	0	1,659	0	0	0	0	0	0	0	0	(8,695)	19
20	Fees, Subscriptions & Promotions	(53,873)	0	3,293	0	0	0	0	0	0	0	0	(50,580)	20
21	Clerical & General Office Expenses	(30,998)	(496,900)	81,961	10,782	0	0	0	0	0	0	0	(435,155)	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	1,183	0	0	0	0	0	0	0	0	1,183	24
25	Other Admin. Staff Transportation	0	0	4,253	0	0	0	0	0	0	0	0	4,253	25
26	Insurance-Prop.Liab.Malpractice	0	7,504	(1,470)	0	0	0	0	0	0	0	0	6,034	26
27	Other (specify):*	(206,060)	0	14,564	0	28,137	0	0	0	0	0	0	(163,359)	27
28	**TOTAL General Administration**	(301,285)	(772,396)	105,443	160,445	28,137	0	0	0	0	0	0	(779,656)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(303,255)	(772,396)	114,698	168,158	28,937	0	0	0	0	0	0	(763,858)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER **#** 0037358 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	6,479	147,113	2,580	0	0	0	0	0	0	0	0	156,172	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(670)	289,647	2,215	0	0	0	0	0	0	0	0	291,192	32
33	Real Estate Taxes	0	0	4,437	0	0	0	0	0	0	0	0	4,437	33
34	Rent-Facility & Grounds	0	(489,240)	0	0	0	0	0	0	0	0	0	(489,240)	34
35	Rent-Equipment & Vehicles	0	0	11,978	0	0	0	0	0	0	0	0	11,978	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	5,809	(52,480)	21,210	0	0	0	0	0	0	0	0	(25,461)	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)	(297,446)	(824,876)	135,908	168,158	28,937	0	0	0	0	0	0	(789,319)	45

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 283,000	DYNAMIC HEALTHCARE		$	$ (283,000)	1
2	V	21	BOOKKEEPING SERVICE	496,900	" "			(496,900)	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		" "		287,782	287,782	10
11	V	26	PROPERTY/BOILER INSURANCE		" "		7,504	7,504	11
12	V								12
13	V								13
14	Total			$ 1,269,140			$ 444,264	$ * (824,876)	14

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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%	$ 1,296	$ 1,296	15
16	V	6	REPAIR & MAINT.		" "		7,710	7,710	16
17	V	7	EMP BEN-GEN SERV		" "		249	249	17
18	V	19	PROFESSIONAL FEES		" "		1,103	1,103	18
19	V	20	DUES AND SUBSCRIPTION		" "		3,293	3,293	19
20	V	21	CLERICAL & GENERAL		" "		81,961	81,961	20
21	V	24	SEMINARS AND TRAVEL		" "		1,183	1,183	21
22	V	25	AUTO EXPENSE		" "		4,253	4,253	22
23	V	26	INSURANCE		" "		(1,470)	(1,470)	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" "		14,564	14,564	24
25	V	30	DEPRECIATION		" "		2,580	2,580	25
26	V	32	INTEREST		" "		2,215	2,215	26
27	V	33	REAL ESTATE TAXES		" "		4,437	4,437	27
28	V	19	REAL ESTATE TAX PROTEST FEES		" "		556	556	28
29	V	35	AUTO RENTAL		" "		11,890	11,890	29
30	V	35	EQUIPMENT RENTAL		" "		88	88	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			$			$ 135,908	$ * 135,908	39

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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%	$ 7,713	$ 7,713	15
16	V	17	ADMIN COMP - M MAUER		" "		23,141	23,141	16
17	V	17	ADMIN COMP - M AARON		" "		26,021	26,021	17
18	V	17	ADMIN COMP - F AARON		" "		2,200	2,200	18
19	V	17	ADMIN COMP - D AARON		" "		23,933	23,933	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "				20
21	V	17	ADMIN COMP - S HARAMARAS		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		19,560	19,560	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		14,766	14,766	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		16,903	16,903	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		23,139	23,139	26
27	V	21	CLERICAL COMP - S AARON		" "		10,082	10,082	27
28	V	21	CLERICAL COMP - E MARYLES		" "		700	700	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			$			$ 168,158	$ * 168,158	39

