

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0048819

Facility Name: Bridgeway Christian Village Rehab & SNF

Address: 111 East Washington St. Bensenville 60106
Number City Zip Code

County: Du Page

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

HFS ID Number:

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

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code	501c3	☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Susan McGhee Telephone Number: 314-587-7903
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2010 to June 30, 2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	Susan McGhee	
	(Title)	Chief Financial Officer	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Chad D. Kunze, CPA Principal	
	(Firm Name & Address)	LarsonAllen LLP 600 Washington Avenue, Suite 1800, St. Louis, MO 63101	
	(Telephone)	314-925-4321	Fax # 314-925-4350
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>222</u>	Skilled (SNF)	<u>222</u>	<u>81,020</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>222</u>	TOTALS	<u>222</u>	<u>81,020</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,209</u>	<u>11,743</u>	<u>15,891</u>	<u>59,843</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,209</u>	<u>11,743</u>	<u>15,891</u>	<u>59,843</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.86%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Emergency maint. And Chaplain services provided for independent living residents

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 7/1/2007

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/30/07 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 222 and days of care provided 14,039

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2010 Ending: June 30, 2011
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	563,305	57,600	56,818	677,723		677,723		677,723			1
2	Food Purchase		453,359		453,359		453,359	(23,729)	429,630			2
3	Housekeeping	249,001	35,982	187,016	471,999		471,999		471,999			3
4	Laundry	17,815	348		18,163		18,163		18,163			4
5	Heat and Other Utilities			460,915	460,915		460,915	3,706	464,621			5
6	Maintenance	244,170	18,199	135,149	397,518		397,518	(2,207)	395,311			6
7	Other (specify):*											7
8	TOTAL General Services	1,074,291	565,488	839,898	2,479,677		2,479,677	(22,230)	2,457,447			8
	B. Health Care and Programs											
9	Medical Director			59,104	59,104		59,104		59,104			9
10	Nursing and Medical Records	5,042,523	495,052	106,778	5,644,353		5,644,353	(14,747)	5,629,606			10
10a	Therapy			1,555,921	1,555,921		1,555,921		1,555,921			10a
11	Activities	150,706	16,155	6,258	173,119		173,119		173,119			11
12	Social Services	185,139	3,746	6,414	195,299		195,299		195,299			12
13	CNA Training											13
14	Program Transportation			801	801		801		801			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,378,368	514,953	1,735,276	7,628,597		7,628,597	(14,747)	7,613,850			16
	C. General Administration											
17	Administrative	118,388		822,482	940,870		940,870	(699,834)	241,036			17
18	Directors Fees											18
19	Professional Services			48,941	48,941		48,941	44,420	93,361			19
20	Dues, Fees, Subscriptions & Promotions			27,546	27,546		27,546	10,352	37,898			20
21	Clerical & General Office Expenses	338,810	33,548	145,492	517,850		517,850	198,407	716,257			21
22	Employee Benefits & Payroll Taxes			1,288,697	1,288,697		1,288,697	64,499	1,353,196			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,973	12,973		12,973	20,671	33,644			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			142,696	142,696		142,696	(28,233)	114,463			26
27	Other (specify):* Marketing	70,502	13,255	25,299	109,056		109,056	(109,056)				27
28	TOTAL General Administration	527,700	46,803	2,514,126	3,088,629		3,088,629	(498,774)	2,589,855			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,980,359	1,127,244	5,089,300	13,196,903		13,196,903	(535,751)	12,661,152			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			529,030	529,030		529,030	(54,194)	474,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			523,637	523,637		523,637	(103,981)	419,656			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			67,150	67,150		67,150	8,377	75,527			35
36	Other (specify):*											36
37	TOTAL Ownership			1,119,817	1,119,817		1,119,817	(149,798)	970,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			781,066	781,066		781,066	(76,204)	704,862			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			902,611	902,611		902,611	(76,204)	826,407			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,980,359	1,127,244	7,111,728	15,219,331		15,219,331	(761,753)	14,457,578			45

