FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CTR

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 01/01/2017 to 12/31/2017 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 HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			7,410	7,410	8
9	SNF/PED					9
10	ICF	17,112	15,642	2,494	35,248	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,112	15,642	9,904	42,658	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.05%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 _____ and days of care provided 5,860

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	137,887	21,758	380,990	540,635		540,635		540,635			1
2	Food Purchase		125,265		125,265		125,265	(1,611)	123,654			2
3	Housekeeping	68,524	19,012		87,536		87,536		87,536			3
4	Laundry	51,163	30,198	72,617	153,978		153,978		153,978			4
5	Heat and Other Utilities			124,506	124,506		124,506	1,349	125,855			5
6	Maintenance	176,360	90,022	151,364	417,746		417,746	73,807	491,553			6
7	Other (specify):*			13,766	13,766		13,766	1,228	14,994			7
8	TOTAL General Services	433,934	286,255	743,243	1,463,432		1,463,432	74,773	1,538,205			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,196,972	164,363	20,266	3,381,601		3,381,601		3,381,601			10
10a	Therapy	488,568	6,262	24,000	518,830		518,830		518,830			10a
11	Activities	272,018	40,051	2,516	314,585		314,585		314,585			11
12	Social Services			2,000	2,000		2,000		2,000			12
13	CNA Training											13
14	Program Transportation			29,906	29,906		29,906		29,906			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,957,558	210,676	114,688	4,282,922		4,282,922		4,282,922			16
	C. General Administration											
17	Administrative	211,999		126,000	337,999		337,999	50,683	388,682			17
18	Directors Fees											18
19	Professional Services			212,651	212,651		212,651	(18,791)	193,860			19
20	Dues, Fees, Subscriptions & Promotions			109,999	109,999		109,999	(43,837)	66,162			20
21	Clerical & General Office Expenses	325,226	45,326	813,592	1,184,144		1,184,144	(626,693)	557,451			21
22	Employee Benefits & Payroll Taxes			876,513	876,513		876,513		876,513			22
23	Inservice Training & Education			3,763	3,763		3,763		3,763			23
24	Travel and Seminar							452	452			24
25	Other Admin. Staff Transportation			18,219	18,219		18,219	4,026	22,245			25
26	Insurance-Prop.Liab.Malpractice			198,244	198,244		198,244	5,427	203,671			26
27	Other (specify):* Admitting	55,129		279,893	335,022		335,022	(215,798)	119,224			27
28	TOTAL General Administration	592,354	45,326	2,638,874	3,276,554		3,276,554	(844,531)	2,432,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,983,846	542,257	3,496,805	9,022,908		9,022,908	(769,758)	8,253,150			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BRIDGEVIEW HEALTH CARE CTR **#0037358** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,325	
	REPAIRS & MAINTENANCE		0	
	OUTSIDE SERVICES-DIETARY		370,665	380,990
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		225	
	CONTRACTED LAUNDRY SERVICES		72,392	72,617
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		27,140	
	ELECTRICITY		50,781	
	WATER		43,927	
	CABLE TV - LOBBY		2,658	
				124,506
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,331	
	PAINTING & DECORATING		2,218	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,763	
	ELEVATOR MAINTENANCE & REPAIR		14,865	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,695	
	FIRE SERVICE		0	
	CONTRACTED BUILDING MAINT.		114,492	
				151,364
7	**OTHER**			
	SCAVENGER		13,766	
	SECURITY SERVICE		0	
				13,766
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	36,000	36,000

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	12,314	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	NURSING PROGRAM CONSULTANT	XVIII B 38-2	743	
	SPECIAL CARE UNIT		7,209	
				20,266
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	24,000	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				24,000
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,516	
				2,516
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,000	
				2,000
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR **#0037358** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		29,906	
				29,906
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	126,000	126,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	115,500	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	97,151	
				212,651
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	48,695	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	19,799	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	26,201	
	LICENSES & PERMITS	XIX F	11,496	
	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	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,890	
	PATIENT BACKGROUND CHECKS	XIX F	918	
				109,999
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		10,275	
	EQUIPMENT REPAIR & MAINTENANCE		44,548	
	OUTSIDE CLERICAL SERVICES		726,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	62	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		27,907	
	MESSENGER SERVICE		0	
	ADMINISTRATIVE & MEETING FEES		4,200	813,592

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	382,594	
	UNEMPLOYMENT COMPENSATION	XIX D	67,497	
	WORKERS COMPENSATION INSURANC	XIX D	106,407	
	HOSPITALIZATION INSURANCE	XIX D	287,679	
	EMPLOYEE BENEFITS - OTHER	XIX D	32,336	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				876,513
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,763	
				3,763
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,219	
				18,219
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		198,244	
				198,244
27	**OTHER**			
	BAD DEBTS	VI 24	279,893	
				279,893

