

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0037358</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>BRIDGEVIEW HEALTH CARE CTR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> 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.																							
Address: <u>8100 S HARLEM AVE</u> <u>BRIDGEVIEW</u> <u>60455</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>SANFORD BOKOR</u> and Title) <u>PRESIDENT</u></td></tr><tr><td>(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	Paid Preparer	(Date) _____	(Print Name <u>SANFORD BOKOR</u> and Title) <u>PRESIDENT</u>	(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>10/02/91</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR# 0037358 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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>97</u>	Skilled (SNF)	<u>97</u>	<u>35,502</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,934</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>146</u>	TOTALS	<u>146</u>	<u>53,436</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>5,765</u>	<u>5,765</u>	8
9	SNF/PED					9
10	ICF	<u>33,207</u>	<u>8,948</u>		<u>42,155</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,207</u>	<u>8,948</u>	<u>5,765</u>	<u>47,920</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.68%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. 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 10/2/91

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

YES ☐

Date _____

NO ☒

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

YES ☒NO ☐If YES, enter number
of beds certified 97 and days of care provided 5,765Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

	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		7,452	601,767	609,219		609,219		609,219		1
2	Food Purchase		2,711		2,711		2,711	(1,484)	1,227		2
3	Housekeeping		23,558	180,591	204,149		204,149		204,149		3
4	Laundry		10,277	132,355	142,632		142,632		142,632		4
5	Heat and Other Utilities			123,800	123,800		123,800	1,364	125,164		5
6	Maintenance	111,801	62,150	35,294	209,245		209,245	19,852	229,097		6
7	Other (specify):*			10,332	10,332		10,332	1,100	11,432		7
8	TOTAL General Services	111,801	106,148	1,084,139	1,302,088		1,302,088	20,832	1,322,920		8
	B. Health Care and Programs										
9	Medical Director			2,100	2,100		2,100		2,100		9
10	Nursing and Medical Records	2,516,985	121,059	10,515	2,648,559		2,648,559		2,648,559		10
10a	Therapy	403,146	1,928	92,813	497,887		497,887		497,887		10a
11	Activities	283,022	16,747	816	300,585		300,585		300,585		11
12	Social Services			421	421		421		421		12
13	CNA Training										13
14	Program Transportation			11,955	11,955		11,955		11,955		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,203,153	139,734	118,620	3,461,507		3,461,507		3,461,507		16
	C. General Administration										
17	Administrative	137,958		234,000	371,958		371,958	(78,725)	293,233		17
18	Directors Fees										18
19	Professional Services			68,688	68,688		68,688	(9,069)	59,619		19
20	Dues, Fees, Subscriptions & Promotions			94,394	94,394		94,394	(64,297)	30,097		20
21	Clerical & General Office Expenses	261,414	40,811	552,559	854,784		854,784	(429,018)	425,766		21
22	Employee Benefits & Payroll Taxes			679,206	679,206		679,206		679,206		22
23	Inservice Training & Education			11,989	11,989		11,989		11,989		23
24	Travel and Seminar							3,154	3,154		24
25	Other Admin. Staff Transportation			18,567	18,567		18,567	(615)	17,952		25
26	Insurance-Prop.Liab.Malpractice			223,084	223,084		223,084	7,606	230,690		26
27	Other (specify):*			52,146	52,146		52,146	(12,836)	39,310		27
28	TOTAL General Administration	399,372	40,811	1,934,633	2,374,816		2,374,816	(583,800)	1,791,016		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,714,326	286,693	3,137,392	7,138,411		7,138,411	(562,968)	6,575,443		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 PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	0	
	REPAIRS & MAINTENANCE	0	
	CONTRACTED DIETARY SERVICES	601,767	601,767
3	HOUSEKEEPING		
	CONTRACTED HOUSEKEEPING SERVICES	180,591	
		0	180,591
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	6,270	
	CONTRACTED LAUNDRY SERVICES	126,085	132,355
5	HEAT & OTHER UTILITIES		
	GAS HEAT	30,838	
	ELECTRICITY	52,778	
	WATER	40,184	
	CABLE TV - LOBBY	0	
		0	123,800
6	MAINTENANCE		
	GROUNDS MAINTENANCE	6,279	
	PAINTING & DECORATING	1,679	
	BUILDING REPAIRS	0	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	13,418	
	ELEVATOR MAINTENANCE & REPAIR	9,343	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	4,575	
	FIRE SERVICE	0	
		0	
		0	
		0	
		0	35,294
7	OTHER		
	SCAVENGER	10,332	
	SECURITY SERVICE	0	
		0	
		0	10,332
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,100	2,100