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

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	(31,644)	2		4
5	Telephone, TV & Radio in Resident Rooms	(33,727)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	7,367	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,100)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,251)	21		24
25	Fund Raising, Advertising and Promotional	(109,056)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(253,482)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (502,893)		\$	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)	(258,860)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (258,860)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (761,753)		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

Report Period Beginning: ID# 0048819

Ending: July 1, 2010

June 30, 2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Miscellaneous	\$ (14,747)	10	1
2	Office Space Rental - Interest Expense	(112,656)	32	2
3	Office Space Rental - Insurance	(30,000)	26	3
4	Office Space Rental - Depreciation	(91,428)	30	4
5	Charity Care	(12,566)	21	5
6	Vending Revenue	7,915	2	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(253,482)		49

Summary B

June 30, 2011

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing of Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 3,706	\$ 3,706	1
2	V	6	Maintenance				31,520	31,520	2
3	V	17	Administration	822,482			122,648	(699,834)	3
4	V	19	Professional Services				44,420	44,420	4
5	V	21	Clerical				293,324	293,324	5
6	V	22	Employee Benefits				64,499	64,499	6
7	V	24	Travel and Seminar				20,671	20,671	7
8	V	26	Insurance				1,767	1,767	8
9	V	30	Depreciation				37,234	37,234	9
10	V	32	Interest				1,308	1,308	10
11	V	20	Dues and Subscriptions				10,352	10,352	11
12	V	35	Rental and Leasing				8,377	8,377	12
13	V	39	Pharmacy Services	772,082	Senior Care Pharmacy	0.00%	695,878	(76,204)	13
14	Total			\$ 1,594,564			\$ 1,335,704	\$ * (258,860)	14

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
Hours						Percent	Description	Amount			
1	This workpaper is not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF # 0048819 Report Period Beginning: July 1, 2010 Ending: ne 30, 2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	Illinois Finance Authority		X	Purchase Facility		6/30/07	\$ 9,736,678	\$ 9,481,307		0.0567	\$ 523,637	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 9,736,678	\$ 9,481,307			\$ 523,637	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 9,736,678	\$ 9,481,307			\$ 523,637	15

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006		8	
	2007		9	
	2008		10	
	2009		11	
	2010		12	

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bridgeway Christian Village Rehab & SNF COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0048819

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>N/A</u>	<u>N/A</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,352

B. General Construction Type: Exterior Brick Frame Steel and Wood Number of Stories 1

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

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

D. Does the Operating Entity? ☒ (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Home Office Allocation			\$ 11,362	1
2					2
3	TOTALS			\$ 11,362	3