GRAND TOTAL COLUMN 3 OTHER **3,496,805**

BRIDGEVIEW HEALTH CARE CTR
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	125,265
LESS SALES TAX	(1,611)
NET FOOD	123,654
TOTAL PATIENT CENSUS	42,658
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	127,974
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	0
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	0
NET FOOD	123,654
DIVIDE TOTAL MEALS/YEAR	0
COST PER MEAL	#DIV/0!
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**#DIV/0!**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR #0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			104,203	104,203		104,203	172,150	276,353			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,254	28,254		28,254	540,411	568,665			32
33	Real Estate Taxes							475,222	475,222			33
34	Rent-Facility & Grounds			946,240	946,240		946,240	(946,240)				34
35	Rent-Equipment & Vehicles			18,585	18,585		18,585	16,988	35,573			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,097,282	1,097,282		1,097,282	258,531	1,355,813			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,541		156,541		156,541	(665)	155,876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			335,118	335,118		335,118		335,118			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		156,541	335,118	491,659		491,659	(665)	490,994			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,983,846	698,798	4,929,205	10,611,849		10,611,849	(511,892)	10,099,957			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(89,784)	30		9
10	Interest and Other Investment Income	(6,561)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,611)	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	(62)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(19,916)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(279,893)	27		24
25	Fund Raising, Advertising and Promotional	(48,695)	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 SEE PG 5A	(36,517)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (483,039)		$	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)	(28,853)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,853)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (511,892)		37

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

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

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

BRIDGEVIEW HEALTH CARE CTR

ID# 0037358

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (35,917)	21	1
2	MARKETING TRAVEL	(600)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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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**	(36,517)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,611)	0	0	0	0	0	0	0	0	0	0	(1,611)	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	1,349	0	0	0	0	0	0	0	0	1,349	5
6	Maintenance	0	54,513	10,475	8,819	0	0	0	0	0	0	0	73,807	6
7	Other (specify):*	0	0	275	0	953	0	0	0	0	0	0	1,228	7
8	TOTAL General Services	(1,611)	54,513	12,099	8,819	953	0	0	0	0	0	0	74,773	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	(126,000)	0	176,683	0	0	0	0	0	0	0	50,683	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(19,916)	0	1,125	0	0	0	0	0	0	0	0	(18,791)	19
20	Fees, Subscriptions & Promotions	(48,695)	0	4,858	0	0	0	0	0	0	0	0	(43,837)	20
21	Clerical & General Office Expenses	(35,979)	(726,600)	125,659	10,227	0	0	0	0	0	0	0	(626,693)	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	452	0	0	0	0	0	0	0	0	452	24
25	Other Admin. Staff Transportation	(600)	0	4,626	0	0	0	0	0	0	0	0	4,026	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,427	0	0	0	0	0	0	0	0	5,427	26
27	Other (specify):*	(279,893)	0	19,999	0	44,096	0	0	0	0	0	0	(215,798)	27
28	TOTAL General Administration	(385,083)	(852,600)	162,146	186,910	44,096	0	0	0	0	0	0	(844,531)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(386,694)	(798,087)	174,245	195,729	45,049	0	0	0	0	0	0	(769,758)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(89,784)	258,145	3,789	0	0	0	0	0	0	0	0	172,150	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,561)	544,652	2,320	0	0	0	0	0	0	0	0	540,411	32
33	Real Estate Taxes	0	471,008	4,214	0	0	0	0	0	0	0	0	475,222	33
34	Rent-Facility & Grounds	0	(946,240)	0	0	0	0	0	0	0	0	0	(946,240)	34
35	Rent-Equipment & Vehicles	0	0	16,988	0	0	0	0	0	0	0	0	16,988	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(96,345)	327,565	27,311	0	0	0	0	0	0	0	0	258,531	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	(665)	0	0	0	0	0	0	0	0	(665)	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	(665)	0	0	0	0	0	0	0	0	(665)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(483,039)	(470,522)	200,891	195,729	45,049	0	0	0	0	0	0	(511,892)	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 126,000	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (126,000)	1
2	V	21	BOOKKEEPING SREVICE	726,600	DYNAMIC HEALTHCARE CONSULTANTS	100.00%		(726,600)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	946,240	BRIDGEVIEW ASSOCIATES LLC	100.00%		(946,240)	7
8	V	30	DEPRECIATION		BRIDGEVIEW ASSOCIATES LLC	100.00%	258,145	258,145	8
9	V	32	AMORTIZATION		BRIDGEVIEW ASSOCIATES LLC	100.00%	19,421	19,421	9
10	V	32	INTEREST		BRIDGEVIEW ASSOCIATES LLC	100.00%	525,231	525,231	10
11	V	33	REAL ESTATE TAX		BRIDGEVIEW ASSOCIATES LLC	100.00%	471,008	471,008	11
12	V	6	MAINTENANCE		BRIDGEVIEW ASSOCIATES LLC	100.00%	54,513	54,513	12
13	V								13
14	Total			$ 1,798,840			$ 1,328,318	$ * (470,522)	14

