FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 0037358

Facility Name: BRIDGEVIEW HLTH CARE CENTER

Address: 8101 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 01/01/2015 to 12/31/2015 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: 01/01/2015 Ending: 12/31/2015

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	142	Skilled (SNF)	142	51,830	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	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	7,949	2,226	6,006	16,181	8
9	SNF/PED					9
10	ICF	23,794	4,922	3,306	32,022	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,743	7,148	9,312	48,203	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.45%

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 6,006

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		426	636,695	637,121		637,121		637,121			1
2	Food Purchase		14,321		14,321		14,321	(1,815)	12,506			2
3	Housekeeping		1,045	209,906	210,951		210,951		210,951			3
4	Laundry		20,884	133,775	154,659		154,659		154,659			4
5	Heat and Other Utilities			118,128	118,128		118,128	1,256	119,384			5
6	Maintenance	98,867	65,284	34,736	198,887		198,887	17,736	216,623			6
7	Other (specify):*			12,830	12,830		12,830	1,146	13,976			7
8	**TOTAL General Services**	98,867	101,960	1,146,070	1,346,897		1,346,897	18,323	1,365,220			8
	B. Health Care and Programs											
9	Medical Director			39,074	39,074		39,074		39,074			9
10	Nursing and Medical Records	2,847,179	165,632	18,611	3,031,422		3,031,422		3,031,422			10
10a	Therapy	673,077	10,164		683,241		683,241		683,241			10a
11	Activities	362,048	24,254	832	387,134		387,134		387,134			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			19,135	19,135		19,135		19,135			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,882,304	200,050	77,652	4,160,006		4,160,006		4,160,006			16
	C. General Administration											
17	Administrative	121,609		265,000	386,609		386,609	(108,035)	278,574			17
18	Directors Fees											18
19	Professional Services			130,678	130,678		130,678	(17,099)	113,579			19
20	Dues, Fees, Subscriptions & Promotions			113,981	113,981		113,981	(52,450)	61,531			20
21	Clerical & General Office Expenses	365,419	41,839	643,242	1,050,500		1,050,500	(495,151)	555,349			21
22	Employee Benefits & Payroll Taxes			851,219	851,219		851,219		851,219			22
23	Inservice Training & Education			11,858	11,858		11,858		11,858			23
24	Travel and Seminar							3,185	3,185			24
25	Other Admin. Staff Transportation			20,407	20,407		20,407	2,634	23,041			25
26	Insurance-Prop.Liab.Malpractice			166,697	166,697		166,697	11,357	178,054			26
27	Other (specify):*			197,938	197,938		197,938	(150,914)	47,024			27
28	**TOTAL General Administration**	487,028	41,839	2,401,020	2,929,887		2,929,887	(806,473)	2,123,414			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,468,199	343,849	3,624,742	8,436,790		8,436,790	(788,150)	7,648,640			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: 01/01/2015** **Ending: 12/31/2015**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		1,455	
	CONTRACTED DIETARY SERVICES		635,240	636,695
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKEEPING SERVICE		209,906	
				209,906
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,710	
	CONTRACTED LAUNDRY SRVICES		132,065	133,775
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,139	
	ELECTRICITY		51,522	
	WATER		42,467	
	CABLE TV - LOBBY		0	
				118,128
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		12,048	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,227	
	ELEVATOR MAINTENANCE & REPAIR		8,332	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,129	
	FIRE SERVICE		0	
				34,736
7	**OTHER**			
	SCAVENGER		12,830	
	SECURITY SERVICE		0	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	10,302	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	SPECIAL CARE UNIT		8,309	
				18,611
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 CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	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	832	
				832
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	

				12,830
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	39,074	39,074

				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER **#0037358** **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		19,135	
				19,135
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	265,000	265,000
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	60,440	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	70,238	
				130,678
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	50,533	
	EMPLOYEE WANT ADS	XIX F	24,975	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	24,946	
	LICENSES & PERMITS	XIX F	7,138	
	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	4,729	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	920	
	PATIENT BACKGROUND CHECKS	XIX F	240	
				113,981
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		10,508	
	EQUIPMENT REPAIR & MAINTENANCE		33,009	
	OUTSIDE CLERICAL SERVICES		575,700	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,271	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,754	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	338,820	
	UNEMPLOYMENT COMPENSATION	XIX D	97,355	
	WORKERS COMPENSATION INSURANC	XIX D	97,699	
	HOSPITALIZATION INSURANCE	XIX D	285,138	
	EMPLOYEE BENEFITS - OTHER	XIX D	32,207	
	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	
				851,219
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		11,858	
				11,858
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		20,407	
				20,407
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		166,697	
				166,697
27	**OTHER**			
	BAD DEBTS	VI 24	197,938	
				197,938

GRAND TOTAL COLUMN 3 OTHER **3,624,742**

MESSENGER SERVICE	0	
		643,242

BRIDGEVIEW HLTH CARE CENTER
SCHEDULES
12/31/2015

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

TOTAL FOOD PURCHASE	14,321
LESS SALES TAX	(1,815)
NET FOOD	12,506
TOTAL PATIENT CENSUS	48,203
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	144,609
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	144,609
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	144,609
NET FOOD	12,506
DIVIDE TOTAL MEALS/YEAR	144,609
COST PER MEAL	0.09
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