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	222		2007	1975	\$ 5,013,500	\$ 200,540	25	\$ 200,540	\$	\$ 902,430	4
5											5
6											6
7											7
8	Home Office Allocation				117,468	7,580		7,580		269,786	8
	Improvement Type**										
9	2007 Fixed Asset			2007	16,737	3,049	Various	3,049		13,417	9
10	Floors for coolers & freezers			2008	4,874	487	10	487		1,624	10
11	Eldercare Interiors Project-Professional			2008	4,678	234	20	234		721	11
12	Oxygen Storage Room-General contracting			2008	1,389	69	20	69		214	12
13	Professional Architectural Services			2008	32,518	1,626	20	1,626		5,013	13
14	Prep walls for painting-Southeast wing			2008	13,275	664	20	664		2,047	14
15	(12) 9500 BTU cooling units			2008	16,680	1,668	10	1,668		5,143	15
16	B-Wing and Therapy renovations,			2008	846,416	42,321	20	42,321		130,489	16
17	Engineer Consulting Services-			2008	48,790	2,440	20	2,440		7,522	17
18	MTR Universal Fusion Tilt Wall Mount			2008	2,071	207	10	207		638	18
19	(29) Duett Standard toilet tissue			2008	559	56	10	56		172	19
20	2 Cisco IP telephone 48 port voice over			2008	20,505	2,050	10	2,050		6,322	20
21	Countertops, cabinets, shelves			2008	20,848	1,042	20	1,042		3,214	21
22	Nurse Call System			2008	16,842	842	20	842		2,596	22
23	Install 10 cable lines and straighten			2008	5,243	524	10	524		1,616	23
24	Site survey, hydraulic calculations			2008	925	93	10	93		286	24
25	Install new windows, reglaze windows			2008	2,200	220	10	220		678	25
26	Fitting-Outdoor water main-parking lot			2008	6,866	343	20	343		1,058	26
27	Resurface doors			2008	9,800	980	10	980		3,022	27
28	Surface mounted cabinets			2008	1,840	92	20	92		284	28
29	Carpet & Installation			2008	158,638	15,864	10	15,864		48,914	29
30	Sentronics device & room signs			2008	1,543	154	10	154		475	30
31	(60) Replacement escutcheon for			2008	1,174	59	20	59		181	31
32	SnackShop ceiling & countertop			2008	3,120	156	20	156		481	32
33	Cabinets & set of tops			2008	930	46	20	46		143	33
34	Trace all resident cables to main closet			2008	9,701	970	10	970		2,991	34
35	Programming & Schematic Phase			2008	7,467	373	20	373		1,151	35
36	Landscaping, lay new sod			2008	1,728	173	10	173		533	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Exterior lights	2008	\$ 12,440	\$ 1,244	10	\$ 1,244	\$	\$ 3,732	37
38 Courtyard wallpacks work	2008	5,400	540	10	540		1,575	38
39 Roof- Downpayment & north end	2008	97,254	4,863	20	4,863		13,778	39
40 Blower Assembly - Lobby	2008	6,799	680	10	680		1,813	40
41 A wing - Exterior wall repairs	2008	6,950	695	10	695		1,853	41
42 Ejector pump	2009	9,100	910	10	910		2,275	42
43 Cabling - C Wing	2009	2,423	242	10	242		565	43
44 Watermain	2009	4,595	460	10	460		1,034	44
45 Heat Exchange for Boiler	2009	11,586	1,159	10	1,159		2,414	45
46 Replace Water Main	2009	14,220	1,422	10	1,422		2,726	46
47 Repaving Project	2009	284,445	35,556	8	35,556		68,148	47
48 Roof	2009	126,783	12,678	10	12,678		21,131	48
49 Parking Lot Light Pole	2010	1,960	196	10	196		278	49
50 Painting Supplies	2010	4,090	409	10	409		511	50
51 Door Elopement System	2010	7,500	750	10	750		938	51
52 Wallcovering/Wallpaper	2010	14,775	1,477	10	1,477		1,847	52
53 Rail, Ceiling, & Light Fixtures	2010	24,968	2,497	10	2,497		3,121	53
54 Ceiling Tile	2010	148,277	14,828	10	14,828		18,535	54
55 Door Alarm System	2010	7,000	700	10	700		875	55
56 31 TV's and Wall Brackets	2010	15,422	1,542	10	1,542		1,928	56
57 Carpeting	2010	21,034	2,103	10	2,103		2,629	57
58 5 Gallons of Paint & Masking Tape	2010	469	47	10	47		59	58
59 Architectural Drawings	2010	2,400	240	10	240		300	59
60 Caulk & Shelving	2010	441	44	10	44		55	60
61 Beds & Mattresses	2010	15,608	1,561	10	1,561		1,951	61
62 Ceiling Fixtures	2010	1,593	159	10	159		199	62
63 Paint 2 Rooms & Wallpaper	2010	2,170	217	10	217		271	63
64 25 Brass Lamps & Bulbs	2010	1,950	195	10	195		244	64
65 Wallpaper Border for 23 Rooms	2010	3,682	368	10	368		460	65
66 HVAC Vents Lobby	2010	5,850	585	10	585		731	66
67 Sheet Floor C-Wing Foyer	2010	6,695	670	10	670		837	67
68 Door	2010	3,550	355	10	355		444	68
69 Lobby Trac Light	2010	650	65	10	65		81	69
70 TOTAL (lines 4 thru 69)		\$ 7,260,404	\$ 374,379		\$ 374,379	\$	\$ 1,570,500	70

