FOR BHF USE

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

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.

I. IDPH License ID Number: 0048819

Facility Name: Bridgeway Chr Vlg Reh & SNF

Address: 111 E Washington St (Number) Bensenville (City) 60106 (Zip Code)

County: Du Page

Telephone Number: 630-766-5800 **Fax #** 630-766-5473

HFS ID Number:

Date of Initial License for Current Owners: 7/1/2007

Type of Ownership:

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

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Susan McGhee **Telephone Number:** 314-587-7903
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 July 1, 2013 to June 30, 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) Susan McGhee
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Steve Howell, Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4497 Fax # 314-925-4350

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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	222	Skilled (SNF)	222	81,030	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	222	TOTALS	222	81,030	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	35,819	9,160	11,110	56,089	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,819	9,160	11,110	56,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.22%

D. How many bed-hold days during this year were paid by the Department?
None (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)
Emergency maint. and Chaplain services provided for independent living residents

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/30/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 222 and days of care provided 10,075

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 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	484,103	48,151	47,093	579,347		579,347		579,347			1
2	Food Purchase		437,102		437,102		437,102	(11,603)	425,499			2
3	Housekeeping	216,512	30,572	188,724	435,808		435,808		435,808			3
4	Laundry	21,525			21,525		21,525		21,525			4
5	Heat and Other Utilities			438,054	438,054		438,054	(34,963)	403,091			5
6	Maintenance	181,540	18,455	143,085	343,080		343,080	8,538	351,618			6
7	Other (specify):*											7
8	**TOTAL General Services**	903,680	534,280	816,956	2,254,916		2,254,916	(38,028)	2,216,888			8
	B. Health Care and Programs											
9	Medical Director			56,835	56,835		56,835		56,835			9
10	Nursing and Medical Records	4,727,831	283,779	88,769	5,100,379		5,100,379		5,100,379			10
10a	Therapy		2,212	1,329,560	1,331,772		1,331,772		1,331,772			10a
11	Activities	84,410	12,707	6,004	103,121		103,121		103,121			11
12	Social Services	188,275	1,097	5,192	194,564		194,564		194,564			12
13	CNA Training											13
14	Program Transportation			3,019	3,019		3,019		3,019			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,000,516	299,795	1,489,379	6,789,690		6,789,690		6,789,690			16
	C. General Administration											
17	Administrative	105,103		914,600	1,019,703		1,019,703	(715,841)	303,862			17
18	Directors Fees											18
19	Professional Services			35,273	35,273		35,273	66,651	101,924			19
20	Dues, Fees, Subscriptions & Promotions			35,005	35,005		35,005		35,005			20
21	Clerical & General Office Expenses	260,151	12,656	276,659	549,466		549,466	197,620	747,086			21
22	Employee Benefits & Payroll Taxes			1,290,435	1,290,435		1,290,435	75,556	1,365,991			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,739	18,739		18,739	30,351	49,090			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			180,938	180,938		180,938	3,068	184,006			26
27	Other (specify):* **Marketing**	77,438	2,492	22,455	102,385		102,385	(102,385)				27
28	**TOTAL General Administration**	442,692	15,148	2,774,104	3,231,944		3,231,944	(444,980)	2,786,964			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,346,888	849,223	5,080,439	12,276,550		12,276,550	(483,008)	11,793,542			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 Number Bridgeway Chr Vlg Reh & SNF #0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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			600,277	600,277		600,277	66,398	666,675			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			520,752	520,752		520,752	(79,311)	441,441			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			96,499	96,499		96,499	(4,400)	92,099			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,217,528	1,217,528		1,217,528	(17,313)	1,200,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			557,880	557,880		557,880	(23,862)	534,018			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			400,422	400,422		400,422		400,422			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			958,302	958,302		958,302	(23,862)	934,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,346,888	849,223	7,256,269	14,452,380		14,452,380	(524,183)	13,928,197			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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	(17,445)	2		4
5	Telephone, TV & Radio in Resident Rooms	(38,193)	5		5
6	Rented Facility Space	(4,400)	35		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(60,914)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(838)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(184,006)	21		24
25	Fund Raising, Advertising and Promotional	(102,385)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(110)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (408,291)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(115,892)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (115,892)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (524,183)		37