BRIDGEVIEW HEALTHCARE CENTER, LTD.
TRAVEL - STAFF
12/31/15

A/C# 18370

DATE	NAME	PURPOSE	AMOUNT
JAN	SHELL OIL COMPANY	GAS	558
	DYNAMIC	TRAVEL,TOLLS,MILEAGE	1,439
	DYNAMIC	GAS	1
	SINGER NETWORKS	GAS	85
	SINGER NETWORKS	GAS	50
	CARDMEMBER SERVICES	TRAVEL,TOLLS,MILEAGE	1,092
	CARDMEMBER SERVICES	TRAVEL,TOLLS,MILEAGE	98
FEB	SHELL OIL COMPANY	GAS	390
	DYNAMIC	TRAVEL,TOLLS,MILEAGE	559
	DYNAMIC	TRAVEL,TOLLS,MILEAGE	95
	DYNAMIC	TRAVEL,TOLLS,MILEAGE	119
	DYNAMIC	TRAVEL,TOLLS,MILEAGE	75
	DYNAMIC	TRAVEL,TOLLS,MILEAGE	272
	SINGER NETWORKS	GAS	48
	CARDMEMBER SERVICES	ROOM AND BOARD	1,221
	CARDMEMBER SERVICES	TAXI	91
MAR	SHELL OIL COMPANY	GAS	300
	SHELL OIL COMPANY	GAS	246
	SHELL OIL COMPANY	GAS	545
	DYNAMIC	GAS	4
	DYNAMIC	GAS	8
	SINGER NETWORKS	GAS	25
	CARDMEMBER SERVICES	GAS	36
APR	SHELL OIL COMPANY	GAS	216
	DYNAMIC	GAS	2
	DYNAMIC	GAS	5
MAY	SHELL OIL COMPANY	GAS	287
	DYNAMIC	GAS	3
	ARIS MICHAELS	GAS	59
	DENNIS NEHMER	GAS	91
	CARDMEMBER SERVICES	TRAVEL, TOLLS,MILEAGE	99

	CARDMEMBER SERVICES	TRAVEL, TOLLS,MILEAGE	5
	SHELL OIL COMPANY	GAS	572
JUNE	DYNAMIC	TRAVEL, TOLLS,MILEAGE	86
	DYNAMIC	TRAVEL, TOLLS,MILEAGE	803
	DYNAMIC	TRAVEL, TOLLS,MILEAGE	199
	DYNAMIC	TRAVEL, TOLLS,MILEAGE	15
	SINGER NETWORKS	GAS	60
	DENNIS NEHMER	GAS	10
JULY	SHELL OIL COMPANY	GAS	800
	DYNAMIC HEALTH CARE	GAS	246
	SINGER NETWORKS	GAS	70
	CARDMEMBER SERVICES	GAS	99
	CARDMEMBER SERVICES	GAS	60
AUG	CARDMEMBER SERVICES	GAS	31
	CARDMEMBER SERVICES	GAS	146
	SHELL OIL COMPANY	GAS	588
	SHELL OIL COMPANY	GAS	558
	DYNAMIC	GAS	226
SEPT	SHELL OIL COMPANY	GAS	221
	SHELL OIL COMPANY	GAS	421
	CARDMEMBER SVC	ROOM AND BOARD	852
	DYNAMIC HEALTH CARE	GAS	51
	DYNAMIC HEALTH CARE	GAS	4
OCT	SHELL OIL COMPANY	GAS	171
	SHELL OIL COMPANY	GAS	447
	CARDMEMBER SVC	GAS	30
	CARDMEMBER SVC	GAS	40
	CARDMEMBER SVC	GAS	83
	DYNAMIC HEALTH CARE	GAS	153
	DYNAMIC HEALTH CARE	GAS	109
	DYNAMIC HEALTH CARE	GAS	4
NOV	SHELL OIL COMPANY	GAS	179
	KELLY AYERS	TRAVEL, TOLLS,MILEAGE, GAS	250
	KELLY AYERS	TRAVEL, TOLLS,MILEAGE, GAS	250
	DYNAMIC HEALTH CARE	TRAVEL, TOLLS,MILEAGE, GAS	233
	SHELL OIL COMPANY	TRAVEL, TOLLS,MILEAGE, GAS	252
	ARIS MICHAELS	CAR REPAIR	306
	AUTOMASTERS	GAS	64

	HEALTH DATA SYSTEMS	TRAVEL, TOLLS,MILEAGE, GAS	149
	NTT DATA LTC	TRAVEL, TOLLS,MILEAGE, GAS	238
	CARDMEMBER SVC	TRAVEL, TOLLS,MILEAGE, GAS	526
DEC	SHELL OIL COMPANY	GAS	175
	SHELL OIL COMPANY	GAS	284
	KELLY AYERS	TRAVEL, TOLLS,MILEAGE, GAS	250
	DYNAMIC	GAS	134
	DYNAMIC	GAS	7
	HEALTH DATA SYSTEMS	GAS	148
	CARDMEMBER SVC	GAS	30
	CARDMEMBER SVC	TRAVELERS AUTO INSURANCE, G	1,226
	CARDMEMBER SVC	TRAVEL, TOLLS,MILEAGE, GAS	429
			- - - - - -
			20,407
			= = = =