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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%	$ 800	$ 800	15
16	V	27	EMP BEN - M MAUER		" "		1,330	1,330	16
17	V	27	EMP BEN - M AARON		" "		1,874	1,874	17
18	V	27	EMP BEN - F AARON		" "		7,526	7,526	18
19	V	27	EMP BEN - D AARON		" "		1,949	1,949	19
20	V	27	EMP BEN - S GOLDSTEIN		" "				20
21	V	27	EMP BEN - S HARAMARAS		" "				21
22	V	27	EMP BEN - D KUFTA		" "		1,400	1,400	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "		3,581	3,581	24
25	V	27	EMP BEN - NON OWNER		" "		5,362	5,362	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,805	2,805	26
27	V	27	EMP BEN - S AARON		" "		1,951	1,951	27
28	V	27	EMP BEN - E MARYLES		" "		359	359	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			$			$ 28,937	$ * 28,937	39

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	8.03	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 TRI	6.25						17
18	BOB KAGDA	4.8						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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		SCHEDULE	4.63	11.57	SALARY	$ 23,141	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIVE		ATTACHED	5.2	13.01		26,021	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL			4.63	11.57		10,082	21-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE			9			38,500	17-1	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIVE						2,200	17-7	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIVE			6.51	13.01		19,560	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			5.2	13.01		7,713	6-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.32	1.16		700	21-7	8
9	DANIEL AARON		ADMINISTRATIVE			15.88	39.71		23,933	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 151,850		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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	452,396	12	$ 11,795	$	49,723	$ 1,296	1
2	6	REPAIR & MAINT.	PATIENT DAYS	452,396	12	70,149	38,885	49,723	7,710	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	452,396	12	2,266		49,723	249	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	12	10,039		49,723	1,103	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	452,396	12	29,965		49,723	3,293	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	12	745,706	528,878	49,723	81,961	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	12	10,766		49,723	1,183	7
8	25	AUTO EXPENSE	PATIENT DAYS	452,396	12	38,698		49,723	4,253	8
9	26	INSURANCE	PATIENT DAYS	452,396	12	(13,379)		49,723	(1,470)	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	452,396	12	132,506		49,723	14,564	10
11	30	DEPRECIATION	PATIENT DAYS	452,396	12	23,478		49,723	2,580	11
12	32	INTEREST	PATIENT DAYS	452,396	12	20,148		49,723	2,215	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	12	40,366		49,723	4,437	13
14	19	REAL ESTATE TAX PROTEST FEI	PATIENT DAYS	452,396	12	5,056		49,723	556	14
15	35	AUTO RENTAL	PATIENT DAYS	452,396	12	108,178		49,723	11,890	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	12	802		49,723	88	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,236,539	$ 567,763		$ 135,908	25

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	$ 59,284	$ 59,284	5	$ 7,713	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	23,141	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	5	26,021	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	11,000	11,000	9	2,200	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271	16	23,933	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	103,196	103,196			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	76,737	76,737			7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	150,258	150,258	7	19,560	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	127,632	127,632	5	14,766	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	129,197	129,197	6	16,903	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	40	11	200,000	200,000	5	23,139	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	87,119	87,119	5	10,082	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	60,541	60,541	0	700	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,477,235	$ 1,477,235		$ 168,158	25

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	$ 6,150	$	5	$ 800	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	11,498		5	1,330	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,402		5	1,874	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	37,628		9	7,526	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,909		16	1,949	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,033				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	25,836				7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	9	10,754		7	1,400	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,085				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	11	30,956		5	3,581	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	9	40,985		6	5,362	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	11	24,244		5	2,805	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	11	16,859		5	1,951	13
14			WGHTD AVG HOURS	28	12	30,999		0	359	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 293,338	$		$ 28,937	25

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	10/41	5.8500	$ 287,782	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL							42,684	6
7	PHARMACY		X	AP FINANCING							1,137	7
8												8
9	TOTAL Facility Related				$49,218.18		$ 5,722,000	$			$ 331,603	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	$			$ 331,603	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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 372,000	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.)		$ 375,476	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,476	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 383,000	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.		$ 386,476	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	239,768	8
	2010	257,629	9
	2011	338,246	10
	2012	364,663	11
	2013	375,476	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HLTH CARE CENTER 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 375,475.63	$ 375,475.63
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 375,475.63	$ 375,475.63