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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%	$ 1,349	$ 1,349	15
16	V	6	REPAIR & MAINT. - SALARIES		" "		4,090	4,090	16
17	V	6	REPAIR & MAINT. - OTHER		" "		6,385	6,385	17
18	V	7	EMP BEN-GEN SERV		" "		275	275	18
19	V	19	PROFESSIONAL FEES		" "		786	786	19
20	V	20	DUES AND SUBSCRIPTION		" "		4,858	4,858	20
21	V	21	CLERICAL & GENERAL - SALARIES		" "		89,635	89,635	21
22	V	21	CLERICAL & GENERAL - GENERAL		" "		36,024	36,024	22
23	V	24	SEMINARS AND TRAVEL		" "		452	452	23
24	V	25	AUTO EXPENSE		" "		4,626	4,626	24
25	V	26	INSURANCE		" "		5,427	5,427	25
26	V	27	EMP. BEN. - GEN, ADMIN.		" "		19,999	19,999	26
27	V	30	DEPRECIATION		" "		3,789	3,789	27
28	V	32	INTEREST		" "		2,320	2,320	28
29	V	33	REAL ESTATE TAXES		" "		4,214	4,214	29
30	V	19	REAL ESTATE TAX PROTEST FEES		" "		339	339	30
31	V	35	AUTO RENTAL				16,291	16,291	31
32	V	35	EQUIPMENT RENTAL				697	697	32
33	V								33
34	V								34
35	V	39	ANCILARY	6,016	LIFESCAN LAB		5,351	(665)	35
36	V	14	ANCILARY	1,039	LIFELINE AMBULANCE		1,039		36
37	V								37
38	V								38
39	Total			$ 7,055			$ 207,946	$ * 200,891	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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%	$ 8,819	$ 8,819	15
16	V	17	ADMIN COMP - M MAUER		" "		26,181	26,181	16
17	V	17	ADMIN COMP - M AARON		" "		30,233	30,233	17
18	V	17	ADMIN COMP - F AARON		" "		500	500	18
19	V	17	ADMIN COMP - D AARON		" "		10,295	10,295	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		" "		22,348	22,348	24
25	V	17	ADMIN COMP - HOWARD ALTER		" "				25
26	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		17,517	17,517	26
27	V	17	ADMIN COMP - NON OWNER - A CASSATA		" "				27
28	V	17	ADMIN COMP - NON OWNER		" "		38,186	38,186	28
29	V	17	ADMIN COMP - NON OWNER - CFO		" "		31,423	31,423	29
30	V	21	CLERICAL COMP - S AARON		" "		10,162	10,162	30
31	V	21	CLERICAL COMP - E MARYLES		" "		65	65	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 195,729	$ * 195,729	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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%	$ 953	$ 953	15
16	V	27	EMP BEN - M MAUER		" "		4,929	4,929	16
17	V	27	EMP BEN - M AARON		" "		6,285	6,285	17
18	V	27	EMP BEN - F AARON		" "		8,509	8,509	18
19	V	27	EMP BEN - D AARON		" "		1,041	1,041	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		" "		1,738	1,738	24
25	V	27	EMP BEN - HOWARD ALTER		" "				25
26	V	27	EMP BEN - NON OWNER - V DAVIS		" "		4,698	4,698	26
27	V	27	EMP BEN - NON OWNER - A CASSATA		" "				27
28	V	27	EMP BEN - NON OWNER		" "		10,371	10,371	28
29	V	27	EMP BEN - NON OWNER - CFO		" "		3,631	3,631	29
30	V	27	EMP BEN - S AARON		" "		2,429	2,429	30
31	V	27	EMP BEN - E MARYLES		" "		465	465	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 45,049	$ * 45,049	39

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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						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 HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	5.24	10.47	SALARY	$ 26,181	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIVE		ATTACHED	6.05	15.12	SALARY	30,233	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL			5.24	13.09	SALARY	10,162	21-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE			9		SALARY	42,000	21-1	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIVE					SALARY	107,796	17-1	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIVE			6.05	15.12	SALARY	22,348	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			6.05	15.12	SALARY	88	6-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.37	1.31	SALARY	65	21-7	8
9	DANIEL AARON		ADMINISTRATIVE			5.38	13.45	SALARY	10,295	17-1	9
10											10
11											11
12											12
13								TOTAL	$ 249,168		13