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

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

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

Bridgeway Chr Vlg Reh & SNF

ID# 0048819

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous	$ (5,831)	21	1
2	Late Fees	(121)	21	2
3	Vending Revenue	5,842	2	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**	(110)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF **#** 0048819 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 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	(11,603)	0	0	0	0	0	0	0	0	0	0	(11,603)	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	(38,193)	3,230	0	0	0	0	0	0	0	0	0	(34,963)	5
6	Maintenance	0	8,538	0	0	0	0	0	0	0	0	0	8,538	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(49,796)	11,768	0	0	0	0	0	0	0	0	0	(38,028)	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	(715,841)	0	0	0	0	0	0	0	0	0	(715,841)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	66,651	0	0	0	0	0	0	0	0	0	66,651	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(190,796)	388,416	0	0	0	0	0	0	0	0	0	197,620	21
22	Employee Benefits & Payroll Taxes	0	75,556	0	0	0	0	0	0	0	0	0	75,556	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	30,351	0	0	0	0	0	0	0	0	0	30,351	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,068	0	0	0	0	0	0	0	0	0	3,068	26
27	Other (specify):*	(102,385)	0	0	0	0	0	0	0	0	0	0	(102,385)	27
28	**TOTAL General Administration**	(293,181)	(151,799)	0	0	0	0	0	0	0	0	0	(444,980)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(342,977)	(140,031)	0	0	0	0	0	0	0	0	0	(483,008)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 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	0	66,398	0	0	0	0	0	0	0	0	0	66,398	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(60,914)	(18,397)	0	0	0	0	0	0	0	0	0	(79,311)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(4,400)	0	0	0	0	0	0	0	0	0	0	(4,400)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(65,314)	48,001	0	0	0	0	0	0	0	0	0	(17,313)	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	(23,862)	0	0	0	0	0	0	0	0	0	(23,862)	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	(23,862)	0	0	0	0	0	0	0	0	0	(23,862)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(408,291)	(115,892)	0	0	0	0	0	0	0	0	0	(524,183)	45

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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 attached listing of Board of Directors						

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	5	Utilities	$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	$ 3,230	$ 3,230	1
2	V	6	Maintenance				8,538	8,538	2
3	V	17	Administration	914,600			198,759	(715,841)	3
4	V	19	Professional Services				66,651	66,651	4
5	V	21	Clerical				387,389	387,389	5
6	V	22	Employee Benefits				75,556	75,556	6
7	V	24	Travel and Seminar				30,351	30,351	7
8	V	26	Insurance				3,068	3,068	8
9	V	30	Depreciation				66,398	66,398	9
10	V	32	Interest				(18,397)	(18,397)	10
11	V	21	Other Administrative Expense				1,027	1,027	11
12	V								12
13	V	39	Pharmacy Services	485,009	Senior Care Pharmacy Services	0.00%	461,147	(23,862)	13
14	Total			$ 1,399,609			$ 1,283,717	$ * (115,892)	14

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

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: ne 30, 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 [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	Illinois Finance Authority		X	Purchase Facility	$42,155.00	6/30/07	$ 9,736,678	$ 9,010,684	5/15/2031	0.0567	$ 517,597	1
2	Illinois Finance Authority		X	Purchase Facility		7/29/10	53,720	53,381	5/15/2027	0.0613	3,155	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$42,155.00		$ 9,790,398	$ 9,064,065			$ 520,752	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,790,398	$ 9,064,065			$ 520,752	15

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

*** 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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012		11
2013		12

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 Bridgeway Chr Vlg Reh & SNF COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0048819

CONTACT PERSON REGARDING THIS REPORT This page is N/A

TELEPHONE ( ) FAX #: ( )

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.	N/A	N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,352 B. General Construction Type: Exterior Brick Frame Steel & Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [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).

182 - Unit Independent Living Facility

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	HOME OFFICE ALLOCATION			$ 12,686	1
2					2
3	TOTALS			$ 12,686	3