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER #0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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							
		1	2	3	4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			103,793	103,793		103,793	163,105	266,898			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,324	48,324		48,324	419,110	467,434			32
33	Real Estate Taxes			380,736	380,736		380,736	74,929	455,665			33
34	Rent-Facility & Grounds			463,913	463,913		463,913	(463,913)				34
35	Rent-Equipment & Vehicles			6,175	6,175		6,175	13,030	19,205			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,002,941	1,002,941		1,002,941	206,261	1,209,202			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,286		140,286		140,286		140,286			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			335,398	335,398		335,398		335,398			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		140,286	335,398	475,684		475,684		475,684			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,468,199	484,135	4,963,081	9,915,415		9,915,415	(581,889)	9,333,526			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: 01/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,937	30		9
10	Interest and Other Investment Income	(892)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,815)	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	(1,271)	21		18
19	Entertainment		20		19
20	Contributions	(5,229)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(20,706)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(197,938)	27		24
25	Fund Raising, Advertising and Promotional	(50,533)	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	(37,635)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (303,082)		$	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)	(278,807)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (278,807)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (581,889)		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

BRIDGEVIEW HLTH CARE CENTER

ID# 0037358

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (37,635)	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**	(37,635)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(1,815)	0	0	0	0	0	0	0	0	0	0	(1,815)	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	1,256	0	0	0	0	0	0	0	0	1,256	5
6	Maintenance	0	0	9,310	8,426	0	0	0	0	0	0	0	17,736	6
7	Other (specify):*	0	0	271	0	875	0	0	0	0	0	0	1,146	7
8	**TOTAL General Services**	(1,815)	0	10,837	8,426	875	0	0	0	0	0	0	18,323	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	(265,000)	0	156,965	0	0	0	0	0	0	0	(108,035)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,706)	0	3,607	0	0	0	0	0	0	0	0	(17,099)	19
20	Fees, Subscriptions & Promotions	(55,762)	0	3,312	0	0	0	0	0	0	0	0	(52,450)	20
21	Clerical & General Office Expenses	(38,906)	(575,700)	108,214	11,241	0	0	0	0	0	0	0	(495,151)	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	3,185	0	0	0	0	0	0	0	0	3,185	24
25	Other Admin. Staff Transportation	0	0	2,634	0	0	0	0	0	0	0	0	2,634	25
26	Insurance-Prop.Liab.Malpractice	0	7,643	3,714	0	0	0	0	0	0	0	0	11,357	26
27	Other (specify):*	(197,938)	0	16,434	0	30,590	0	0	0	0	0	0	(150,914)	27
28	**TOTAL General Administration**	(313,312)	(833,057)	141,100	168,206	30,590	0	0	0	0	0	0	(806,473)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(315,127)	(833,057)	151,937	176,632	31,465	0	0	0	0	0	0	(788,150)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	12,937	147,113	3,055	0	0	0	0	0	0	0	0	163,105	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(892)	417,458	2,544	0	0	0	0	0	0	0	0	419,110	32
33	Real Estate Taxes	0	70,167	4,762	0	0	0	0	0	0	0	0	74,929	33
34	Rent-Facility & Grounds	0	(463,913)	0	0	0	0	0	0	0	0	0	(463,913)	34
35	Rent-Equipment & Vehicles	0	0	13,030	0	0	0	0	0	0	0	0	13,030	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	12,045	170,825	23,391	0	0	0	0	0	0	0	0	206,261	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)**	(303,082)	(662,232)	175,328	176,632	31,465	0	0	0	0	0	0	(581,889)	45

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 265,000	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (265,000)	1
2	V	21	BOOKKEEPING SREVICE	575,700	DYNAMIC HEALTHCARE CONSULTANTS	100.00%		(575,700)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	463,913	BRIDGEVIEW ASSOCIATES LLC	100.00%		(463,913)	7
8	V	30	DEPRECIATION		BRIDGEVIEW ASSOCIATES LLC	100.00%	147,113	147,113	8
9	V	32	AMORTIZATION		BRIDGEVIEW ASSOCIATES LLC	100.00%	53,124	53,124	9
10	V	32	INTEREST		BRIDGEVIEW ASSOCIATES LLC	100.00%	364,334	364,334	10
11	V	26	PROPERTY/BOILER INSURANCE		BRIDGEVIEW ASSOCIATES LLC	100.00%	7,643	7,643	11
12	V	33	REAL ESTATE TAX		BRIDGEVIEW ASSOCIATES LLC	100.00%	70,167	70,167	12
13	V								13
14	Total			$ 1,304,613			$ 642,381	$ * (662,232)	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: 01/01/2015 Ending: 12/31/2015