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 [ ] 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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	$ 2,551,516	4
5											5
6											6
7	RELATED PARTY				48,756	1,250	35	1,393	143	29,718	7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		743	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		62,289	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		1,107	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		4,288	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		617	14
15	CARPET INSTALL			1995	1,303	33	39	33		634	15
16	RAIL BUMPER			1995	917	24	39	24		457	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		2,543	17
18	PAINTING WORK			1996	8,400	215	39	215		3,951	18
19	WALL COVERING			1996	1,435	37	39	37		677	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		1,120	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		1,215	21
22	CONDENCING UNIT			1999	3,824	98	39	98		1,534	22
23	DRAPES			1999	5,369	138	39	138		2,124	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		3,390	24
25	DOOR WORK			1999	10,490	269	39	269		4,127	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		2,309	26
27	TILES			2000	8,855	322	27.5	322		4,644	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		2,121	28
29	ROD MAIN SEWER			2000	1,100	41	27.5	41		588	29
30	DRAPERIES			2001	2,118		7			2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		4,164	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		4,885	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		18,142	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		4,032	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		3,254	35
36				2003	4,023	134	15	134		3,553	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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	$ 733	37
38	COIL	2003	806	29	27.5	29		332	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,663	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		699	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		2,795	41
42	FLOOR COVERING	2004	888	32	27.5	32		335	42
43	CABINETS	2004	2,594	95	27.5	95		993	43
44	BOILER	2004	2,574	93	27.5	93		973	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		450	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		3,014	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		24,129	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		3,424	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		473	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		7,264	50
51	NETWORK CABLING	2006	855	31	27.5	31		262	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		1,099	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		677	53
54	FANS	2006	1,108	40	27.5	40		338	54
55	DOORS	2006	1,711	62	27.5	62		525	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		13,413	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		999	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		7,593	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		910	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		5,422	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		8,152	61
62	CONDENSER	2007	1,712	62	27.5	62		463	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		536	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		4,276	64
65	DOORS	2008	1,645	60	27.5	60		387	65
66	BOILER	2008	5,104	185	27.5	185		1,195	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		311	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		2,729	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		9,028	69
70	TOTAL (lines 4 thru 69)		$ 5,699,293	$ 152,714		$ 152,857	$ 143	$ 2,830,167	70

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 5,699,293	$ 152,714		$ 152,857	$ 143	$ 2,830,167	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		21,337	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		879	3
4	HEATING WORK	2009	9,475	345	27.5	345		1,883	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		2,140	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	608	27.5	608		2,711	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		860	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		2,835	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		1,025	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		5,528	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	621	27.5	621		2,769	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		2,720	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		499	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	233	27.5	233		1,039	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		669	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TILE	2010	5,691	207	27.5	207		923	16
17	CEILING PIPING	2010	2,825	103	27.5	103		459	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		2,051	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		691	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		406	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		468	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	126	27.5	126		558	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	67	27.5	67		299	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	56	27.5	56		250	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		1,017	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	97	27.5	97		429	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	63	27.5	63		281	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		1,656	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		2,417	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	369	27.5	369		1,274	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		2,877	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		1,511	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS	2011	65,023	2,364	27.5	2,364		8,176	33
34	TOTAL (lines 1 thru 33)		$ 6,149,666	$ 169,092		$ 169,235	$ 143	$ 2,902,804	34

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 6,149,666	$ 169,092		$ 169,235	$ 143	$ 2,902,804	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		647	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		3,891	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		744	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		1,048	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		2,352	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		4,475	7
8	FLOORING/TACKBOARD/LIGHT fixtures	2011	2,809	102	27.5	102		354	8
9									9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		40,634	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		35,153	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		78,584	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		24,567	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		23,890	18
19	NURSE STATION	2002	17,320	229	39	229		10,829	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		55,113	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		13,007	21
22	NURSE STATION	2004	27,559	707	39	707		7,394	22
23	CARPET, TILE, WALLCOVERING	2004	42,388		39			42,388	23
24	MODERNIZE ELEVATORS	2007	175,828	4,508	39	4,508		33,622	24
25	WINDOWS	2006	83,000	2,128	39	2,128		14,807	25
26									26
27	DOORS & WINDOWS	2012	4,075	153	27.5	153		374	27
28	PLUMBING WORK	2012	11,639	433	27.5	433		1,060	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	968	27.5	968		2,376	29
30	FLOORING	2012	8,640	306	27.5	306		756	30
31	SECURITY SYSTEM WORK	2012	5,130	178	27.5	178		442	31
32	ROOF REPAIR	2012	1,595	51	27.5	51		128	32
33	NURSE CALL SYSTEM WORK	2012	1,488	51	27.5	51		127	33
34	TOTAL (lines 1 thru 33)		$ 7,065,067	$ 191,687		$ 191,830	$ 143	$ 3,301,566	34