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	222		2007	1975	$ 5,013,500	$ 200,540	25	$ 200,540	$	$ 1,504,050	4
5											5
6											6
7											7
8	Home Office Allocation				123,111	14,253		14,253		86,115	8
	Improvement Type**										
9	2007 Fixed Assets			2007	16,737	149	VARIOUS	149		15,581	9
10	2008 Fixed Assets			2008	1,369,464	81,776	VARIOUS	81,776		495,610	10
11	2009 Fixed Assets			2009	453,152	52,426	VARIOUS	52,426		255,571	11
12	Parking Lot Light Pole			2010	1,960	196	10	196		866	12
13	C Wing Refurb			2010	577,856	57,786	10	57,786		245,589	13
14	C-Wing Nurse Call Station Power Board			2010	3,400	340	10	340		1,332	14
15	E-Wing Basement Door			2010	3,430	343	10	343		1,343	15
16	HVAC unit			2010	5,116	512	10	512		2,004	16
17	Circulating Pumps for Main Boiler			2010	8,690	869	10	869		3,114	17
18	Carpeting			2010	2,068	207	10	207		741	18
19	Roof - Unit B			2010	143,143	14,314	10	14,314		54,871	19
20	Seal & Stripe Parking Lot			2010	19,550		2			19,550	20
21	Roof Exhaust Fans			2011	2,026	203	10	203		642	21
22	Trane Chiller			2011	79,400	7,940	10	7,940		24,482	22
23	Room 1405 - Carpet			2011	2,253	225	10	225		695	23
24	Men's Restroom - Remodel			2011	17,600	1,760	10	1,760		5,427	24
25	Women's Restroom - Remodeling			2011	17,175	1,718	10	1,718		5,296	25
26	Architectural Consulting for Life Safe			2011	1,473	147	10	147		466	26
27	Roof "C"			2011	56,704	5,670	10	5,670		15,121	27
28	Roof			2011	13,577	1,358	10	1,358		3,621	28
29	Roof "E"			2011	9,584	958	10	958		2,556	29
30	Front Entrance - Sidewalks			2011	20,045	2,005	10	2,005		6,181	30
31	2011 Landscaping			2011	18,700	1,870	10	1,870		5,766	31
32	Brick Wall			2011	4,165	417	10	417		1,284	32
33	Memorial Garden - Landscaping			2011	9,580	958	10	958		2,954	33
34	Reseal Parking Lot			2011	10,000	1,250	2	1,250		10,000	34
35	Foundation Study			2012	21,770	2,177	10	2,177		3,628	35
36	New pickets for balconies			2012	4,700	470	10	470		744	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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	UNIT C AND D ROOF	2013	$ 102,466	$ 8,539	10	$ 8,539	$	$ 8,539	37
38	Fire Doors	2013	5,960	596	10	596		695	38
39	Unit A Roof - HVAC Duct Insullation	2013	5,375	538	10	538		582	39
40	Unit D Roof	2013	99,312	4,966	20	4,966		5,793	40
41	Smoke Wall	2013	3,915	392	10	392		587	41
42	Fire rated ceiling tile	2013	2,936	220	10	220		220	42
43	Hot water pump and valves for unit D	2013	5,650	377	10	377		377	43
44	6x8 "Caution Oxidizing Gases" signs	2014	192	10	10	10		10	44
45	Fire Caulking	2014	329	16	10	16		16	45
46	Wet Sprinkler valves replace	2014	3,337	167	10	167		167	46
47	Smoke Wall Penetrations	2014	10,332	344	10	344		344	47
48	Architect fees for smoke wall	2014	6,048	252	10	252		252	48
49	Replace flue piping on #1 steam boiler	2014	4,700	39	10	39		39	49
50	Roof fans	2014	1,993	33	10	33		33	50
51	York Road Landscaping project	2014	27,510	229	10	229		229	51
52	Tie to GL			30		30		30	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,309,981	$ 469,583		$ 469,583	$	$ 2,793,112	70

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

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	$ 720,344	$ 105,385	$ 105,385	$	various	$ 440,230	71
72	Current Year Purchases	119,404	10,646	10,646		various	10,646	72
73	Fully Depreciated Assets	249,007	27,788	27,788		various	249,007	73
74	Home Office Allocation	485,314	47,020	47,020			289,313	74
75	TOTALS	$ 1,574,069	$ 190,839	$ 190,839	$		$ 989,196	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				$	$	$	$		$	76
77										77
78										78
79	Home Office Allocation			44,270	5,125	5,125			25,213	79
80	TOTALS			$ 44,270	$ 5,125	$ 5,125	$		$ 25,213	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)	$ 9,941,006	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 665,547	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 665,547	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,807,521	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	2005 Chevy Silverado, acquired 2007	$ 20,708	$	$ 20,708	86
87	Maintenance Utility Vehicle, acquired 201	4,633	1,158	3,379	87
88					88
89					89
90					90
91	TOTALS	$ 25,341	$ 1,158	$ 24,087	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 188	92
93			93
94			94
95		$ 188	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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:	N/A			$			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: $ 96,499 Description: See Attached Schedule
    (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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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.

   BCV HIRES ONLY CERTIFIED CNAS

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 Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	10A-3	hrs	$	9,548	$ 532,347	$	9,548	$ 532,347	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		3,427	195,050		3,427	195,050	2
3	Licensed Recreational Therapist	10-3	hrs		237	14,896		237	14,896	3
4	Licensed Physical Therapist	10A-3	hrs		18,139	602,163		18,139	602,163	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	31,351	$ 1,344,456	$	31,351	$ 1,344,456	14

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

STATE OF ILLINOIS

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 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	$ 2,393,262	$	1
2	Cash-Patient Deposits	41,772		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 247,619)	2,652,344		3
4	Supply Inventory (priced at)	25,790		4
5	Short-Term Investments	154		5
6	Prepaid Insurance	18,230		6
7	Other Prepaid Expenses	20,627		7
8	Accounts Receivable (owners or related parties)	11,363		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,163,542	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,755,596		14
15	Leasehold Improvements, at Historical Cost	431,274		15
16	Equipment, at Historical Cost	1,114,096		16
17	Accumulated Depreciation (book methods)	(4,476,011)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	142,378		21
22	Other Long-Term Assets (spe **Deferred Financing**	122,902		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,090,235	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,253,777	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 257,075	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,772		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	417,806		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	64,475		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	161,981		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 943,109	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,064,065		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)**	$ 9,064,065	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,007,174	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 246,603	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,253,777	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,528,928	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,528,928	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,282,327)	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	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **Rounding**	2	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,282,325)	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)**	$ 246,603	24	*