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%	$ 1,256	$ 1,256	15
16	V	6	REPAIR & MAINT.		" "		9,310	9,310	16
17	V	7	EMP BEN-GEN SERV		" "		271	271	17
18	V	19	PROFESSIONAL FEES		" "		3,607	3,607	18
19	V	20	DUES AND SUBSCRIPTION		" "		3,312	3,312	19
20	V	21	CLERICAL & GENERAL		" "		108,214	108,214	20
21	V	24	SEMINARS AND TRAVEL		" "		3,185	3,185	21
22	V	25	AUTO EXPENSE		" "		2,634	2,634	22
23	V	26	INSURANCE		" "		3,714	3,714	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" "		16,434	16,434	24
25	V	30	DEPRECIATION		" "		3,055	3,055	25
26	V	32	INTEREST		" "		2,544	2,544	26
27	V	33	REAL ESTATE TAXES		" "		4,762	4,762	27
28	V	19	REAL ESTATE TAX PROTEST FEES		" "				28
29	V	35	AUTO RENTAL		" "		12,939	12,939	29
30	V	35	EQUIPMENT RENTAL		" "		91	91	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			$			$ 175,328	$ * 175,328	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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 8,426	$ 8,426	15
16	V	17	ADMIN COMP - M MAUER		" "		24,910	24,910	16
17	V	17	ADMIN COMP - M AARON		" "		28,382	28,382	17
18	V	17	ADMIN COMP - F AARON		" "		1,100	1,100	18
19	V	17	ADMIN COMP - D AARON		" "		24,442	24,442	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "				20
21	V	17	ADMIN COMP - B FREIDMAN		" "				21
22	V	17	ADMIN COMP - R AARON		" "				22
23	V	17	ADMIN COMP - S HARAMARAS		" "				23
24	V	17	ADMIN COMP - D KUFTA		" "		20,939	20,939	24
25	V	17	ADMIN COMP - HOWARD ALTER		" "				25
26	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		14,298	14,298	26
27	V	17	ADMIN COMP - NON OWNER - A CASSATA		" "				27
28	V	17	ADMIN COMP - NON OWNER		" "		18,602	18,602	28
29	V	17	ADMIN COMP - NON OWNER - CFO		" "		24,292	24,292	29
30	V	21	CLERICAL COMP - S AARON		" "		10,437	10,437	30
31	V	21	CLERICAL COMP - E MARYLES		" "		804	804	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 176,632	$ * 176,632	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: 01/01/2015 Ending: 12/31/2015

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%	$ 875	$ 875	15
16	V	27	EMP BEN - M MAUER		" "		1,434	1,434	16
17	V	27	EMP BEN - M AARON		" "		2,006	2,006	17
18	V	27	EMP BEN - F AARON		" "		7,852	7,852	18
19	V	27	EMP BEN - D AARON		" "		1,972	1,972	19
20	V	27	EMP BEN - S GOLDSTEIN		" "				20
21	V	27	EMP BEN - B FREIDMAN		" "				21
22	V	27	EMP BEN - R AARON		" "				22
23	V	27	EMP BEN - S HARAMARAS		" "				23
24	V	27	EMP BEN - D KUFTA		" "		1,491	1,491	24
25	V	27	EMP BEN - HOWARD ALTER		" "				25
26	V	27	EMP BEN - NON OWNER - V DAVIS		" "		3,995	3,995	26
27	V	27	EMP BEN - NON OWNER - A CASSATA		" "				27
28	V	27	EMP BEN - NON OWNER		" "		6,138	6,138	28
29	V	27	EMP BEN - NON OWNER - CFO		" "		3,087	3,087	29
30	V	27	EMP BEN - S AARON		" "		2,148	2,148	30
31	V	27	EMP BEN - E MARYLES		" "		467	467	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 31,465	$ * 31,465	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: 01/01/2015 Ending: 12/31/2015

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	WILLOW CREST NURSING PAVILION	SANDWICH				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: 01/01/2015 Ending: 12/31/2015

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	4.98	9.96	SALARY	$ 24,910	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIVE		ATTACHED	5.68	11.35	SALARY	28,382	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL			4.98		SALARY	10,437	21-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE			9		SALARY	1,100	17-1	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIVE			9		SALARY	4,200	21-7	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIVE			7.1	14.19	SALARY	20,939	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			5.68		SALARY	8,426	6-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.35		SALARY	804	21-7	8
9	DANIEL AARON		ADMINISTRATIVE			15.27	38.16	SALARY	24,442	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 123,640		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: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	407,367	13	$ 10,618	$	48,203	$ 1,256	1
2	6	REPAIR & MAINT.	PATIENT DAYS	407,367	13	78,675	35,168	48,203	9,310	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	407,367	13	2,289		48,203	271	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,367	13	30,482		48,203	3,607	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	407,367	13	27,992		48,203	3,312	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,367	13	914,524	670,657	48,203	108,214	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,367	13	26,915		48,203	3,185	7
8	25	AUTO EXPENSE	PATIENT DAYS	407,367	13	22,263		48,203	2,634	8
9	26	INSURANCE	PATIENT DAYS	407,367	13	31,386		48,203	3,714	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	407,367	13	138,888		48,203	16,434	10
11	30	DEPRECIATION	PATIENT DAYS	407,367	13	25,822		48,203	3,055	11
12	32	INTEREST	PATIENT DAYS	407,367	13	21,500		48,203	2,544	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,367	13	40,240		48,203	4,762	13
14	19	REAL ESTATE TAX PROTEST FEI	PATIENT DAYS	407,367	13			48,203	0	14
15	35	AUTO RENTAL	PATIENT DAYS	407,367	13	109,345		48,203	12,939	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	407,367	13	770		48,203	91	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,481,709	$ 705,825		$ 175,328	25

