

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>1/1/2020</u> to <u>12/31/2020</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>8101 S HARLEM AVENUE</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) <u>MARSHALL MAUER</u></td></tr><tr><td>(Title) <u>TREASURER</u></td></tr><tr><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u></td></tr><tr><td>(Firm Name & Address) <u>KBKB, LTD</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-3585</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARSHALL MAUER</u>	(Title) <u>TREASURER</u>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>KATHLEEN MCNAMARA</u> <u>VICE-PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD</u> <u>6201 W. HOWARD STREET SUITE 201, NILES, IL 60714</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-3585</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-3585</u>																								
Date of Initial License for Current Owners: <u>10/2/91</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>KATHLEEN MCNAMARA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR

0037358 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>142</u>	Skilled (SNF)	<u>142</u>	<u>51,972</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>4</u>	Intermediate (ICF)	<u>4</u>	<u>1,464</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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>7,308</u>	<u>7,308</u>	8
9	SNF/PED					9
10	ICF	<u>29,139</u>	<u>3,023</u>		<u>32,162</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,139</u>	<u>3,023</u>	<u>7,308</u>	<u>39,470</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 reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 10/2/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 142 and days of care provided 7,308

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CTR** # **0037358** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
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	373,744	28,859	23,888	426,491		426,491		426,491			1
2	Food Purchase		250,151		250,151	(14,420)	235,731	(2,226)	233,505			2
3	Housekeeping	272,250	27,032		299,282		299,282		299,282			3
4	Laundry	56,269	21,178	4,065	81,512		81,512		81,512			4
5	Heat and Other Utilities			146,027	146,027		146,027	1,427	147,454			5
6	Maintenance	169,501	92,435	59,342	321,278		321,278	20,454	341,732			6
7	Other (specify):*			21,129	21,129		21,129		21,129			7
8	TOTAL General Services	871,764	419,655	254,451	1,545,870	(14,420)	1,531,450	19,655	1,551,105			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	3,702,301	337,083	442,398	4,481,782		4,481,782	15,476	4,497,258			10
10a	Therapy											10a
11	Activities	282,515	22,158	1,632	306,305		306,305		306,305			11
12	Social Services	98,362	6,770	1,344	106,476		106,476		106,476			12
13	CNA Training											13
14	Program Transportation			28,854	28,854		28,854		28,854			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,083,178	366,011	488,028	4,937,217		4,937,217	15,476	4,952,693			16
	C. General Administration											
17	Administrative	130,719		126,000	256,719		256,719	93,417	350,136			17
18	Directors Fees											18
19	Professional Services			280,027	280,027		280,027	5,260	285,287			19
20	Dues, Fees, Subscriptions & Promotions			106,845	106,845		106,845	(51,816)	55,029			20
21	Clerical & General Office Expenses	264,070	11,034	810,125	1,085,229		1,085,229	(667,410)	417,819			21
22	Employee Benefits & Payroll Taxes			942,472	942,472	14,420	956,892		956,892			22
23	Inservice Training & Education			212	212		212		212			23
24	Travel and Seminar			12,588	12,588		12,588	336	12,924			24
25	Other Admin. Staff Transportation							2,589	2,589			25
26	Insurance-Prop.Liab.Malpractice			487,073	487,073		487,073	4,171	491,244			26
27	Other (specify):*	84,839		306,140	390,979		390,979	(226,738)	164,241			27
28	TOTAL General Administration	479,628	11,034	3,071,482	3,562,144	14,420	3,576,564	(840,191)	2,736,373			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,434,570	796,700	3,813,961	10,045,231		10,045,231	(805,060)	9,240,171			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	LINE
1	DIETARY		
	DIETITIAN CONSULTANT XVIII B 35-2	23,888	
	REPAIRS & MAINTENANCE	0	
	CONTRACTED DIETARY SERVICES	0	
		23,888	
3	HOUSEKEEPING		
	CONTRACTED HOUSEKEEPING SERVICES	0	
		0	
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE	4,065	
	CONTRACTED LAUNDRY SERVICES	0	
		4,065	
5	HEAT & OTHER UTILITIES		
	GAS HEAT	26,853	
	ELECTRICITY	53,732	
	WATER	59,622	
	CABLE TV - LOBBY	5,820	
		146,027	
6	MAINTENANCE		
	GROUNDS MAINTENANCE	11,049	
	PAINTING & DECORATING	0	
	BUILDING REPAIRS	0	
	MAINTENANCE TRAVEL	0	
	EQUIPMENT MAINTENANCE & REPAIR	29,432	
	ELEVATOR MAINTENANCE & REPAIR	14,481	
	OUTSIDE LABOR	0	
	EXTERMINATING SERVICE	4,380	
	FIRE SERVICE	0	
		59,342	
7	OTHER		
	SCAVENGER	21,129	
	SECURITY SERVICE	0	
		21,129	
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	13,800	13,800