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	371,884	10	$ 10,844	$	46,247	$ 1,349	1
2	6	REPAIR & MAINT. - SALARY	PATIENT DAYS	371,884	10	32,891	32,891	46,247	4,090	2
3	6	REPAIR & MAINT. - OTHER	PATIENT DAYS	371,884	10	51,340		46,247	6,385	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	371,884	10	2,209		46,247	275	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	371,884	10	6,316		46,247	786	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	371,884	10	39,064		46,247	4,858	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	371,884	10	720,780	720,780	46,247	89,635	7
8	21	CLERICAL & GENERAL - OTHER	PATIENT DAYS	371,884	10	289,675		46,247	36,024	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	371,884	10	3,633		46,247	452	9
10	25	AUTO EXPENSE	PATIENT DAYS	371,884	10	37,201		46,247	4,626	10
11	26	INSURANCE	PATIENT DAYS	371,884	10	43,644		46,247	5,428	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	371,884	10	160,819		46,247	19,999	12
13	30	DEPRECIATION	PATIENT DAYS	371,884	10	30,466		46,247	3,789	13
14	32	INTEREST	PATIENT DAYS	371,884	10	18,656		46,247	2,320	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	371,884	10	33,889		46,247	4,214	15
16	19	REAL ESTATE TAX PROTEST FE	PATIENT DAYS	371,884	10	2,725		46,247	339	16
17	35	AUTO RENTAL	PATIENT DAYS	371,884	10	130,997		46,247	16,291	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	371,884	10	5,607		46,247	697	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,620,756	$ 753,671		$ 201,557	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	7	$ 58,337	$ 58,337	6	$ 8,819	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	26,181	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000	200,000	6	30,233	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500	9	500	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	11	76,541	76,541	5	10,295	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	101,000	101,000			6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS							7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	61,541	61,541			8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	71,909	71,909			9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	147,753	147,753	6	22,348	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	9	133,816	133,816	5	17,517	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS							13
14	17	ADMIN COMP - NON OWNER	WGHTD AVG HOURS	45	7	252,333	252,333	7	38,186	14
15	17	ADMIN COMP - NON OWNER - CF	WGHTD AVG HOURS	40	9	240,048	240,048	5	31,423	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	77,614	77,614	5	10,162	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	5,000	5,000	0	65	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,640,392	$ 1,640,392		$ 195,729	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	7	$ 6,305	$	6	$ 953	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	37,655		5	4,929	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	7	41,575		6	6,285	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	42,544		9	8,509	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	11	7,737		5	1,041	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,621				6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS							7
8	27	EMP BEN - R AARON	WGHTD AVG HOURS	40	1	27,046				8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	28,711				9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	40	7	11,492		6	1,738	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,095				11
12	27	EMP BEN - NON OWNER - V DAVI	WGHTD AVG HOURS	40	9	35,890		5	4,698	12
13	27	EMP BEN - NON OWNER - A CASS	WGHTD AVG HOURS							13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	7	68,533		7	10,371	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	9	27,736		5	3,631	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	9	18,548		5	2,429	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	35,535		0	465	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 428,023	$		$ 45,049	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK LEUMI		X	MORTGAGE	INTEREST		$ 8,360,000	$ 8,360,000	10/24/20	5.0000	$ 448,981	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL				500,000			28,254	6
7	BANK LEUMI		X		INTEREST		1,800,000	1,800,000	10/24/20	5.0000	76,250	7
8												8
9	TOTAL Facility Related						$ 10,160,000	$ 10,660,000			$ 553,485	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,160,000	$ 10,660,000			$ 553,485	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 440,000	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.)		$ 455,222	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,222	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 460,000	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.		$ 475,222	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	364,663	8
	2013	375,476	9
	2014	412,903	10
	2015	427,103	11
	2016	455,222	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 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	$ 451,008.32	$ 451,008.32
2.			$	$
3.		RELATED PARTY	$	$ 4,214.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 451,008.32	$ 455,222.32

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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				55,166	1,414		1,576	162	38,353	7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	26	31.5	32	6	839	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715	70	15		(70)	2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,193	31.5	2,718	525	70,443	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	41	31.5	51	10	1,260	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		4,915	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		713	14
15	CARPET INSTALL			1995	1,303	33	39	33		733	15
16	RAIL BUMPER			1995	917	24	39	24		529	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		2,954	17
18	PAINTING WORK			1996	8,400	215	39	215		4,596	18
19	WALL COVERING			1996	1,435	37	39	37		788	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		1,312	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		1,431	21
22	CONDENCING UNIT			1999	3,824	98	39	98		1,828	22
23	DRAPES			1999	5,369	138	39	138		2,538	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		4,047	24
25	DOOR WORK			1999	10,490	269	39	269		4,934	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		2,756	26
27	TILES			2000	8,855	229	27.5	322	93	5,610	27
28	ELEVATOR REPAIR			2000	4,240	109	27.5	153	44	2,580	28
29	ROD MAIN SEWER			2000	1,100	26	27.5	41	15	711	29
30	DRAPERIES			2001	2,118	54	7		(54)	2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		5,205	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		6,106	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		22,732	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		5,040	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		4,106	35
36				2003	4,023	134	15	134		3,955	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$	$ 925	37
38	COIL	2003	806	29	27.5	29		419	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		2,098	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		882	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		3,527	41
42	FLOOR COVERING	2004	888	32	27.5	32		431	42
43	CABINETS	2004	2,594	95	27.5	95		1,278	43
44	BOILER	2004	2,574	93	27.5	93		1,252	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		579	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		3,875	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		31,023	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		4,510	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		623	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		9,568	50
51	NETWORK CABLING	2006	855	31	27.5	31		355	51
52	COOLING TOWER REPAIR - per audit (2,500)	2006	1,065	130	27.5	130		1,489	52
53	RANGE GUARD SYSTEM - per audit (2,200)	2006		80	27.5	80		917	53
54	FANS - per audit (1,108)	2006		40	27.5	40		458	54
55	DOORS - per audit (1,711)	2006		62	27.5	62		711	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		18,147	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		1,401	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		10,647	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		1,276	59
60	CABLING OF BUILDING - per audit (1,2918)	2007	7,082	727	27.5	727		7,603	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		11,431	61
62	CONDENSER - per audit (1,712)	2007		62	27.5	62		649	62
63	ELEVATOR REPAIRS - per audit (2,275)	2008		83	27.5	83		785	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		6,262	64
65	DOORS - per audit (1,645)	2008		60	27.5	60		567	65
66	BOILER	2008	5,104	185	27.5	185		1,750	66
67	DISH TV EQUIPMENT - per audit (1,575)	2009		57	27.5	57		482	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		4,229	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		13,990	69
70	TOTAL (lines 4 thru 69)		$ 5,678,059	$ 152,309		$ 153,040	$ 731	$ 3,032,066	70