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	$ 59,373	$ 59,373	6	$ 8,426	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	24,910	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	6	28,382	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	5,500	5,500	9	1,100	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	64,041	64,041	15	24,442	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	133,279	133,279			6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS	40	1	200,000	200,000			7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	15,271	15,271			8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	75,266	75,266			9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	147,459	147,459	7	20,939	10
11	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			11
12	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	10	114,789	114,789	5	14,298	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS	40	1	68,028	68,028			13
14	17	ADMIN COMP - NON OWNER	WGHTD AVG HOURS	45	8	130,998	130,998	6	18,602	14
15	17	ADMIN COMP - NON OWNER - CF	WGHTD AVG HOURS	40	10	195,028	195,028	5	24,292	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	83,832	83,832	5	10,437	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	64,541	64,541	0	804	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,769,405	$ 1,769,405		$ 176,632	25

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	$ 6,168	$	6	$ 875	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	11,514		5	1,434	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,139		6	2,006	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	39,260		9	7,852	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	5,167		15	1,972	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	35,129				6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS	40	1	10,844				7
8	27	EMP BEN - R AARON	WGHTD AVG HOURS	40	1	1,340				8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	27,046				9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,501		7	1,491	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,078				11
12	27	EMP BEN - NON OWNER - V DAVI	WGHTD AVG HOURS	40	10	32,072		5	3,995	12
13	27	EMP BEN - NON OWNER - A CASS	WGHTD AVG HOURS	40	1	5,480				13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	43,223		6	6,138	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	10	24,786		5	3,087	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	17,251		5	2,148	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	37,525		0	467	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,523	$		$ 31,465	25

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$49,218.00		$ 5,722,000	$		5.8500	$ 310,712	1
2	BANK LEUMI		X	MORTGAGE		INTEREST	8,360,000	8,360,000	10/24/20	5.0000	44,122	2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL				775,000	5/1/16		48,324	6
7	BANK LEUMI		X			INTEREST	1,800,000	1,800,000	10/24/20	5.0000	9,500	7
8												8
9	TOTAL Facility Related				$49,218.00		$ 15,882,000	$ 10,935,000			$ 412,658	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 15,882,000	$ 10,935,000			$ 412,658	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: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 383,000	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.)		$ 412,903	2
3. Under or (over) accrual (line 2 minus line 1).		$ 29,903	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 421,000	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.		$ 450,903	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	257,629	8
	2011	338,246	9
	2012	364,663	10
	2013	375,476	11
	2014	412,903	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 2014 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.**

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 412,903.00	$ 412,903.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 412,903.00	$ 412,903.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,650 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$	$ 2,682,080	4
5											5
6											6
7	RELATED PARTY				52,490	1,346	35	1,500	154	33,494	7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		775	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		65,007	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		1,158	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		4,497	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		649	14
15	CARPET INSTALL			1995	1,303	33	39	33		667	15
16	RAIL BUMPER			1995	917	24	39	24		481	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		2,680	17
18	PAINTING WORK			1996	8,400	215	39	215		4,166	18
19	WALL COVERING			1996	1,435	37	39	37		714	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		1,184	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		1,287	21
22	CONDENCING UNIT			1999	3,824	98	39	98		1,632	22
23	DRAPES			1999	5,369	138	39	138		2,262	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		3,609	24
25	DOOR WORK			1999	10,490	269	39	269		4,396	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		2,458	26
27	TILES			2000	8,855	322	27.5	322		4,966	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	153		2,274	28
29	ROD MAIN SEWER			2000	1,100	41	27.5	41		629	29
30	DRAPERIES			2001	2,118		7			2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		4,511	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		5,292	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		19,672	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		4,368	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		3,538	35
36				2003	4,023	134	15	134		3,687	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: 01/01/2015 Ending: 12/31/2015