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 7,065,067	$ 191,687		$ 191,830	$ 143	$ 3,301,566	1
2	CEILING REPAIR	2012	2,145	76	27.5	76		188	2
3	ELECTRIC WORK	2012	2,825	102	27.5	102		251	3
4	HANDRAIL SPACERS	2012	2,800	102	27.5	102		251	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	127	27.5	127		308	5
6	SPRINKLER & SECURITY SYSTEM	2013	13,953	507	27.5	507		743	6
7	DOORS & HARDWARE	2013	6,459	235	27.5	235		347	7
8	BATHROOM SINKS, FAUCETS & DRYWALL	2013	15,179	552	27.5	552		801	8
9	OFFICE WALL REPAIR	2013	4,383	160	27.5	160		235	9
10	AC REPAIR & ROOF FAN INSTALL	2013	8,750	318	27.5	318		467	10
11	COMPRESSORS, BREAKERS HEAT COIL	2013	21,983	799	27.5	799		1,159	11
12	WALK IN FREEZER REPAIR	2013	1,055	38	27.5	38		50	12
13	FENCE INSTALL	2013	2,800	102	27.5	102		152	13
14	REPAIRED ELEVATOR DOOR ON THE SECOND FLOOR	2014	5,274	88	27.5	88		88	14
15	WATER HEATERS-TWO RAYPAK MVB MODEL	2014	35,148	586	27.5	586		586	15
16	EMERGENCY ROOF INSPECTION & ANALYSIS	2014	11,040	184	27.5	184		184	16
17	PASSENGER ELEVATOR-REPLACE DETECTOR EDGES	2014	2,136	36	27.5	36		36	17
18	WALK IN FREEZER-REPLACEMENT SYSTEM	2014	5,310	89	27.5	89		89	18
19	SECURITY SYSTEM WORK-INSTALLED WIRELESS DOOR,								19
20	REPLACED CAMERA'S AND DOORS	2014	4,610	77	27.5	77		77	20
21	INSTALL 7 EYEWASH STATIONS	2014	5,100	85	27.5	85		85	21
22	1ST FLOOR AIRCONDITION REPAIR	2014	4,050	67	27.5	67		67	22
23	PLUMBING SUPPLIES	2014	2,969	49	27.5	49		49	23
24	GLASS BLOCK AND GLASS DOORS	2014	5,706	95	27.5	95		95	24
25	INSTALLED SPRINKLER & SATELLITE HEADEND SYSTEM	2014	4,057	68	27.5	68		68	25
26	FIRE RATED DOORS & HARDWARE, SVR EXIT DEVICE	2014	6,739	112	27.5	112		112	26
27	RESIDENT BATHROOMS: FLOOR TILES, SINKS, FAUCETS,								27
28	LIGHTING FIXTURES, WALL AND CEILING TITLES	2014	29,926	499	27.5	499		499	28
29	DIETARY ROOM: ICE MELT, TILES, DROP CEILING	2014	2,193	36	27.5	36		36	29
30	DRYWALL FOR PENTHOUSE; STEEL STORAGE SHELVING								30
31	UNIT; FIX WALLPAPER IN BASEMENT	2014	4,098	68	27.5	68		68	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,278,963	$ 196,944		$ 197,087	$ 143	$ 3,308,657	34