SCHED REF		TOTAL	
LINE	SCHED REF	TOTAL	LINE
10	NURSING		
	CONTRACT NURSING XVIII C 53-2	405,927	
	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	8,431	
	UTILIZATION REVIEW FEES XVIII B __-2	0	
	PHYSICIANS XVIII B __-2	0	
	PSYCHIATRIC XVIII B __-2	9,000	
	RN CONSULTANT XVIII B 38-2	0	
	SPECIAL CARE UNIT	1,040	
	NURSING PROGRAM CONSULTANT		
	PROGRAM CONSULTANT	18,000	
		442,398	
10a	THERAPY		
	PHYSICAL THERAPY SERVICES	0	
	SPEECH THERAPY SERVICES	0	
	OCCUPATIONAL THERAPY SERVICES	0	
	REHABILITATION CONSULTANT XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0	
		0	
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS	0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,632	
		1,632	
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES	0	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0	
	SOCIAL WORKER XVIII B 45-2	1,344	
		1,344	
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS XIII	0	0

V.COST CENTER EXPENSES				PAGE 3 COLUMN 3 OTHER			
LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION						
	PATIENT TRANSPORTATION		28,854				
			28,854				
17	ADMINISTRATIVE						
	MANAGEMENT FEES	XIX B	126,000				126,000
	DIRECTORS FEES						
18	DIRECTORS FEES		0				0
19	PROFESSIONAL SERVICES						
	DATA PROCESSING	XIX C	102,452				
	ADMINISTRATIVE CONSULTANTS	XIX C	0				
	PROFESSIONAL FEES	XIX C	177,575				
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0				
			280,027				
20	FEES,SUBSCRIPTIONS,PROMOTIONS						
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0				
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	36,587				
	EMPLOYEE WANT ADS	XIX F	23,569				
	CONTRIBUTIONS	VI 20 XIX F	0				
	DUES & SUBSCRIPTIONS	XIX F	10,400				
	LICENSES & PERMITS	XIX F	16,524				
	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	17,796				
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	545				
	PATIENT BACKGROUND CHECKS	XIX F	1,424				
			106,845				
21	CLERICAL & GENERAL OFFICE EXPENSES						
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,599				
	EQUIPMENT REPAIR & MAINTENANCE		35,860				
	OUTSIDE CLERICAL SERVICES		736,168				
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,165				
	HOME OFFICE EXPENSE		0				
	THEFT & DAMAGE LOSS		0				
	TELEPHONE		28,333				
	MESSENGER SERVICE		0				
			810,125				

		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	411,565
	UNEMPLOYMENT COMPENSATION	XIX D	26,737
	WORKERS COMPENSATION INSURANCE	XIX D	162,872
	HOSPITALIZATION INSURANCE	XIX D	255,561
	EMPLOYEE BENEFITS - OTHER	XIX D	85,737
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
			942,472
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		212
			212
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	12,588
			12,588
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		0
			0
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		487,073
			487,073
27	OTHER		
	BAD DEBTS	VI 24	306,140
			306,140

GRAND TOTAL COLUMN 3 OTHER 3,813,961

BRIDGEVIEW HEALTH CARE CTR
SCHEDULES
12/31/2020

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

TOTAL FOOD PURCHASE	250,151
LESS SALES TAX	<u>(2,226)</u>
NET FOOD	247,925
TOTAL PATIENT CENSUS	39,470
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	118,410
ADD # EMPLOYEE MEALS/DAY	20
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	7,320
PATIENT MEALS	118,410
ADD EMPLOYEE MEALS	<u>7,320</u>
TOTAL MEALS/YEAR	125,730
NET FOOD	<u>247,925</u>
DIVIDE TOTAL MEALS/YEAR	<u>125,730</u>
COST PER MEAL	2
TIMES EMPLOYEE MEALS	<u>7,320</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>14,420</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			91,214	91,214		91,214	191,136	282,350			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,796	38,796		38,796	532,381	571,177			32
33	Real Estate Taxes							726,237	726,237			33
34	Rent-Facility & Grounds			1,306,000	1,306,000		1,306,000	(1,306,000)				34
35	Rent-Equipment & Vehicles			43,180	43,180		43,180	12,836	56,016			35
36	Other (specify):*											36
37	TOTAL Ownership			1,479,190	1,479,190		1,479,190	156,590	1,635,780			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,599	989,585	1,169,184		1,169,184		1,169,184			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			271,401	271,401		271,401		271,401			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		179,599	1,260,986	1,440,585		1,440,585		1,440,585			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,434,570	976,299	6,554,137	12,965,006		12,965,006	(648,470)	12,316,536			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.)