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

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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	$ 16,215,423	1
2	Discounts and Allowances for all Levels	(9,082,063)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,133,360	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,997,100	6
7	Oxygen	28,226	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,025,326	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	400	13
14	Non-Patient Meals	17,445	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,400	16
17	Sale of Drugs	591,630	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	122,553	19
20	Radiology and X-Ray	43,608	20
21	Other Medical Services	165,545	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 945,581	23
	D. Non-Operating Revenue		
24	Contributions	13,800	24
25	Interest and Other Investment Income***	60,914	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74,714	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	(1,008,928)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,008,928)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,170,053	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,254,916	31
32	Health Care	6,789,690	32
33	General Administration	3,231,944	33
	B. Capital Expense		
34	Ownership	1,217,528	34
	C. Ancillary Expense		
35	Special Cost Centers	557,880	35
36	Provider Participation Fee	400,422	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,452,380	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,282,327)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,282,327)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,252,438	44
45	Private Pay - Net Inpatient Revenue	2,567,903	45
46	Medicare - Net Inpatient Revenue	(656,620)	46
47	Other-(specify) HMO	(37,589)	47
48	Other-(specify) Nursing/Medicare Advantage	7,228	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,133,360	49

* **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.**

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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	3,985	4,298	$ 174,977	$ 40.71	1
2	Assistant Director of Nursing	1,286	1,416	56,582	39.96	2
3	Registered Nurses	52,487	56,712	1,715,906	30.26	3
4	Licensed Practical Nurses	31,974	34,448	755,451	21.93	4
5	CNAs & Orderlies	134,807	144,575	1,721,466	11.91	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,924	2,035	36,705	18.04	9
10	Activity Assistants	3,984	4,148	47,705	11.50	10
11	Social Service Workers	7,517	8,001	188,275	23.53	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	35,905	37,994	484,103	12.74	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	6,965	7,415	181,540	24.48	17
18	Housekeepers	17,829	19,241	216,512	11.25	18
19	Laundry	1,916	2,027	21,525	10.62	19
20	Administrator	2,011	2,171	118,658	54.65	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,995	2,083	48,254	23.16	23
24	Clerical	11,552	12,157	197,395	16.24	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	5,054	5,356	89,397	16.69	31
32	Other Health C: MDS Coordinator	5,660	6,305	214,052	33.95	32
33	Other(specify) Marketing/Commu	2,972	3,270	78,385	23.97	33
34	TOTAL (lines 1 - 33)	329,824	353,650	$ 6,346,888 *	$ 17.95	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	742	$ 33,025	3.1.3	35
36	Medical Director	612	56,835	3.9.3	36
37	Medical Records Consultant	28	1,650	3.10.3	37
38	Nurse Consultant	14	2,247	3.10.3	38
39	Pharmacist Consultant	198	4,425	3.10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	49	4,289	3.12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,643	$ 102,471		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Pyfer	Administrator	0	$ 94,692
Matthew Macklin	Administrator	0	10,411
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,103

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 914,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 914,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
My Innerview	EE Surveys	$ 359
National Research	EE Surveys	1,454
Senior Living Valulation	Consulting	4,000
Davis & Campbell	Legal	30,238
Polsinelli	Legal	111
Tribler, Orpett	Legal	(889)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 35,273

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 222,752
Unemployment Compensation Insurance	54,951
FICA Taxes	472,755
Employee Health Insurance	494,190
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	23,003
Employee Uniforms	1,420
Employee Expenses	15,614
457 Plan Expense	5,750
Home Office Allocation	75,556
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,365,991

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	$
Advertising: Employee Recruitment	(220)
Health Care Worker Background Check	
(Indicate # of checks performed 65)	1,585
Patient Background Checks 265	3,377
License	3,708
Dues	21,435
Subscriptions	5,120
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,005

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 11,262
In-State Travel	5,177
Seminar Expense	2,300
Home Office Allocation	30,351
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 49,090

**See instructions.

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 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	This workpaper is not applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bridgeway Chr Vlg Reh & SNF # 0048819 Report Period Beginning: July 1, 2013 Ending: June 30, 201

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services, $3,368.46 / LSN, $10,244.88**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **N/A**

(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? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,188** 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. **N/A**

(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. $ **400,422**
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. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **17,445**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
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? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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? **YES**
Firm Name: **CliftonLarsonAllen, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.