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 5,678,059	$ 152,309		$ 153,040	$ 731	$ 3,032,066	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		33,064	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		1,362	3
4	HEATING WORK	2009	9,475	345	27.5	345		2,918	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		3,316	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR - p	2010	14,072	608	27.5	608		4,535	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		1,439	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		4,743	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		1,715	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		9,248	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF - per audit (1	2010	15,715	621	27.5	621		4,632	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		4,550	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		835	13
14	PACH PARKING LOT IN THE BACK OF BUILDING - per audi	2010	4,000	233	27.5	233		1,738	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		1,119	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TIL	2010	5,691	207	27.5	207		1,544	16
17	CEILING PIPING	2010	2,825	103	27.5	103		768	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		3,431	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		1,156	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		679	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		783	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM - pe	2010		126	27.5	126		936	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM - per audit (1,850)	2010		67	27.5	67		500	23
24	REHAB ROOM - ELECTRIC WORK - per audit (1,546)	2010		56	27.5	56		418	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		1,701	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	97	27.5	97		720	26
27	AIR CONDITIONING SYSTEM REPAIR - per audit (1,735)	2010		63	27.5	63		470	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		3,093	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		4,514	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	369	27.5	369		2,381	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		5,373	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		2,822	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS - pe	2011	61,018	2,364	27.5	2,364		15,268	33
34	TOTAL (lines 1 thru 33)		$ 6,109,420	$ 168,687		$ 169,418	$ 731	$ 3,153,837	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 6,109,420	$ 168,687		$ 169,418	$ 731	$ 3,153,837	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		1,208	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		7,266	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		1,389	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		1,957	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		4,392	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		8,357	7
8	FLOORING/TACKBOARD/LIGHT fixtures	2011	2,809	102	27.5	102		660	8
9									9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		43,214	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		37,385	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		83,573	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		26,127	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		25,408	18
19	NURSE STATION	2002	17,320	229	39	229		11,516	19
20	ASPHALT PAVING	2002	57,615	4,409	15		(4,409)	57,615	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		13,832	21
22	NURSE STATION	2004	27,559	707	39	707		9,515	22
23	CARPET, TILE, WALLCOVERING	2004	42,388		39			42,388	23
24	MODERNIZE ELEVATORS	2007	175,828	4,508	39	4,508		47,146	24
25	WINDOWS	2006	83,000	2,128	39	2,128		21,191	25
26									26
27	DOORS & WINDOWS	2012	4,075	153	27.5	153		833	27
28	PLUMBING WORK	2012	11,639	433	27.5	433		2,359	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	968	27.5	968		5,280	29
30	FLOORING	2012	8,640	306	27.5	306		1,674	30
31	SECURITY SYSTEM WORK	2012	5,130	178	27.5	178		976	31
32	ROOF REPAIR	2012	1,595	51	27.5	51		281	32
33	NURSE CALL SYSTEM WORK	2012	1,488	51	27.5	51		280	33
34	TOTAL (lines 1 thru 33)		$ 7,024,821	$ 191,282		$ 187,604	$ (3,678)	$ 3,609,659	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 7,024,821	$ 191,282		$ 187,604	$ (3,678)	$ 3,609,659	1
2	CEILING REPAIR	2012	2,145	76	27.5	76		416	2
3	ELECTRIC WORK	2012	2,825	102	27.5	102		557	3
4	HANDRAIL SPACERS	2012	2,800	102	27.5	102		557	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	127	27.5	127		689	5