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,260,404	\$ 374,379		\$ 374,379	\$	\$ 1,570,500	1
2	Chappel 8 Light Fixtures	2010	3,200	320	10	320		400	2
3	Chappel HVAC Steam Vent & Drain	2010	1,900	190	10	190		238	3
4	Lobby Bay Light	2010	800	80	10	80		100	4
5	Rubber Base	2010	1,750	175	10	175		219	5
6	Remove/Install Drywall, Door, Handrails, Crash Boards, Windows	2010	39,640	3,964	10	3,964		4,955	6
7	Furniture for 23 Rooms	2010	8,743	874	10	874		1,093	7
8	31 Wingback Chairs & Freight for 3 Drawer Chests	2010	14,771	1,477	10	1,477		1,846	8
9	Blinds, Borders, & Wallcoverings	2010	8,176	818	10	818		1,022	9
10	Patch Walls/Drywall	2010	876	88	10	88		110	10
11	Dining Eating Area	2010	20,959	2,096	10	2,096		2,620	11
12	Emergency Power Nurses Station	2010	3,970	397	10	397		496	12
13	Handrails, Crash Rail Demo, Suspended Ceiling, Room Outlet Reloc	2010	59,119	5,912	10	5,912		7,390	13
14	Emergency Outlets End Hallway	2010	970	97	10	97		121	14
15	TV Outlet Dining Room & Cable	2010	500	50	10	50		63	15
16	Rubber Base	2010	2,500	250	10	250		313	16
17	Crown Molding Dining Area	2010	1,200	120	10	120		150	17
18	Sign	2010	1,478	148	10	148		185	18
19	Vertical Blinds	2010	1,679	168	10	168		210	19
20	Mini-Blinds, Draperies, & Furniture for Lobby	2010	28,324	2,832	10	2,832		3,540	20
21	37 Custom Bedspreads	2010	6,433	643	10	643		804	21
22	Freezer Door for Main Kitchen	2010	2,563	256	10	256		320	22
23	Wheelchairs	2010	5,074	507	10	507		634	23
24	Automatic Door Therapy Gym	2010	2,889	289	10	289		361	24
25	Door Operator Therapy Room	2010	1,915	192	10	192		239	25
26	Fire Door	2010	1,650	165	10	165		206	26
27	Boiler Feed System	2010	2,038	204	10	204		255	27
28	6 Beds	2010	4,477	448	10	448		560	28
29	30 Gallon Tilting Skillet	2010	12,191	1,219	10	1,219		1,524	29
30	10 Beds, Panels, & Rails	2010	13,471	1,347	10	1,347		1,684	30
31	Boelter	2010	3,993	399	10	399		499	31
32	30 Microwaves	2010	870	87	10	87		109	32
33	30 Compact Refrigerators	2010	3,000	300	10	300		375	33
34	TOTAL (lines 1 thru 33)		\$ 7,521,521	\$ 400,491		\$ 400,491	\$	\$ 1,603,139	34