		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	10,552	30		9
10	Interest and Other Investment Income	(3,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,226)	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	(2,165)	21		18
19	Entertainment		20		19
20	Contributions	(17,796)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(306,140)	27		24
25	Fund Raising, Advertising and Promotional	(36,587)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(91,650)	22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (449,373)		\$	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	2	
		Amount	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)	(199,097)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (199,097)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (648,470)		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	2	3	4	
		Yes	No	Amount	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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (90,900)	21	1
2	MARKETING TRAVEL	(750)	25	2
3				3
4				4
5				5
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45				45
46				46
47				47
48				48
49	Total	(91,650)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR# 0037358

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,226)	0	0	0	0	0	0	0	0	0	0	(2,226)	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	1,427	0	0	0	0	0	0	0	0	1,427	5
6	Maintenance	0	0	8,876	11,578	0	0	0	0	0	0	0	20,454	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,226)	0	10,303	11,578	0	0	0	0	0	0	0	19,655	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	15,476	0	0	0	0	0	0	0	0	15,476	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	15,476	0	0	0	0	0	0	0	0	15,476	16
	C. General Administration													
17	Administrative	0	0	(126,000)	219,417	0	0	0	0	0	0	0	93,417	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,050	4,210	0	0	0	0	0	0	0	0	5,260	19
20	Fees, Subscriptions & Promotions	(54,383)	0	2,567	0	0	0	0	0	0	0	0	(51,816)	20
21	Clerical & General Office Expenses	(93,065)	0	(598,389)	24,044	0	0	0	0	0	0	0	(667,410)	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	336	0	0	0	0	0	0	0	0	336	24
25	Other Admin. Staff Transportation	(750)	0	3,339	0	0	0	0	0	0	0	0	2,589	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,171	0	0	0	0	0	0	0	0	4,171	26
27	Other (specify):*	(306,140)	0	79,402	0	0	0	0	0	0	0	0	(226,738)	27
28	TOTAL General Administration	(454,338)	1,050	(630,364)	243,461	0	0	0	0	0	0	0	(840,191)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(456,564)	1,050	(604,585)	255,039	0	0	0	0	0	0	0	(805,060)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	10,552	179,068	1,516	0	0	0	0	0	0	0	0	191,136	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,361)	532,932	2,810	0	0	0	0	0	0	0	0	532,381	32
33	Real Estate Taxes	0	720,955	5,282	0	0	0	0	0	0	0	0	726,237	33
34	Rent-Facility & Grounds	0	(1,306,000)	0	0	0	0	0	0	0	0	0	(1,306,000)	34
35	Rent-Equipment & Vehicles	0	0	12,836	0	0	0	0	0	0	0	0	12,836	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,191	126,955	22,444	0	0	0	0	0	0	0	0	156,590	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)	(449,373)	128,005	(582,141)	255,039	0	0	0	0	0	0	0	(648,470)	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	34	RENT	\$ 1,306,000	BRIDGEVIEW ASSOCIATES LLC	100.00%	\$	\$ (1,306,000)	1
2	V	30	DEPRECIATION				179,068	179,068	2
3	V	32	AMORTIZATION				17,803	17,803	3
4	V	32	INTEREST				515,129	515,129	4
5	V	33	REAL ESTATE TAX				720,955	720,955	5
6	V	19	PROFESSIONAL FEES				1,050	1,050	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,306,000			\$ 1,434,005	\$ * 128,005	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.