6	SPRINKLER & SECURITY SYSTEM	2013	13,953	507	27.5	507		2,264	6
7	DOORS & HARDWARE	2013	6,459	235	27.5	235		1,052	7
8	BATHROOM SINKS, FAUCETS & DRYWALL	2013	15,179	552	27.5	552		2,457	8
9	OFFICE WALL REPAIR	2013	4,383	160	27.5	160		715	9
10	AC REPAIR & ROOF FAN INSTALL	2013	8,750	318	27.5	318		1,421	10
11	COMPRESSORS, BREAKERS HEAT COIL	2013	21,983	799	27.5	799		3,556	11
12	WALK IN FREEZER REPAIR	2013	1,055	38	27.5	38		164	12
13	FENCE INSTALL	2013	2,800	102	27.5	102		458	13
14	REPAIRED ELEVATOR DOOR ON THE SECOND FLOOR	2014	5,274	192	27.5	192		664	14
15	WATER HEATERS-TWO RAYPAK MVB MODEL	2014	35,148	1,278	27.5	1,278		4,420	15
16	EMERGENCY ROOF INSPECTION & ANALYSIS	2014	11,040	401	27.5	401		1,387	16
17	PASSENGER ELEVATOR-REPLACE DETECTOR EDGES	2014	2,136	78	27.5	78		270	17
18	WALK IN FREEZER-REPLACEMENT SYSTEM	2014	5,310	193	27.5	193		668	18
19	SECURITY SYSTEM WORK-INSTALLED WIRELESS DOOR,								19
20	REPLACED CAMERA'S AND DOORS	2014	4,610	168	27.5	168		581	20
21	INSTALL 7 EYEWASH STATIONS	2014	5,100	185	27.5	185		640	21
22	1ST FLOOR AIRCONDITION REPAIR	2014	4,050	147	27.5	147		508	22
23	PLUMBING SUPPLIES	2014	2,969	108	27.5	108		373	23
24	GLASS BLOCK AND GLASS DOORS	2014	5,706	207	27.5	207		716	24
25	INSTALLED SPRINKLER & SATELLITE HEADEND SYSTEM	2014	4,057	148	27.5	148		512	25
26	FIRE RATED DOORS & HARDWARE, SVR EXIT DEVICE	2014	6,739	245	27.5	245		847	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		3,763	28
29	DIETARY ROOM: ICE MELT, TILES, DROP CEILING	2014	2,193	80	27.5	80		276	29
30	DRYWALL FOR PENTHOUSE; STEEL STORAGE SHELVING								30
31	UNIT; FIX WALLPAPER IN BASEMENT	2014	4,098	149	27.5	149		515	31
32	MANSARD METAL ROOF REPAIR	2015	3,960	102	39	102		255	32
33	MAIN OFFICE CORRIDOR WALLCOVERING/HANDRAIL	2015	824	21	39	21		53	33
34	TOTAL (lines 1 thru 33)		$ 7,243,501	$ 199,190		$ 195,512	$ (3,678)	$ 3,640,413	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 7,243,501	$ 199,190		$ 195,512	$ (3,678)	$ 3,640,413	1
2	HOT WATER HEATER/BOILER	2015	14,546	373	39	186	(187)	558	2
3	BOOSTER HEATER FOR DISHMACHINE & SUPPLIES	2015	3,751	96	39	48	(48)	144	3
4	EXHAUST FAN IN MECHANICAL ROOM	2015	12,344	316	39	158	(158)	474	4
5	COMPRESSOR 1ST FLOOR AC UNIT/COIL REPAIR	2015	7,055	181	39	90	(91)	270	5
6	1 HEAT MUA UNIT	2015	1,354	35	39	17	(18)	51	6
7	ROOFTOP EXHAUST VENTILATOR	2015	6,767	174	39	87	(87)	261	7
8	NALCO WATER TREATMENT	2015	4,316	111	39	55	(56)	165	8
9	5 ROOMS, DEMO FLOOR BASEBOARD, PATCH, PRIME, PAINT,INSTALL VINYL FLOOR, BASEBOARDS								9
10		2015	11,750	301	39	151	(150)	453	10
11	3 SECURITY CAMERAS BY ELEVATOR	2015	1,470	38	39	19	(19)	57	11
12	SECURITY CAMERAS, DOOR OPENER	2016	1,665	40	39	40		80	12
13	FLOORING	2016	6,158	132	39	132		264	13
14	ELEVATOR ELECTRONIC DETECTOR EDGE	2016	2,136	46	39	46		92	14
15	CUBICLE CURTAINS, PICTURES, MIRRORS	2016	6,238	23	39	23		46	15
16	FIRE DOOR	2016	358	5	39	5		10	16
17	AIR HANDLER/DUCT WORK	2016	17,531	160	39	160		320	17
18	ROOF REPAIR	2016	3,080	46	39	46		92	18
19	FLOORING 1ST - 3RD FLOOR	2016	26,991	88	39	88		176	19
20	FENCING	2016	9,114	101	15	101		202	20
21	RESIDENT BATHROOMS TILE, DRYWALL, PAINT	2016	34,181	114	39	114		228	21
22	OVERBED LIGHTS	2016	9,330	28	39	28		56	22
23	WALL GUARDS	2016	8,741	12	39	12		24	23
24	3rd FLOOR PATIENT RMS, BATHROOMS-FLOORING, WALLS FIXTURES								24
25		2017	15,240		39	391	391	391	25
26	FENCING	2017	9,084		15	606	606	606	26
27	BASEMENT FLOORING, WALL REPAIR	2017	509		39	13	13	13	27
28	AC REPAIR,STARTER MOTOR, COMPRESSOR	2017	11,710		39	300	300	300	28
29	ELEVATOR DOOR OPERATOR	2017	8,395		39	215	215	215	29
30	LANDLORD								30
31	3rd FLOOR PATIENT RMS, BATHROOMS-FLOORING, WALLS FIXTURES								31
32		2017	257,688		39	6,607	6,607	6,607	32
33	ASBESTOR REMOVEL	2017	40,745		39	1,045	1,045	1,045	33
34	TOTAL (lines 1 thru 33)		$ 7,775,748	$ 201,610		$ 206,295	$ 4,685	$ 3,653,613	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 12E, Carried Forward		$ 7,775,748	$ 201,610		$ 206,295	$ 4,685	$ 3,653,613	1
2	LANDLORD CONTINUED								2
3	3RD FLOOR CORRIDOR, DINING RM, DON OFFICE, THERAPY RM - FLOORING, WALLPAPER, CORNER GUARDS, MILLWORK								3
4		2017	82,867		39	2,125	2,125	2,125	4
5	PARKING LOT SEALING	2017	6,800		15	453	453	453	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				162,153			(162,153)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,865,415	$ 363,763		$ 208,873	$ (154,890)	$ 3,656,191	34