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 569,643	$ 22,530	$ 55,855	$ 33,325	10 YRS	$ 303,305	71
72	Current Year Purchases	56,641	33,985	2,832	(31,153)	10YRS	2,832	72
73	Fully Depreciated Assets	294,743					294,743	73
74	RELATED PARTY	29,406	778	1,208	430		24,678	74
75	TOTALS	$ 950,433	$ 57,293	$ 59,895	$ 2,602		$ 625,558	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			$ 25,905	$ 552	$ 4,286	$ 3,734		$ 16,355	76
77										77
78										78
79										79
80	TOTALS			$ 25,905	$ 552	$ 4,286	$ 3,734		$ 16,355	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)	$ 8,559,301	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 254,789	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 261,268	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,479	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,950,570	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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 6,564 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			$	$ 1,664	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,664	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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			2,120			2,120	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				135,987		135,987	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 XRAY						18,604		18,604	13
14	TOTAL			$		$ 2,120	$ 154,591		$ 156,711	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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 289,355	$ 380,514	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (540000)	3,082,844	3,082,844	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,613	138,039	6
7	Other Prepaid Expenses	47,355	53,955	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROWS	310,032	295,746	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,842,199	$ 3,951,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		304,000	13
14	Buildings, at Historical Cost		5,092,000	14
15	Leasehold Improvements, at Historical Cost	1,389,321	2,138,206	15
16	Equipment, at Historical Cost	921,027	1,451,543	16
17	Accumulated Depreciation (book methods)	(1,218,563)	(4,680,581)	17
18	Deferred Charges		49,887	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	557,009	557,009	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,648,794	$ 4,912,064	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,490,993	$ 8,863,162	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 676,212	$ 1,214,612	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,125,000	1,125,000	29
30	Accrued Salaries Payable	358,018	358,018	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,890	35,890	31
32	Accrued Real Estate Taxes(Sch.IX-B)	383,000	383,000	32
33	Accrued Interest Payable	3,772	27,580	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)**	$ 2,581,892	$ 3,144,100	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,175,632	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)**	$	$ 5,175,632	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,581,892	$ 8,319,732	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,909,101	$ 543,430	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,490,993	$ 8,863,162	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,033,645	1	
2	Restatements (describe):		2	
3	ILLINOIS REPLACEMENT TAX	(3,958)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,029,687	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,122,614	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	(243,200)	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)**	$ 879,414	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)**	$ 2,909,101	24	*

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 10,440,920	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,440,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	282,818	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 282,818	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***	670	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 670	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)**	$ 10,724,408	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,364,263	31
32	Health Care	3,930,583	32
33	General Administration	2,840,153	33
	B. Capital Expense		
34	Ownership	1,032,861	34
	C. Ancillary Expense		
35	Special Cost Centers	156,711	35
36	Provider Participation Fee	346,487	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(69,264)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,601,794	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,122,614	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,122,614	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,459,822	44
45	Private Pay - Net Inpatient Revenue	1,721,896	45
46	Medicare - Net Inpatient Revenue	3,012,667	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	246,535	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,440,920	49

TAX RETURN NOT COMPLETED

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

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

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

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,655	1,697	$ 85,866	$ 50.60	1
2	Assistant Director of Nursing	2,013	2,240	89,640	40.02	2
3	Registered Nurses	10,934	11,964	402,220	33.62	3
4	Licensed Practical Nurses	31,885	36,159	1,004,839	27.79	4
5	CNAs & Orderlies	94,656	104,321	1,099,795	10.54	5
6	CNA Trainees					6
7	Licensed Therapist	13,094	13,915	583,542	41.94	7
8	Rehab/Therapy Aides					8
9	Activity Director	9,793	10,846	227,660	20.99	9
10	Activity Assistants	13,553	14,563	135,714	9.32	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	5,613	5,965	116,764	19.57	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,037	2,365	162,073	68.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,180	14,809	337,875	22.82	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	2,033	2,313	51,283	22.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,446	221,157	$ 4,297,271 *	$ 19.43	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	192	33,350	9-3	36
37	Medical Records Consultant	8	150	10-3	37
38	Nurse Consultant		1,560	10-3	38
39	Pharmacist Consultant	192	10,162	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	824	11-3	44
45	Social Service Consultant	24	679	12-3	45
46	Other(specify)				46
47	PSYCHIATRIC	96	6,715	10-3	47
48					48
49	TOTAL (lines 35 - 48)	529	$ 53,440		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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR	0	$ 123,573
FRED AARON	ADMINISTRATIVE	7.89	38,500
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 162,073

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 283,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 283,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		105,205
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 105,205

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,026
Unemployment Compensation Insurance	102,663
FICA Taxes	324,932
Employee Health Insurance	244,367
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	31,090
TOTAL (agree to Schedule V, line 22, col.8)	$ 798,078

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	$ 1,990
Advertising: Employee Recruitment	14,600
Health Care Worker Background Check	830
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	3,599
MARKETING/ADV/PROMO	50,274
LICENSES/DUES/SUBSCRIPTIONS	29,256
MGMT CO ALLOC	3,293
TRUST/FRANCHISE/CONTRIB/ETC	(3,599)
Less: Public Relations Expense	(0)
Non-allowable advertising	(50,274)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	1,183
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,183

**See instructions.

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 $15,330**

(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. $ **23,772** 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. $ **346,487**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.