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

Facility Name & ID Number Bridgeway Christian Village Rehab & SNF

0048819

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 7,521,521	\$ 400,491		\$ 400,491	\$	\$ 1,603,139	1
2 Batteries for Lifts	2010	1,088	109	10	109		136	2
3 14 Hi-Low Beds	2010	8,667	867	10	867		1,083	3
4 Lifts for Units	2010	3,530	353	10	353		441	4
5 6 Heat Pumps	2010	6,870	687	10	687		859	5
6 PTAC Units	2010	8,460	846	10	846		1,058	6
7 C-Wing Nurse Call Station Power Board	2010	3,400	312	10	312		312	7
8 E-Wing Basement Door	2010	3,430	314	10	314		314	8
9 HVAC Unit	2010	5,116	469	10	469		469	9
10 Circulating Pumps for Main Boiler	2010	8,690	507	10	507		507	10
11 Carpeting	2010	2,068	121	10	121		121	11
12 Roof - Unit B	2010	143,143	11,929	10	11,929		11,929	12
13 Roof Exhaust Fans	2011	2,026	34	10	34		34	13
14 Trane Chiller	2011	79,400	662	10	662		662	14
15 Room 1405 - Carpet	2011	2,253	19	10	19		19	15
16 Men's Public Restroom	2011	17,600	147	10	147		147	16
17 Women's Public Restroom	2011	17,175	143	10	143		143	17
18 Architectural Consulting for Life Safety	2011	1,473	25	10	25		25	18
19 Seal & Stripe Parking Lot	2011	19,550	7,331	2	7,331		7,331	19
20 Front Entrance - Sidewalks	2011	20,045	167	10	167		167	20
21 2011 Landscaping	2011	18,700	156	10	156		156	21
22 Brick Wall	2011	4,165	35	10	35		35	22
23 Memorial Garden - Landscaping	2011	9,580	80	10	80		80	23
24 Office Space Rental			(91,428)		(91,428)			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)		\$ 7,907,950	\$ 334,373		\$ 334,373	\$	\$ 1,629,165	34

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

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	\$ 682,363	\$ 103,996	\$ 103,996	\$	Various	\$ 309,288	71
72	Current Year Purchases	75,987	6,990	6,990		Various	6,990	72
73	Fully Depreciated Assets	22,177	57	57		Various	22,177	73
74	Home Office Allocation	556,927	35,940	35,940			61,795	74
75	TOTALS	\$ 1,337,454	\$ 146,983	\$ 146,983	\$		\$ 400,250	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	Home Office Allocation			\$ 68,743	\$ 4,436	\$ 4,436	\$		\$ 28,787	76
77										77
78										78
79										79
80	TOTALS			\$ 68,743	\$ 4,436	\$ 4,436	\$		\$ 28,787	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,325,509	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 485,792	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 485,792	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,058,202	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2005 Chevy Silverado, acquired in 2007	\$ 20,708	\$	\$ 20,708	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 20,708	\$	\$ 20,708	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 108,600	92
93			93
94			94
95		\$ 108,600	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.

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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

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: \$ 67,150
- Description:
- See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ NO

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

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

Bridgeway Christian Village does not train C N A's. They hire them already certified.

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		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	10a-3	hrs	\$	11,718	\$ 617,504	\$	11,718	\$ 617,504	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,997	164,321		3,997	164,321	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		20,251	774,096		20,251	774,096	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	35,966	\$ 1,555,921	\$	35,966	\$ 1,555,921	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.

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	\$ 4,234,686	\$	1
2	Cash-Patient Deposits	66,658		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 105,316)	1,238,206		3
4	Supply Inventory (priced at)	24,804		4
5	Short-Term Investments			5
6	Prepaid Insurance	183		6
7	Other Prepaid Expenses	14,193		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corp, and Other	77,895		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,656,625	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,396,718		14
15	Leasehold Improvements, at Historical Cost	393,764		15
16	Equipment, at Historical Cost	801,235		16
17	Accumulated Depreciation (book methods)	(1,718,542)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	67,750		21
22	Other Long-Term Assets (spe Deferred Fin Costs	43,784		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,984,709	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,641,334	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 317,147	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,658		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	679,810		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	67,750		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	37,289		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,168,654	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,481,307		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,481,307	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,649,961	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,991,373	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,641,334	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 777,808	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 777,808	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,213,564	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,213,565	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)	\$ 1,991,373	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Bridgeway Christian Village Rehab & SNF**# **0048819**Report Period Beginning: **July 1, 2010**Ending: **June 30, 2011**