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	9,250	
	UTILIZATION REVIEW FEES XVIII B -2	0	
	PHYSICIANS XVIII B -2	0	
	PSYCHIATRIC XVIII B -2	0	
	RN CONSULTANT XVIII B 38-2	125	
	SPECIAL CARE UNIT	1,140	
		0	10,515
10a	THERAPY		
	PHYSICAL THERAPY SERVICES	536	
	SPEECH THERAPY SERVICES	92,277	
	OCCUPATIONAL THERAPY SERVICES	0	
	REHABILITATION CONSULTANT XVIII B -2	0	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0	
			92,813
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS	0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	816	
		0	816
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES	0	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0	
	SOCIAL WORKER XVIII B 45-2	421	
			421
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS XIII	0	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	11,955	11,955
		0	
17	ADMINISTRATIVE		
	MANAGEMENT FEES XIX B	234,000	234,000
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	24,776	
	ADMINISTRATIVE CONSULTANTS XIX C	0	
	PROFESSIONAL FEES XIX C	43,912	
		0	68,688
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	64,147	
	EMPLOYEE WANT ADS XIX F	3,367	
	CONTRIBUTIONS VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS XIX F	19,872	
	LICENSES & PERMITS XIX F	4,498	
	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	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,510	
	PATIENT BACKGROUND CHECKS XIX F	0	
			94,394
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	13,455	
	EQUIPMENT REPAIR & MAINTENANCE	24,580	
	OUTSIDE CLERICAL SERVICES	493,700	
	PENALTIES / OVERDRAFT CHARGES VI 18	0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	20,824	
	MESSENGER SERVICE	0	
		0	552,559

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES XIX D	289,093	
	UNEMPLOYMENT COMPENSATION XIX D	75,747	
	WORKERS COMPENSATION INSURANC XIX D	106,964	
	HOSPITALIZATION INSURANCE XIX D	182,525	
	EMPLOYEE BENEFITS - OTHER XIX D	24,877	
	EMPLOYEE PHYSICAL EXAMS XIX D	0	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS XIX D	0	
	CHICAGO HEAD TAX XIX D	0	
		0	679,206
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	11,989	
			11,989
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G	0	
	TRAVEL XIX G	0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	18,567	
			18,567
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	223,084	
			223,084
27	OTHER		
	BAD DEBTS VI 24	52,146	
			52,146

GRAND TOTAL COLUMN 3 OTHER

3,137,392

BRIDGEVIEW HEALTH CARE CTR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	2,711
LESS SALES TAX	(1,484)
NET FOOD	<u>1,227</u>
TOTAL PATIENT CENSUS	47,920
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	143,760
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	143,760
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	143,760
NET FOOD	1,227
DIVIDE TOTAL MEALS/YEAR	<u>143,760</u>
COST PER MEAL	0.01
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

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			87,919	87,919		87,919	160,083	248,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,362	38,362		38,362	302,191	340,553			32
33	Real Estate Taxes			420,246	420,246		420,246	4,412	424,658			33
34	Rent-Facility & Grounds			489,240	489,240		489,240	(489,240)				34
35	Rent-Equipment & Vehicles			8,765	8,765		8,765	11,293	20,058			35
36	Other (specify):*											36
37	TOTAL Ownership			1,044,532	1,044,532		1,044,532	(11,261)	1,033,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		158,206	795	159,001		159,001		159,001			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			336,411	336,411		336,411		336,411			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		158,206	337,206	495,412		495,412		495,412			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,714,326	444,899	4,519,130	8,678,355		8,678,355	(574,229)	8,104,126			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	9,526	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,484)	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		21		18
19	Entertainment		20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(10,733)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,146)	27		24
25	Fund Raising, Advertising and Promotional	(64,147)	20		25
	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	(15,253)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (135,267)		\$	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)	(438,962)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (438,962)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (574,229)		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