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	$	$ 797	37
38	COIL	2003	806	29	27.5	29		361	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,808	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		760	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		3,039	41
42	FLOOR COVERING	2004	888	32	27.5	32		367	42
43	CABINETS	2004	2,594	95	27.5	95		1,088	43
44	BOILER	2004	2,574	93	27.5	93		1,066	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		493	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		3,301	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		26,427	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		3,786	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		523	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		8,032	50
51	NETWORK CABLING	2006	855	31	27.5	31		293	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		1,229	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		757	53
54	FANS	2006	1,108	40	27.5	40		378	54
55	DOORS	2006	1,711	62	27.5	62		587	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		14,991	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		1,133	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		8,611	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		1,032	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		6,149	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		9,245	61
62	CONDENSER	2007	1,712	62	27.5	62		525	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		619	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		4,938	64
65	DOORS	2008	1,645	60	27.5	60		447	65
66	BOILER	2008	5,104	185	27.5	185		1,380	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		368	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		3,229	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		10,682	69
70	TOTAL (lines 4 thru 69)		$ 5,703,027	$ 152,810		$ 152,964	$ 154	$ 2,985,407	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: 01/01/2015 Ending: 12/31/2015

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		$ 5,703,027	$ 152,810		$ 152,964	$ 154	$ 2,985,407	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		25,246	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		1,040	3
4	HEATING WORK	2009	9,475	345	27.5	345		2,228	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		2,532	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	608	27.5	608		3,319	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		1,053	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		3,471	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		1,255	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		6,768	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	621	27.5	621		3,390	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		3,330	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		611	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	233	27.5	233		1,272	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		819	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TILE	2010	5,691	207	27.5	207		1,130	16
17	CEILING PIPING	2010	2,825	103	27.5	103		562	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		2,511	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		846	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		497	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		573	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	126	27.5	126		684	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	67	27.5	67		366	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	56	27.5	56		306	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		1,245	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	97	27.5	97		526	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	63	27.5	63		344	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		2,135	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		3,116	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	369	27.5	369		1,643	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		3,709	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		1,948	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS	2011	65,023	2,364	27.5	2,364		10,540	33
34	TOTAL (lines 1 thru 33)		$ 6,153,400	$ 169,188		$ 169,342	$ 154	$ 3,074,422	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: 01/01/2015 Ending: 12/31/2015

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		$ 6,153,400	$ 169,188		$ 169,342	$ 154	$ 3,074,422	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		834	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		5,016	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		959	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		1,351	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		3,032	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		5,769	7
8	FLOORING/TACKBOARD/LIGHT fixtures	2011	2,809	102	27.5	102		456	8
9									9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		41,494	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		35,897	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		80,247	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		25,087	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		24,396	18
19	NURSE STATION	2002	17,320	229	39	229		11,058	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		59,522	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		13,282	21
22	NURSE STATION	2004	27,559	707	39	707		8,101	22
23	CARPET, TILE, WALLCOVERING	2004	42,388		39			42,388	23
24	MODERNIZE ELEVATORS	2007	175,828	4,508	39	4,508		38,130	24
25	WINDOWS	2006	83,000	2,128	39	2,128		16,935	25
26									26
27	DOORS & WINDOWS	2012	4,075	153	27.5	153		527	27
28	PLUMBING WORK	2012	11,639	433	27.5	433		1,493	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	968	27.5	968		3,344	29
30	FLOORING	2012	8,640	306	27.5	306		1,062	30
31	SECURITY SYSTEM WORK	2012	5,130	178	27.5	178		620	31
32	ROOF REPAIR	2012	1,595	51	27.5	51		179	32
33	NURSE CALL SYSTEM WORK	2012	1,488	51	27.5	51		178	33
34	TOTAL (lines 1 thru 33)		$ 7,068,801	$ 191,783		$ 191,937	$ 154	$ 3,495,779	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: 01/01/2015 Ending: 12/31/2015