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,742,573	1
2	Discounts and Allowances for all Levels	(6,661,311)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,081,262	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,696,989	6
7	Oxygen	36,116	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,733,105	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	1,600	13
14	Non-Patient Meals	31,644	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,200	16
17	Sale of Drugs	1,128,319	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	125,903	19
20	Radiology and X-Ray	49,043	20
21	Other Medical Services	244,926	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,584,635	23
	D. Non-Operating Revenue		
24	Contributions	37,654	24
25	Interest and Other Investment Income***	(7,367)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,287	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending and Miscellaneous Income	3,606	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,606	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,432,895	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,479,677	31
32	Health Care	7,628,597	32
33	General Administration	3,088,629	33
	B. Capital Expense		
34	Ownership	1,119,817	34
	C. Ancillary Expense		
35	Special Cost Centers	781,066	35
36	Provider Participation Fee	121,545	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,219,331	40
41	Income before Income Taxes (line 30 minus line 40)**	1,213,564	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,213,564	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	5,482	6,116	\$ 300,117	\$ 49.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	50,325	54,195	1,974,252	36.43	3
4	Licensed Practical Nurses	27,742	29,667	670,666	22.61	4
5	CNAs & Orderlies	140,151	149,825	1,742,772	11.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,848	2,080	46,850	22.52	9
10	Activity Assistants	8,243	8,895	103,856	11.68	10
11	Social Service Workers	7,878	8,344	185,139	22.19	11
12	Dietician					12
13	Food Service Supervisor	6,243	6,738	158,373	23.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,047	38,388	404,932	10.55	15
16	Dishwashers					16
17	Maintenance Workers	11,552	12,517	244,170	19.51	17
18	Housekeepers	21,376	23,272	249,001	10.70	18
19	Laundry	1,747	1,906	17,815	9.35	19
20	Administrator	2,008	2,080	118,388	56.92	20
21	Assistant Administrator					21
22	Other Administrative	2,940	3,198	85,515	26.74	22
23	Office Manager	1,984	2,080	45,125	21.69	23
24	Clerical	9,778	10,564	166,236	15.74	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	7,496	8,097	114,389	14.13	31
32	Other Health Care: MDS Coordinator	6,729	7,367	240,327	32.62	32
33	Other(specify) Marketing Beautician	4,212	4,418	112,436	25.45	33
34	TOTAL (lines 1 - 33)	353,781	379,747	\$ 6,980,359 *	\$ 18.38	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	887	\$ 41,377	ln 1, col 3	35
36	Medical Director	720	59,104	ln 9, col 3	36
37	Medical Records Consultant	12	720	ln 10, col 3	37
38	Nurse Consultant	35	2,172	ln 10, col 3	38
39	Pharmacist Consultant	216	5,833	ln 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	55	4,108	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,925	\$ 113,314		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount		
John Hurley	Administrator	0	\$ 118,388	Workers' Compensation Insurance		\$ 146,388	IDPH License Fee	\$ 15,175		
				Unemployment Compensation Insurance		56,072	Advertising: Employee Recruitment			
				FICA Taxes		508,090	Health Care Worker Background Check			
				Employee Health Insurance		483,816	(Indicate # of checks performed _____)			
				Employee Meals			Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*			License	1,765		
				Employee Physicals		21,595	Dues	9,963		
				Employee Uniforms		(2,891)	Subscriptions	587		
				Employee Expense		68,002	Miscellaneous (See Attachment)	56		
				457 Plan Expense		7,625	Home Office Allocation	10,352		
				Home Office Allocation		64,499	Less: Public Relations Expense	()		
							Non-allowable advertising	()		
							Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 118,388	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 37,898	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)						
Description			Amount							
Management Fee Expense			\$ 822,482							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 822,482							
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
Davis & Campbell	Legal Services		\$ 27,754	N/A		\$	Out-of-State Travel	\$ 2,504		
Receivable Management Services	Collection Services		225							
My Innerview	Satisfaction Survey		1,712							
Management Resources	Placement Services		19,250				In-State Travel	7,935		
							Seminar Expense	2,534		
							Home Office Allocation	20,671		
							Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			(agree to Sch. V, line 24, col. 8)			\$ 33,644

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$6,862; AAHSA - \$2,767

(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? 5 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 88,789 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. \$ 121,545
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 31,644

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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? None
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP

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

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.