STATE OF ILLINOIS
BRIDGEVIEW HEALTH CARE CTR

Page 5A

Report Period Beginning: ID# 0037358
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (14,553)	21	1
2	MARKETING TRAVEL	(700)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,253)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,484)	0	0	0	0	0	0	0	0	0	0	(1,484)	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	1,364	0	0	0	0	0	0	0	0	1,364	5
6	Maintenance	0	0	11,714	8,138	0	0	0	0	0	0	0	19,852	6
7	Other (specify):*	0	0	251	0	849	0	0	0	0	0	0	1,100	7
8	TOTAL General Services	(1,484)	0	13,329	8,138	849	0	0	0	0	0	0	20,832	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	(234,000)	0	155,275	0	0	0	0	0	0	0	(78,725)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,733)	0	1,664	0	0	0	0	0	0	0	0	(9,069)	19
20	Fees, Subscriptions & Promotions	(65,147)	0	850	0	0	0	0	0	0	0	0	(64,297)	20
21	Clerical & General Office Expenses	(14,553)	(493,700)	68,627	10,608	0	0	0	0	0	0	0	(429,018)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,154	0	0	0	0	0	0	0	0	3,154	24
25	Other Admin. Staff Transportation	(700)	0	85	0	0	0	0	0	0	0	0	(615)	25
26	Insurance-Prop.Liab.Malpractice	0	7,606	0	0	0	0	0	0	0	0	0	7,606	26
27	Other (specify):*	(52,146)	0	13,238	0	26,072	0	0	0	0	0	0	(12,836)	27
28	TOTAL General Administration	(143,279)	(720,094)	87,618	165,883	26,072	0	0	0	0	0	0	(583,800)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(144,763)	(720,094)	100,947	174,021	26,921	0	0	0	0	0	0	(562,968)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,526	147,113	3,444	0	0	0	0	0	0	0	0	160,083	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	298,180	4,041	0	0	0	0	0	0	0	0	302,191	32
33	Real Estate Taxes	0	0	4,412	0	0	0	0	0	0	0	0	4,412	33
34	Rent-Facility & Grounds	0	(489,240)	0	0	0	0	0	0	0	0	0	(489,240)	34
35	Rent-Equipment & Vehicles	0	0	11,293	0	0	0	0	0	0	0	0	11,293	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,496	(43,947)	23,190	0	0	0	0	0	0	0	0	(11,261)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(135,267)	(764,041)	124,137	174,021	26,921	0	0	0	0	0	0	(574,229)	45

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.

☒ 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	17	MANAGEMENT FEES	\$ 234,000			\$	\$ (234,000)	1
2	V	21	BOOKKEEPING SERVICES	493,700				(493,700)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	489,240				(489,240)	7
8	V	30	DEPRECIATION				147,113	147,113	8
9	V	32	AMORTIZATION				1,865	1,865	9
10	V	32	INTEREST				296,315	296,315	10
11	V	26	PROPERTY/BOILER INSURANCE				7,606	7,606	11
12	V								12
13	V								13
14	Total			\$ 1,216,940			\$ 452,899	\$ * (764,041)	14

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

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		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)	
15	V	5	UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 1,364	\$ 1,364	15
16	V	6	REPAIR & MAINT.		" "		11,714	11,714	16
17	V	7	EMP BEN-GEN SERV		" "		251	251	17
18	V	19	PROFESSIONAL FEES		" "		1,664	1,664	18
19	V	20	DUES AND SUBSCRIPTION		" "		850	850	19
20	V	21	CLERICAL & GENERAL		" "		68,627	68,627	20
21	V	24	SEMINARS AND TRAVEL		" "		3,154	3,154	21
22	V	25	AUTO EXPENSE		" "		85	85	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" "		13,238	13,238	23
24	V	30	DEPRECIATION		" "		3,444	3,444	24
25	V	32	INTEREST		" "		4,041	4,041	25
26	V	33	REAL ESTATE TAXES		" "		4,412	4,412	26
27	V	35	EQUIPMENT RENTAL		" "		10,897	10,897	27
28	V	35	EQUIPMENT RENTAL		" "		396	396	28
29	V				" "				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 124,137	\$ * 124,137	39