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		$ 7,068,801	$ 191,783		$ 191,937	$ 154	$ 3,495,779	1
2	CEILING REPAIR	2012	2,145	76	27.5	76		264	2
3	ELECTRIC WORK	2012	2,825	102	27.5	102		353	3
4	HANDRAIL SPACERS	2012	2,800	102	27.5	102		353	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	127	27.5	127		435	5
6	SPRINKLER & SECURITY SYSTEM	2013	13,953	507	27.5	507		1,250	6
7	DOORS & HARDWARE	2013	6,459	235	27.5	235		582	7
8	BATHROOM SINKS, FAUCETS & DRYWALL	2013	15,179	552	27.5	552		1,353	8
9	OFFICE WALL REPAIR	2013	4,383	160	27.5	160		395	9
10	AC REPAIR & ROOF FAN INSTALL	2013	8,750	318	27.5	318		785	10
11	COMPRESSORS, BREAKERS HEAT COIL	2013	21,983	799	27.5	799		1,958	11
12	WALK IN FREEZER REPAIR	2013	1,055	38	27.5	38		88	12
13	FENCE INSTALL	2013	2,800	102	27.5	102		254	13
14	REPAIRED ELEVATOR DOOR ON THE SECOND FLOOR	2014	5,274	192	27.5	192		280	14
15	WATER HEATERS-TWO RAYPAK MVB MODEL	2014	35,148	1,278	27.5	1,278		1,864	15
16	EMERGENCY ROOF INSPECTION & ANALYSIS	2014	11,040	401	27.5	401		585	16
17	PASSENGER ELEVATOR-REPLACE DETECTOR EDGES	2014	2,136	78	27.5	78		114	17
18	WALK IN FREEZER-REPLACEMENT SYSTEM	2014	5,310	193	27.5	193		282	18
19	SECURITY SYSTEM WORK-INSTALLED WIRELESS DOOR,								19
20	REPLACED CAMERA'S AND DOORS	2014	4,610	168	27.5	168		245	20
21	INSTALL 7 EYEWASH STATIONS	2014	5,100	185	27.5	185		270	21
22	1ST FLOOR AIRCONDITION REPAIR	2014	4,050	147	27.5	147		214	22
23	PLUMBING SUPPLIES	2014	2,969	108	27.5	108		157	23
24	GLASS BLOCK AND GLASS DOORS	2014	5,706	207	27.5	207		302	24
25	INSTALLED SPRINKLER & SATELLITE HEADEND SYSTEM	2014	4,057	148	27.5	148		216	25
26	FIRE RATED DOORS & HARDWARE, SVR EXIT DEVICE	2014	6,739	245	27.5	245		357	26
27	RESIDENT BATHROOMS: FLOOR TILES, SINKS, FAUCETS,								27
28	LIGHTING FIXTURES, WALL AND CEILING TITLES	2014	29,926	1,088	27.5	1,088		1,587	28
29	DIETARY ROOM: ICE MELT, TILES, DROP CEILING	2014	2,193	80	27.5	80		116	29
30	DRYWALL FOR PENTHOUSE; STEEL STORAGE SHELVING								30
31	UNIT; FIX WALLPAPER IN BASEMENT	2014	4,098	149	27.5	149		217	31
32	MANSARD METAL ROOF REPAIR	2015	3,960	51	39	51		51	32
33	MAIN OFFICE CORRIDOR WALLCOVERING/HANDRAIL	2015	824	11	39	11		11	33
34	TOTAL (lines 1 thru 33)		$ 7,287,481	$ 199,630		$ 199,784	$ 154	$ 3,510,717	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: 01/01/2015 Ending: 12/31/2015

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 12D, Carried Forward		$ 7,287,481	$ 199,630		$ 199,784	$ 154	$ 3,510,717	1
2	HOT WATER HEATER/BOILER	2015	14,546	186	39	186		186	2
3	BOOSTER HEATER FOR DISHMACHINE & SUPPLIES	2015	3,751	48	39	48		48	3
4	EXHAUST FAN IN MECHANICAL ROOM	2015	12,344	158	39	158		158	4
5	COMPRESSOR 1ST FLOOR AC UNIT/COIL REPAIR	2015	7,055	90	39	90		90	5
6	1 HEAT MUA UNIT	2015	1,354	17	39	17		17	6
7	ROOFTOP EXHAUST VENTILATOR	2015	6,767	87	39	87		87	7
8	NALCO WATER TREATMENT	2015	4,316	55	39	55		55	8
9	5 ROOMS, DEMO FLOOR BASEBOARD, PATCH, PRIME, PAINT,INSTALL VINYL FLOOR, BASEBOARDS								9
10		2015	11,750	151	39	151		151	10
11	3 SECURITY CAMERAS BY ELEVATOR	2015	1,470	19	39	19		19	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	TOTAL (lines 1 thru 33)		$ 7,350,834	$ 200,441		$ 200,595	$ 154	$ 3,511,528	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: 01/01/2015 Ending: 12/31/2015

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	$ 604,036	$ 22,185	$ 57,647	$ 35,462	10 YRS	$ 341,626	71
72	Current Year Purchases	53,784	29,626	2,689	(26,937)	10 YRS	2,689	72
73	Fully Depreciated Assets	316,901				10 YRS	316,901	73
74	RELATED PARTY	31,658	1,266	1,563	297		28,132	74
75	TOTALS	$ 1,006,379	$ 53,077	$ 61,899	$ 8,822		$ 689,348	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			$ 27,889	$ 443	$ 4,404	$ 3,961		$ 22,011	76
77										77
78										78
79										79
80	TOTALS			$ 27,889	$ 443	$ 4,404	$ 3,961		$ 22,011	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)	$ 8,689,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 253,961	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 266,898	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,937	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,222,887	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 4,689 Description:
(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			$	$ 1,486	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,486	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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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
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				126,879		126,879	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	39-2					13,407		13,407	13
14	TOTAL			$		$	$ 140,286		$ 140,286	14

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

STATE OF ILLINOIS

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ 249,052	$ 2,577,896	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 660,000)	2,659,356	2,659,356	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,945	113,865	6
7	Other Prepaid Expenses	49,280	49,280	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,069,633	$ 5,400,397	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,356	13
14	Buildings, at Historical Cost		5,483,213	14
15	Leasehold Improvements, at Historical Cost	1,430,889	2,179,774	15
16	Equipment, at Historical Cost	974,811	1,505,327	16
17	Accumulated Depreciation (book methods)	(1,203,364)	(4,964,632)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe LOAN COSTS NET		95,487	22
23	Other(specify): DEPOSITS	29,509	29,509	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,231,845	$ 4,656,034	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,301,478	$ 10,056,431	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 554,396	$ 565,296	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	775,000	775,000	29
30	Accrued Salaries Payable	379,485	379,485	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,520	37,520	31
32	Accrued Real Estate Taxes(Sch.IX-B)		421,000	32
33	Accrued Interest Payable	3,089	46,833	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			10,160,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,749,490	$ 12,385,134	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,749,490	$ 12,385,134	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,551,988	$ (2,328,703)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,301,478	$ 10,056,431	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,909,101	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(8,022)	3
4	481 A/GAAP DEPRECIATION ADJUSTMENT	92,423	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,993,502	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	754,786	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	(1,196,300)	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)**	$ (441,514)	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)**	$ 2,551,988	24 *