☒ 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	17	MANAGEMENT FEES	\$ 126,000	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$	\$ (126,000)	15
16	V	21	BOOKKEEPING SREVICE	736,168				(736,168)	16
17	V								17
18	V								18
19	V	5	UTILITIES				1,427	1,427	19
20	V	6	REPAIR & MAINT.-OTHER EXPENSE				8,876	8,876	20
21	V	10	NURSE CONSULTANT				15,476	15,476	21
22	V	19	PROFESSIONAL FEES				4,210	4,210	22
23	V	20	DUES AND SUBSCRIPTION				2,567	2,567	23
24	V	21	CLERICAL & GENERAL - SALARIES				105,526	105,526	24
25	V	21	CLERICAL & GENERAL-OTHER EXPENSE				32,253	32,253	25
26	V	24	SEMINARS AND TRAVEL				336	336	26
27	V	25	AUTO EXPENSE				3,339	3,339	27
28	V	26	INSURANCE				4,171	4,171	28
29	V	27	EMP. BEN. - GEN, ADMIN.				79,402	79,402	29
30	V	30	DEPRECIATION				1,516	1,516	30
31	V	32	INTEREST				2,810	2,810	31
32	V	33	REAL ESTATE TAXES				5,282	5,282	32
33	V	35	AUTO RENTAL				12,489	12,489	33
34	V	35	EQUIPMENT RENTAL				347	347	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 862,168			\$ 280,027	\$ * (582,141)	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	6	MAINT COMP - D NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 11,578	\$ 11,578	15
16	V	17	ADMIN COMP - M MAUER				39,438	39,438	16
17	V	17	ADMIN COMP - M AARON				49,188	49,188	17
18	V	17	ADMIN COMP - F AARON				42,982	42,982	18
19	V	17	ADMIN COMP - D AARON				3,231	3,231	19
20	V	17	ADMIN COMP - S GOLDSTEIN						20
21	V	17	ADMIN COMP - R AARON				7,180	7,180	21
22	V	17	ADMIN COMP - S HARAMARAS						22
23	V	17	ADMIN COMP - D KUFTA				33,058	33,058	23
24	V	17	ADMIN COMP - HOWARD ALTER						24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS				26,040	26,040	25
26	V	17	ADMIN COMP - CONTROLLER-NON OWNER				18,300	18,300	26
27	V	21	CLERICAL COMP - S AARON				15,268	15,268	27
28	V	21	CLERICAL COMP - E MARYLES				8,776	8,776	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			\$			\$ 255,039	\$ * 255,039	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:

1/1/2020

Ending:

12/31/2020

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			BRIDGEVIEW ASSOCIATES LLC		BUILDING CO	1
2	MAURICE AARON	19.74	GROSS POINTE MANOR LLC	NILES	DYNAMIC HEALTH CARE		BOOKKEEPING/C	2
3	MARSHALL MAUER	8.03	OTTAWA PAVILION LTD	OTTAWA	SEASONS HOSPICE		HOSPICE	3
4	FRED AARON	7.89	PARK RIDGE CARE CENTER LTD	PARK RIDGE				4
5	SHIMON GOLDSTEIN	3.94	WILLOW CREST NURSING PAVILION	SANDWICH				5
6	SHARON AARON	.41	WATERFRONT TERRACE INC	CHICAGO				6
7	CHANA MAUER-RAY	4.44	WOODBIDGE NURSING PAVILION LTD	CHICAGO				7
8	DENNIS NEHMER	.41						8
9	DIANA KUFTA	.41						9
10	ESTHER MARYLES	4.44	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11	HOWIE & SUSIE ALTER	.82	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12	SUE KOPLIN HARAMARAS	.41						12
13	SYLVIA AARON	.16						13
14	FRANCES MAUER	6.58						14
15	MARK HOLLANDER DISCRETIONARY	6.25						15
16	SHARON HOLLANDER DISCRETIONARY	6.25						16
17	FEIGE KNOBEL DISCRETIONARY TRU	6.25						17
18	BOB KAGDA	4.8						18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number **BRIDGEVIEW HEALTH CARE CTR** # **0037358** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**

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	8.03	SCHEDULE	6.31	15.78	SALARY	\$ 39,438	17-7	1
2	MAURY AARON	SHAREHOLDER	ADMINISTRATIV	19.74	ATTACHED	7.87	15.74	SALARY	49,188	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL	0.41		6.37	15.93	SALARY	15,268	21-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIV	7.89		15.17		SALARY	38,500	17-1	4
5	DANIEL AARON	RELATIVE	ADMINISTRATIVE			0.75	1.36	SALARY	3,231	17-7	5
6	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.41		7.87	19.68	SALARY	33,058	17-7	6
7	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.41		7.9	19.75	SALARY	11,578	6-1	7
8	ROBERT AARON	RELATIVE	ADMINISTRATIVE			2		SALARY	7,180	17-7	8
9	FRED AARON	SHAREHOLDER	ADMINISTRATIV	7.89		15.17		SALARY	42,982	17-7	9
10	ESTHER MARYLES	SHAREHOLDER	CLERICAL	4.44		4.87	12.18	SALARY	8,776	21-07	10
11											11
12											12
13								TOTAL	\$ 249,199		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:

1/1/2020Ending: **2/31/2020**

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	5	UTILITIES	PATIENT DAYS	296,074	9	\$ 10,707	\$ 39,470	\$ 1,427	1
2	6	REPAIR & MAINT.-OTHER EXPEN	PATIENT DAYS	296,074	9	66,584	39,470	8,876	2
3	10	NURSE CONSULTANT	PATIENT DAYS	296,074	9	116,092	39,470	15,476	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	296,074	9	31,579	39,470	4,210	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	296,074	9	19,254	39,470	2,567	5
6	21	CLERICAL & GENERAL - SALAR	PATIENT DAYS	296,074	9	791,573	791,573	105,526	6
7	21	CLERICAL & GENERAL-OTHER	PATIENT DAYS	296,074	9	241,939	39,470	32,253	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	296,074	9	2,520	39,470	336	8
9	25	AUTO EXPENSE	PATIENT DAYS	296,074	9	25,044	39,470	3,339	9
10	26	INSURANCE	PATIENT DAYS	296,074	9	31,289	39,470	4,171	10
11	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	296,074	9	595,611	39,470	79,402	11
12	30	DEPRECIATION	PATIENT DAYS	296,074	9	11,374	39,470	1,516	12
13	32	INTEREST	PATIENT DAYS	296,074	9	21,081	39,470	2,810	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	296,074	9	39,621	39,470	5,282	14
15	35	AUTO RENTAL	PATIENT DAYS	296,074	9	93,680	39,470	12,489	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	296,074	9	2,605	39,470	347	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,100,553	\$ 791,573	\$ 280,027	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR # 0037358 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference		Square Feet)		Allocated Among	Allocated	in Column 6				
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	5	\$ 58,624	\$ 58,624	8	\$ 11,578	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	9	250,000	250,000	6	39,438	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	5	250,000	250,000	8	49,188	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	3	127,500	127,500	15	42,982	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	5	9	21,541	21,541	1	3,231	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	230,000	230,000			6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	6	3	21,541	21,541	2	7,180	7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	1	69,011	69,011			8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	5	168,022	168,022	8	33,058	9
10	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			10
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	5	132,015	132,015	8	26,040	11
12	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	114,916	114,916	6	18,300	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	95,871	95,871	6	15,268	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	40	9	72,080	72,080	5	8,776	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,623,121	\$ 1,623,121		\$ 255,039	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	BANK LEUMI		X	MORTGAGE			\$ 8,360,000	\$ 7,850,700	10/24/20	5.0000	\$ 422,098	1		
2				LOAN COST W/O OVER LOAN			112,073	14,968			17,803	2		
3												3		
4	BANK LEUMI		X	NOTE PAYABLE			1,800,000	1,690,255	10/24/20	5.0000	93,031	4		
5												5		
	Working Capital													
6	BANK LEUMI		X	WORKING CAPITAL				710,000		PRIME+	38,796	6		
7												7		
8	MGMT CO ALLOC										2,810	8		
9	TOTAL Facility Related						\$ 10,272,073	\$ 10,265,923			\$ 574,538	9		
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$	14		
15	TOTALS (line 9+line14)						\$ 10,272,073	\$ 10,265,923			\$ 574,538	15		

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	535,000	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.)				\$	626,237	2
3. Under or (over) accrual (line 2 minus line 1).				\$	91,237	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	635,000	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.				\$	726,237	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	427,103	8		
		2016	455,222	9		
		2017	550,034	10		
		2018	524,782	11		
		2019	626,237	12		
				FOR BHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2019 \$	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.

2019 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 KATHLEEN MCNAMARA

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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 18-36-214-061-0000	NURSING HOME	\$ 620,954.70	\$ 620,954.70
2.		\$	\$
3.		\$	\$
4. 10-23-404-059-0000	DYNAMIC HEALTHCARE	\$ 36,915.77	\$ 5,282.00
5.	ALLOCATION	\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 657,870.47	\$ 626,236.70

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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).