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

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		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)	
15	V	6	MAINT COMP - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 8,138	\$ 8,138	15
16	V	17	ADMIN COMP - M MAUER		" "		24,390	24,390	16
17	V	17	ADMIN COMP - M AARON		" "		27,707	27,707	17
18	V	17	ADMIN COMP - F AARON		" "		9,400	9,400	18
19	V	17	ADMIN COMP - D AARON		" "		19,325	19,325	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "				20
21	V	17	ADMIN COMP - S HARAMARAS		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		21,091	21,091	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		5,885	5,885	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		25,522	25,522	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		21,955	21,955	26
27	V	21	CLERICAL COMP - S AARON		" "		10,414	10,414	27
28	V	21	CLERICAL COMP - E MARYLES				194	194	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 174,021	\$ * 174,021	39

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

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.

☒ 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)	
15	V	7	EMP BEN - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS		\$ 849	\$ 849	15
16	V	27	EMP BEN - M MAUER		" "		1,323	1,323	16
17	V	27	EMP BEN - M AARON		" "		1,912	1,912	17
18	V	27	EMP BEN - F AARON		" "		7,237	7,237	18
19	V	27	EMP BEN - D AARON		" "		1,567	1,567	19
20	V	27	EMP BEN - S GOLDSTEIN		" "				20
21	V	27	EMP BEN - S HARAMARAS		" "				21
22	V	27	EMP BEN - D KUFTA		" "		1,479	1,479	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "		1,011	1,011	24
25	V	27	EMP BEN - NON OWNER		" "		6,841	6,841	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,749	2,749	26
27	V	27	EMP BEN - S AARON		" "		1,936	1,936	27
28	V	27	EMP BEN - E MARYLES				17	17	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 26,921	\$ * 26,921	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:

01/01/2012

Ending:

12/31/2012

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	GROSS POINTE MANOR LLC	NILES	BRIDGEVIEW ASSOCIATES LLC		BUILDING CO	1
2	MAURICE AARON	19.74	OTTAWA PAVILION LTD	OTTAWA	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	MARSHALL MAUER	12.83	PARK RIDGE CARE CENTER LTD	PARK RIDGE	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	FRED AARON	7.89	STERLING PAVILION LTD	STERLING				4
5	SHIMON GOLDSTEIN	3.94	WARREN PARK HEALTH AND LIVING CEN	CHICAGO				5
6	SHARON AARON	.41	WATERFRONT TERRACE INC	CHICAGO				6
7	CHANA MAUER-RAY	4.44	WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				7
8	DENNIS NEHMER	.41	WOODBIDGE NURSING PAVILION LTD	CHICAGO				8
9	DIANA KUFTA	.41	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				9
10	ESTHER MARYLES	4.44	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				10
11	HOWIE & SUSIE ALTER	.82	WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				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 DISCRETIONARY	6.25						16
17	FEIGE KNOBEL DISCRETIONARY TR	6.25						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

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	12.83	175,610	4.88	9.76	SALARY	\$ 24,390	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIV	19.74	172,293	5.54	11.08	SALARY	27,707	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL	0.41	74,972	4.88	12.20	SALARY	10,414	21-7	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIV	7.89	37,600	9		SALARY	9,400	17-7	4
5	FRED AARON	SHAREHOLDER	ADMINISTRATIV	7.89				SALARY	30,000	17-1	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.41	131,079	6.93	13.85	SALARY	21,091	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.41	50,602	5.54	13.85	SALARY	8,138	6-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL	4.44	15,071	0.36	1.27	SALARY	194	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 131,334		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:

01/01/2012Ending: 2/31/2012

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

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	413,728	13	\$ 11,773	\$	47,920	\$ 1,364	1
2	6	REPAIR & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	47,920	11,714	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	413,728	13	2,165		47,920	251	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		47,920	1,664	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	413,728	13	7,338		47,920	850	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	47,920	68,627	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		47,920	3,154	7
8	25	AUTO EXPENSE	PATIENT DAYS	413,728	13	736		47,920	85	8
9	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	413,728	13	114,290		47,920	13,238	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		47,920	3,444	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		47,920	4,041	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		47,920	4,412	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	94,085		47,920	10,897	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		47,920	396	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,071,756	\$ 456,183		\$ 124,137	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 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	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	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	\$ 58,740	\$ 58,740	6	\$ 8,138	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	5	24,390	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	200,000	200,000	6	27,707	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	47,000	47,000	9	9,400	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	52,765	52,765	15	19,325	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	102,086	102,086			6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	73,867	73,867			7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	152,170	152,170	7	21,091	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	8	117,701	117,701	2	5,885	10
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	45	8	184,393	184,393	6	25,522	11
12	17	ADMIN COMP - NON OWNER - C	WGHTD AVG HOURS	45	10	180,028	180,028	5	21,955	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	85,386	85,386	5	10,414	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	15,265	15,265	0	194	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,481,401	\$ 1,481,401		\$ 174,021	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 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	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	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	\$ 6,127	\$	6	\$ 849	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	10,847		5	1,323	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	13,801		6	1,912	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	36,183		9	7,237	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,278		15	1,567	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,829				6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	23,776				7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,672		7	1,479	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,076				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	8	20,219		2	1,011	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45.01	8	49,423		6	6,841	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,545		5	2,749	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40.01	10	15,870		5	1,936	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	1,340		0	17	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 253,986	\$		\$ 26,921	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	CAMBRIDGE		X	MORTGAGE	\$49,218.18		\$ 5,722,000	\$ 5,334,236	10/41	5.8500	\$ 296,315	1	
2												2	
3												3	
4												4	
5	RELATED PARTY											5	
	Working Capital												
6	BANK LEUMI		X	WORKING CAPITAL				875,000			30,543	6	
7	IMPERIAL CREDIT CORP.		X	INSURANCE FINANCING							1,077	7	
8	PHARMACY		X	FINANCING				100,613			6,742	8	
9	TOTAL Facility Related				\$49,218.18		\$ 5,722,000	\$ 6,309,849			\$ 334,677	9	
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,722,000	\$ 6,309,849			\$ 334,677	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	263,000	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.)			\$	338,246	2
3. Under or (over) accrual (line 2 minus line 1).			\$	75,246	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	345,000	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.			\$	420,246	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 192,639 8			
		2008 204,234 9			
		2009 239,768 10			
		2010 257,629 11			
		2011 338,246 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 2011 TAX BILL.					

FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.

2011 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 BOB KAGDA

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 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	18-36-214-061-0000	NURSING HOME	\$ 338,245.97	\$ 338,245.97
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 338,245.97	\$ 338,245.97

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 53,650 **B. General Construction Type:** Exterior BRICK Frame Number of Stories

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).

N/A

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	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:

01/01/2012 Ending:

12/31/2012

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	\$	\$ 2,290,388	4
5											5
6											6
7											7
8	RELATED PARTY				51,380	1,317	35	1,468	151	28,371	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1991		1,017	32	31.5	32		679	9
10	LEASEHOLD IMPROVEMENTS		1991		2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS		1992		85,574	2,718	31.5	2,718		56,853	11
12	LEASEHOLD IMPROVEMENTS		1993		1,600	51	31.5	51		1,005	12
13	LEASEHOLD IMPROVEMENTS		1994		8,141	209	39	209		3,870	13
14	1ST FLOOR CENTRAL A/C		1995		1,250	32	39	32		553	14
15	CARPET INSTALL		1995		1,303	33	39	33		568	15
16	RAIL BUMPER		1995		917	24	39	24		409	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM		1996		5,320	137	39	137		2,269	17
18	PAINTING WORK		1996		8,400	215	39	215		3,521	18
19	WALL COVERING		1996		1,435	37	39	37		603	19
20	FRONT LOBBY/WINDOW, DOOR WORK		1997		2,509	64	39	64		992	20
21	ELEVATOR REPAIR		1998		2,800	72	39	72		1,071	21
22	CONDENCING UNIT		1999		3,824	98	39	98		1,338	22
23	DRAPES		1999		5,369	138	39	138		1,848	23
24	CARPETING AND VINYL FLOORING		1999		8,540	219	39	219		2,952	24
25	DOOR WORK		1999		10,490	269	39	269		3,589	25
26	KITCHEN CABINETS		1999		5,832	149	39	149		2,011	26
27	TILES		2000		8,855	322	27.5	322		4,000	27
28	ELEVATOR REPAIR		2000		4,240	153	27.5	153		1,815	28
29	ROD MAIN SEWER		2000		1,100	41	27.5	41		506	29
30	DRAPERIES		2001		2,118		7			2,118	30
31	RECEPTION DESK/DOOR		2002		9,534	347	27.5	347		3,470	31
32	FLOORING / BUMPER GUARDS		2002		11,198	407	27.5	407		4,071	32
33	WALLPAPER, BORDER, ARTWORK		2002		42,079	1,530	27.5	1,530		15,082	33
34	WIRING, MOTOR		2002		9,224	336	27.5	336		3,360	34
35	HANDRAILS & GUARDS		2003		7,811	284	27.5	284		2,686	35
36			2003		4,023	134	15	134		3,285	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:

01/01/2012

Ending:

12/31/2012

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	
37	ORIENTATION BOARDS	2003	\$ 1,752	\$ 64	27.5	\$ 64	\$	\$ 605	37
38	COIL	2003	806	29	27.5	29		274	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		1,373	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		577	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		2,307	41
42	FLOOR COVERING	2004	888	32	27.5	32		271	42
43	CABINETS	2004	2,594	95	27.5	95		803	43
44	BOILER	2004	2,574	93	27.5	93		787	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		364	45
46	BRICK MOUNT SIGN	2004	4,317	287	15	287		2,440	46
47	PARKING LOT	2004	34,455	2,298	15	2,298		19,533	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		2,700	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		373	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		5,728	50
51	NETWORK CABLING	2006	855	31	27.5	31		200	51
52	COOLING TOWER REPAIR	2006	3,565	130	27.5	130		839	52
53	RANGE GUARD SYSTEM	2006	2,200	80	27.5	80		517	53
54	FANS	2006	1,108	40	27.5	40		258	54
55	DOORS	2006	1,711	62	27.5	62		401	55
56	LANDSCAPING	2006	23,665	1,578	15	1,578		10,257	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		731	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		5,557	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		666	59
60	CABLING OF BUILDING	2007	20,000	727	27.5	727		3,968	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		5,966	61
62	CONDENSER	2007	1,712	62	27.5	62		339	62
63	ELEVATOR REPAIRS	2008	2,275	83	27.5	83		370	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		2,952	64
65	DOORS	2008	1,645	60	27.5	60		267	65
66	BOILER	2008	5,104	185	27.5	185		825	66
67	DISH TV EQUIPMENT	2009	1,575	57	27.5	57		197	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		1,729	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		5,720	69
70	TOTAL (lines 4 thru 69)		\$ 5,701,917	\$ 152,781		\$ 152,932	\$ 151	\$ 2,525,892	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:

01/01/2012 Ending: 12/31/2012

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,701,917	\$ 152,781		\$ 152,932	\$ 151	\$ 2,525,892	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		13,519	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		557	3
4	HEATING WORK	2009	9,475	345	27.5	345		1,193	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		1,356	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR	2010	16,733	608	27.5	608		1,495	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		474	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		1,563	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		565	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		3,048	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF	2010	17,080	621	27.5	621		1,527	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		1,500	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		275	13
14	PACH PARKING LOT IN THE BACK OF BUILDING	2010	6,400	233	27.5	233		573	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		369	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TILI	2010	5,691	207	27.5	207		509	16
17	CEILING PIPING	2010	2,825	103	27.5	103		253	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		1,131	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		381	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		224	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		258	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM	2010	3,450	125	27.5	125		307	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM	2010	1,850	67	27.5	67		165	23
24	REHAB ROOM - ELECTRIC WORK	2010	1,546	56	27.5	56		138	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		561	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	96	27.5	96		236	26
27	AIR CONDITIONING SYSTEM REPAIR	2010	1,735	63	27.5	63		155	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		698	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		1,019	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	368	27.5	368		537	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		1,213	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		637	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS	2011	65,023	2,364	27.5	2,364		3,448	33
34	TOTAL (lines 1 thru 33)		\$ 6,152,290	\$ 169,156		\$ 169,307	\$ 151	\$ 2,565,776	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:

01/01/2012 Ending: 12/31/2012

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		\$ 6,152,290	\$ 169,156		\$ 169,307	\$ 151	\$ 2,565,776	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		273	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		1,641	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		314	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		442	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		992	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		1,887	7
8	FLOORING/TACKBOARD-THERAPY RM/LIGHT FIXTURES	2011	2,809	102	27.5	102		150	8
9	DINING ROOM								9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		38,914	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		33,665	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATME	2002	125,676	1,663	39	1,663		75,258	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		23,527	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		22,878	18
19	NURSE STATION	2002	17,320	229	39	229		10,371	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		46,295	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		12,457	21
22	NURSE STATION	2004	27,559	707	39	707		5,980	22
23	CARPET, TILE, WALLCOVERING	2004	42,388	1,890	39	1,890		44,276	23
24	MODERNIZE ELEVATORS	2007	175,828	2,621	39	2,621		22,719	24
25	WINDOWS	2006	83,000	2,128	39	2,128		10,551	25
26									26
27	DOORS 2ND, 3RD & 4TH FLOOR	2012	4,075	68	27.5	68		68	27
28	PLUMBING WORK 2,3,4 FL EAST SHOWER, ELEVATOR, LA	2012	11,639	194	27.5	194		194	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	440	27.5	440		440	29
30	FLOORING - LOBBY/CORRIDOR	2012	8,640	144	27.5	144		144	30
31	SECURITY SYSTEM WORK	2012	5,130	86	27.5	86		86	31
32	ROOF REPAIR	2012	1,595	26	27.5	26		26	32
33	NURSE CALL SYSTEM WORK	2012	1,488	25	27.5	25		25	33
34	TOTAL (lines 1 thru 33)		\$ 7,067,691	\$ 190,597		\$ 190,748	\$ 151	\$ 2,919,349	34

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

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		\$ 7,067,691	\$ 190,597		\$ 190,748	\$ 151	\$ 2,919,349	1
2	CEILING REPAIR - DINING ROOM	2012	2,145	36	27.5	36		36	2
3	ELECTRIC WORK - GENERATOR & FIRE SUPPRESSION SY	2012	2,825	47	27.5	47		47	3
4	HANDRAIL SPACERS	2012	2,800	47	27.5	47		47	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	54	27.5	54		54	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,078,669	\$ 190,781		\$ 190,932	\$ 151	\$ 2,919,533	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	\$ 512,894	\$ 14,571	\$ 49,329	\$ 34,758	10 YRS	\$ 260,753	71
72	Current Year Purchases	51,661	30,997	2,583	(28,414)	10 YRS	2,583	72
73	Fully Depreciated Assets	224,113				10 YRS	224,113	73
74	RELATED PARTY	26,797	373	841	468		23,865	74
75	TOTALS	\$ 815,465	\$ 45,941	\$ 52,753	\$ 6,812		\$ 511,314	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			\$ 29,063	\$ 1,754	\$ 4,317	\$ 2,563		\$ 8,200	76
77										77
78										78
79										79
80	TOTALS			\$ 29,063	\$ 1,754	\$ 4,317	\$ 2,563		\$ 8,200	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,227,197	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 238,476	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 248,002	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,526	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,439,047	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:☐ YES☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$6,636 Description:SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2010 LEXUS	\$600.00	\$7,200	17
18	PAYROLL ADJ			(5,071)	18
19					19
20					20
21	TOTAL		\$600.00	\$2,129	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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_____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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			795			795	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				132,384		132,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): SUPPLIES, LAB,XRAY,RENTALS						25,822		25,822	13
14	TOTAL			\$		\$ 795	\$ 158,206		\$ 159,001	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,901	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 263,000)	2,297,958		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,643		6
7	Other Prepaid Expenses	65,301		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	306,170		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,845,973	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,186,405		15
16	Equipment, at Historical Cost	788,667		16
17	Accumulated Depreciation (book methods)	(1,009,366)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	556,627		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,522,333	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,368,306	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 769,639	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	975,613		29
30	Accrued Salaries Payable	278,741		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,061		31
32	Accrued Real Estate Taxes(Sch.IX-B)	345,000		32
33	Accrued Interest Payable	3,034		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,402,088	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,402,088	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,966,218	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,368,306	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,265,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,265,243	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	883,375	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	(182,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 700,975	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)	\$ 1,966,218	24 *