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 10,615,546	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,615,546	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	445,597	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 445,597	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***	892	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 892	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)**	$ 11,062,035	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,346,897	31
32	Health Care	4,160,006	32
33	General Administration	2,929,887	33
	B. Capital Expense		
34	Ownership	1,002,941	34
	C. Ancillary Expense		
35	Special Cost Centers	140,286	35
36	Provider Participation Fee	335,398	36
	D. Other Expenses (specify):		
37	PRIOR PERIOD ADJUSTMENT	391,834	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,307,249	40
41	**Income before Income Taxes (line 30 minus line 40)****	754,786	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 754,786	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,342,128	44
45	Private Pay - Net Inpatient Revenue	1,406,361	45
46	Medicare - Net Inpatient Revenue	3,309,177	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	557,880	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,615,546	49

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

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

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

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

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2,037	2,262	$ 113,466	$ 50.16	1
2	Assistant Director of Nursing	1,981	2,094	91,203	43.55	2
3	Registered Nurses	11,920	13,319	450,288	33.81	3
4	Licensed Practical Nurses	31,573	35,994	1,013,986	28.17	4
5	CNAs & Orderlies	91,908	102,895	1,119,077	10.88	5
6	CNA Trainees					6
7	Licensed Therapist	14,797	15,842	673,077	42.49	7
8	Rehab/Therapy Aides					8
9	Activity Director	9,689	11,153	236,211	21.18	9
10	Activity Assistants	12,218	13,778	125,837	9.13	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	3,975	4,360	98,867	22.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,053	2,391	121,609	50.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,672	12,546	365,419	29.13	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	2,281	2,573	59,159	22.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,104	219,207	$ 4,468,199 *	$ 20.38	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	39,074	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,302	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	832	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 50,208		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR		$ 121,609
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,609

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 265,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 265,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 130,678
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 130,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,699
Unemployment Compensation Insurance	97,355
FICA Taxes	338,820
Employee Health Insurance	285,138
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	32,207
TOTAL (agree to Schedule V, line 22, col.8)	$ 851,219

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	24,975
Health Care Worker Background Check	920
(Indicate # of checks performed)	
Patient Background Checks	240
TRUST/FRANCHISE/CONTRIB/ETC	5,229
MARKETING/ADV/PROMO	50,533
LICENSES/DUES/SUBSCRIPTIONS	30,094
MGMT CO ALLOC	3,312
TRUST/FRANCHISE/CONTRIB/ETC	(5,229)
Less: Public Relations Expense	(0)
Non-allowable advertising	(50,533)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,531

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	3,185
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,185

**See instructions.

Facility Name & ID Number BRIDGEVIEW HLTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:** 01/01/2015 **Ending:** 12/31/2015

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 $10,629**

(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. $ **20,280** 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. $ **335,398**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

(19) 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.

BRIDGEVEIW HEALTHCARE CENTER LTD
PROFESSIONAL FEES
COST REPORT 2015

VENDOR	DESCRIPTION	AMOUNT
KRUPNICK,BOKOR	ACCOUNTING	18,160
MARCUM	ACCOUNTING	1,898
SEE ATTACHED	LEGAL	45,222
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	3,058
LEGAT ARCHITECTS	ARCHITECT CONSULTANT	1,463
PROSPECT RESOURCES	UTILITY PROCUREMENT FEE	438
HEALTH DATA SYS	DATA PROCESSING	7,370
E-HEALTH DATA SOLUTION	DATA PROCESSING	4,758
NATIONAL DATACARE	DATA PROCESSING	3,480
CASAMBA	DATA PROCESSING	3,600
CERNER	DATA PROCESSING	12,178
NTT DATA SOLUTIONS	DATA PROCESSING	21,130
POINTCLICKCARE	DATA PROCESSING	6,538
SPECTRIO	DATA PROCESSING	348
LEAPFROG TECHNOLOGY GROUP	DATA PROCESSING	1,039
		130,678

BRIDGEVIEW HEALTHCARE CENTER,LTD
EQUIPMENT RENTAL
COST REPORT 2015

VENDOR	DESCRIPTION	AMOUNT
AUTOMATIC ICEMAKERS	ICEMAKERS	1,680
CARDMEMBER	TOOL EQUIPMENT RENTAI	580
ECOLAB	DISH MACHINE	1,259
COOK COUNTY COPIER	COPIER	315
SUMMIT FUNDING	CABLE EQUIPMENT	119
	TOTAL	**3,954**