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 619,067	$	$ 59,570	$ 59,570	10	$ 358,837	71
72	Current Year Purchases	109,405		5,470	5,470	10	5,470	72
73	Fully Depreciated Assets	1,126,159					423,027	73
74		33,271	490	891	401		31,744	74
75	TOTALS	$ 1,887,902	$ 490	$ 65,931	$ 65,441		$ 819,078	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			$ 36,815	$ 1,884	$ 1,549	$ (335)		$ 29,310	76
77										77
78										78
79										79
80	TOTALS			$ 36,815	$ 1,884	$ 1,549	$ (335)		$ 29,310	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)	$ 10,094,132	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 366,137	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 276,353	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (89,784)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,504,579	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 12,787 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		G37 INFINITI	$ 459.50	$ 5,798	17
18					18
19					19
20					20
21	TOTAL		$ 459.50	$ 5,798	21

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

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
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				129,569		129,569	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): Med Supplies, Lab	39-2					26,972		26,972	13
14	TOTAL			$		$	$ 156,541		$ 156,541	14

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR **#** 0037358 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 152,600	$ 1,765,201	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (840,000))	1,178,943	1,178,943	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,964	139,964	6
7	Other Prepaid Expenses	47,500	47,500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,519,007	$ 3,131,608	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	1,595,241	2,732,225	15
16	Equipment, at Historical Cost	1,151,501	1,854,633	16
17	Accumulated Depreciation (book methods)	(1,399,761)	(5,576,318)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		97,105	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(40,460)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	30,110	30,110	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,377,091	$ 4,907,864	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,896,098	$ 8,039,472	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 584,498	$ 584,498	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	509,255	509,255	29
30	Accrued Salaries Payable	274,840	274,840	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,969	10,969	31
32	Accrued Real Estate Taxes(Sch.IX-B)		460,000	32
33	Accrued Interest Payable	2,009	40,759	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,381,571	$ 1,880,321	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,796,977	39
40	Mortgage Payable		8,360,000	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)**	$	$ 10,156,977	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,381,571	$ 12,037,298	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,514,527	$ (3,997,826)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,896,098	$ 8,039,472	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,286,015	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(8,041)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,277,974	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(398,647)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(364,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (763,447)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,514,527	24 *

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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 10,210,122	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,210,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,348	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,348	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***	6,561	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,561	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,479,031	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,463,432	31
32	Health Care	4,282,922	32
33	General Administration	3,276,554	33
	B. Capital Expense		
34	Ownership	1,097,282	34
	C. Ancillary Expense		
35	Special Cost Centers	156,541	35
36	Provider Participation Fee	335,118	36
	D. Other Expenses (specify):		
37	PRIOR EXPENSE	265,829	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,877,678	40
41	**Income before Income Taxes (line 30 minus line 40)****	(398,647)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (398,647)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,175,484	44
45	Private Pay - Net Inpatient Revenue	1,622,974	45
46	Medicare - Net Inpatient Revenue	2,405,713	46
47	Other-(specify) INSURANCE	5,951	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,210,122	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.**