* This must agree with page 17, line 47.

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.

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,265,790	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,265,790	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,910	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 295,910	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***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	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)	\$ 9,561,730	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,302,088	31
32	Health Care	3,461,507	32
33	General Administration	2,374,816	33
B. Capital Expense			
34	Ownership	1,044,532	34
C. Ancillary Expense			
35	Special Cost Centers	159,001	35
36	Provider Participation Fee	336,411	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,678,355	40
41	Income before Income Taxes (line 30 minus line 40)**	883,375	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 883,375	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,717,062	44
45	Private Pay - Net Inpatient Revenue	1,340,927	45
46	Medicare - Net Inpatient Revenue	2,827,203	46
47	Other-(specify) <u>HOSPICE</u>	380,598	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,265,790	49

**TAX RETURN PREPARED ON CASH BASIS

* 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.

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	989	1,238	\$ 52,653	\$ 42.53	1
2	Assistant Director of Nursing	1,954	2,093	77,421	36.99	2
3	Registered Nurses	7,879	8,699	291,475	33.51	3
4	Licensed Practical Nurses	33,448	38,015	1,007,869	26.51	4
5	CNAs & Orderlies	89,902	100,137	1,042,291	10.41	5
6	CNA Trainees					6
7	Licensed Therapist	11,487	12,105	403,146	33.30	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,743	3,074	58,370	18.99	9
10	Activity Assistants	16,020	17,756	224,652	12.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,141	6,413	111,801	17.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,210	2,627	137,958	52.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,704	13,435	261,414	19.46	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	1,926	2,212	45,276	20.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,403	207,804	\$ 3,714,326 *	\$ 17.87	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	M	\$ 0	1-3	35
36	Medical Director	O	2,100	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	125	10-3	38
39	Pharmacist Consultant	H	9,250	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	816	11-3	44
45	Social Service Consultant	E	421	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,712		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
MARTHA PECK	ADMINISTRATOR		\$ 107,958
FRED AARON	OTHER ADMIN		30,000
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,958
B. Administrative - Other			
Description			Amount
MANAGEMENT FEES			\$ 234,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 234,000
C. Professional Services			
Vendor/Payee	Type		Amount
			\$
SEE SCHEDULE ATTACHED			68,688
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 68,688
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 106,964
Unemployment Compensation Insurance			75,747
FICA Taxes			289,093
Employee Health Insurance			182,525
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			
EMPLOYEE BENEFITS - OTHER			24,877
TOTAL (agree to Schedule V, line 22, col.8)			\$ 679,206
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			\$
Advertising: Employee Recruitment			3,367
Health Care Worker Background Check (Indicate # of checks performed _____)			1,510
Patient Background Checks			0
TRUST/FRANCHISE/CONTRIB/ETC			1,000
MARKETING/ADV/PROMO			64,147
LICENSES/DUES/SUBSCRIPTIONS			24,370
MGMT CO ALLOC			850
TRUST/FRANCHISE/CONTRIB/ETC			(1,000)
Less: Public Relations Expense		(	0)
Non-allowable advertising			(64,147)
Yellow page advertising		(	0)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 30,097
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
MGMT CO ALLOC			3,154
Seminar Expense			
			0
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 3,154

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? YEA
If YES, give association name and amount. ICLTC \$14,454

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,369 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. \$ 336,411
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

(19) 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.