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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	2,238	2,022	$ 118,539	$ 58.62	1
2	Assistant Director of Nursing	2,185	2,020	94,922	46.99	2
3	Registered Nurses	10,114	9,130	361,791	39.63	3
4	Licensed Practical Nurses	39,686	35,584	1,196,277	33.62	4
5	CNAs & Orderlies	99,112	92,323	1,305,837	14.14	5
6	CNA Trainees					6
7	Licensed Therapist	10,945	10,402	488,568	46.97	7
8	Rehab/Therapy Aides					8
9	Activity Director	6,508	5,889	143,579	24.38	9
10	Activity Assistants	12,615	12,014	128,439	10.69	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	985	977	22,723	23.26	13
14	Head Cook	3,016	2,976	41,419	13.92	14
15	Cook Helpers/Assistants	5,962	5,864	73,745	12.58	15
16	Dishwashers					16
17	Maintenance Workers	5,795	5,357	176,360	32.92	17
18	Housekeepers	6,640	6,538	68,524	10.48	18
19	Laundry	4,730	4,651	51,163	11.00	19
20	Administrator	2,243	2,087	104,203	49.93	20
21	Assistant Administrator	2,139	1,922	107,796	56.09	21
22	Other Administrative					22
23	Office Manager	799	712	25,172	35.35	23
24	Clerical	12,910	11,477	300,054	26.14	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	2,018	1,682	50,769	30.18	31
32	Other Health C: Social Svc Director	2,171	1,831	68,837	37.60	32
33	Other(specify) Admissions Direct	2,073	1,958	55,129	28.16	33
34	TOTAL (lines 1 - 33)	234,884	217,416	$ 4,983,846 *	$ 22.92	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	$ 10,325	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	743	10-3	38
39	Pharmacist Consultant	H	12,314	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		24,000	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,516	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) Social Worker Consul	S	2,000	12-3	46
47	Special Care Unit Consultant		7,209	10-3	47
48	Nursing Program Consultant		743	10-3	48
49	TOTAL (lines 35 - 48)		$ 95,850		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR		$ 104,203
FRED AARON	ASST ADMIN		107,796
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 211,999

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 126,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 126,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		212,651
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 212,651

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,407
Unemployment Compensation Insurance	67,497
FICA Taxes	382,594
Employee Health Insurance	287,679
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	32,336
TOTAL (agree to Schedule V, line 22, col.8)	$ 876,513

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	19,799
Health Care Worker Background Check	2,890
(Indicate # of checks performed)	
Patient Background Checks	918
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	48,695
LICENSES/DUES/SUBSCRIPTIONS	35,707
MGMT CO ALLOC	4,858
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(48,695)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,162

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
MGMT CO ALLOC	452
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 452

* Attach copy of IMRF notifications

**See instructions.

BRIDGEVIEW HEALTH CARE CTR
Legal Fee Schedule

DATE	NAME	DESCRIPTION	AMOUNT
2/1/2017	MUCH SHELIST	GENERAL COUNSELING	462.00
3/1/2017	MUCH SHELIST	GENERAL COUNSELING	246.50
4/1/2017	MUCH SHELIST	GENERAL COUNSELING	1,463.00
5/1/2017	MUCH SHELIST	GENERAL COUNSELING	1,051.50
6/26/2017	MUCH SHELIST	GENERAL COUNSELING	350.00
7/1/2017	MUCH SHELIST	GENERAL COUNSELING	437.12
8/1/2017	MUCH SHELIST	GENERAL COUNSELING	968.50
9/1/2017	MUCH SHELIST	GENERAL COUNSELING	2,049.50
10/1/2017	MUCH SHELIST	GENERAL COUNSELING	1,410.59
11/1/2017	MUCH SHELIST	GENERAL COUNSELING	800.59
12/1/2017	MUCH SHELIST	GENERAL COUNSELING	1,023.00
1/1/2018	MUCH SHELIST	GENERAL COUNSELING	790.50
1/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,131.31
2/28/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,697.85
3/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,487.49
4/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	3,073.13
5/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,499.61
6/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,129.52
7/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	827.20
8/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	68.14
9/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	288.92
10/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	598.58
11/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	644.57
12/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,728.38
3/3/2017	SIDNEY R. BERGER	COLLECTIONS	2,420.00
4/1/2017	SIDNEY R. BERGER	COLLECTIONS	1,187.57
1/31/2017	SIMANDL LAW GROUP	COLLECTIONS	134.00
2/28/2017	SIMANDL LAW GROUP	FACILITY AUDITS	31.92
7/12/2017	VON BRIESEN & ROPER	LABOR AND EMPLOYMENT	335.00
8/15/2017	VON BRIESEN & ROPER	GENERAL LITIGATION	6,324.00
9/14/2017	VON BRIESEN & ROPER	GENERAL LITIGATION	68.00
10/17/2017	VON BRIESEN & ROPER	GENERAL LITIGATION	167.50
11/13/2017	VON BRIESEN & ROPER	LABOR AND EMPLOYMENT	780.00
11/20/2017	VON BRIESEN & ROPER	GENERAL LITIGATION	268.00
12/18/2017	VON BRIESEN & ROPER	GENERAL LITIGATION	1,038.50
12/18/2017	VON BRIESEN & ROPER	LABOR AND EMPLOYMENT	442.00
6/21/2017	BANK LEUMI USA	LOAN COUNSEL FEES	1,800.00
			42,223.99

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC $15,152**

(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? _____

(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. $ **24,335** 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. $ **335,118**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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