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	146		1995		\$ 5,092,000	\$ 130,564	39	\$ 130,564	\$	\$ 3,073,772	4
5											5
6											6
7	RELATED PARTY				65,339			1,867	1,867	1,867	7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	26	31.5	32	6	935	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715		15			2,715	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,193	31.5	2,718	525	78,597	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	41	31.5	51	10	1,413	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		5,542	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		809	14
15	CARPET INSTALL			1995	1,303	33	39	33		832	15
16	RAIL BUMPER			1995	917	24	39	24		601	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	137	39	137		3,365	17
18	PAINTING WORK			1996	8,400	215	39	215		5,241	18
19	WALL COVERING			1996	1,435	37	39	37		899	19
20	FRONT LOBBY/WINDOW, DOOR WORK			1997	2,509	64	39	64		1,504	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		1,647	21
22	CONDENCING UNIT			1999	3,824	98	39	98		2,122	22
23	DRAPES			1999	5,369	138	39	138		2,952	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		4,704	24
25	DOOR WORK			1999	10,490	269	39	269		5,741	25
26	KITCHEN CABINETS			1999	5,832	149	39	149		3,203	26
27	TILES			2000	8,855	229	27.5	322	93	6,576	27
28	ELEVATOR REPAIR			2000	4,240	109	27.5	153	44	3,039	28
29	ROD MAIN SEWER			2000	1,100	26	27.5	41	15	834	29
30	DRAPERIES			2001	2,118		7			2,118	30
31	RECEPTION DESK/DOOR			2002	9,534	347	27.5	347		6,246	31
32	FLOORING / BUMPER GUARDS			2002	11,198	407	27.5	407		7,327	32
33	WALLPAPER, BORDER, ARTWORK			2002	42,079	1,530	27.5	1,530		27,322	33
34	WIRING, MOTOR			2002	9,224	336	27.5	336		6,048	34
35	HANDRAILS & GUARDS			2003	7,811	284	27.5	284		4,958	35
36				2003	4,023		15			4,023	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:

1/1/2020

Ending:

12/31/2020

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		\$ 1,117	37
38	COIL	2003	806	29	27.5	29		506	38
39	ELEVATOR REPAIRS	2003	3,991	145	27.5	145		2,533	39
40	WINDOW TREATMENTS	2003	1,672	61	27.5	61		1,065	40
41	LIGHTING & ALARM SYSTEMS	2003	6,701	244	27.5	244		4,259	41
42	FLOOR COVERING	2004	888	32	27.5	32		527	42
43	CABINETS	2004	2,594	95	27.5	95		1,563	43
44	BOILER	2004	2,574	93	27.5	93		1,531	44
45	VINYL TILE & COVE BASE	2004	1,186	43	27.5	43		708	45
46	BRICK MOUNT SIGN	2004	4,317		15			4,317	46
47	PARKING LOT	2004	34,455		15			34,455	47
48	FIREPROOFING PENTHOUSE ROOF	2005	9,950	362	27.5	362		5,596	48
49	SECURITY MONITORS	2005	1,375	50	27.5	50		773	49
50	CARPET & VINYL	2005	21,130	768	27.5	768		11,872	50
51	NETWORK CABLING	2006	855	31	27.5	31		448	51
52	COOLING TOWER REPAIR - per audit (2,500)	2006	1,065	130	27.5	130		1,879	52
53	RANGE GUARD SYSTEM - per audit (2,200)	2006		80	27.5	80		1,157	53
54	FANS - per audit (1,108)	2006		40	27.5	40		578	54
55	DOORS - per audit (1,711)	2006		62	27.5	62		897	55
56	LANDSCAPING	2006	23,665	1,577	15	1,577		22,878	56
57	FIRE DOORS, PANIC DEVICE, CONTROL PANEL	2007	3,676	134	27.5	134		1,803	57
58	ELEVATOR RECALL SYSTEM	2007	28,000	1,018	27.5	1,018		13,701	58
59	RETRACTABLE AWNING	2007	3,336	122	27.5	122		1,642	59
60	CABLING OF BUILDING - per audit (1,2918)	2007	7,082	727	27.5	727		9,784	60
61	VINYL TILE & COVE BASE	2007	30,063	1,093	27.5	1,093		14,710	61
62	CONDENSER - per audit (1,712)	2007		62	27.5	62		835	62
63	ELEVATOR REPAIRS - per audit (2,275)	2008		83	27.5	83		1,034	63
64	FLOOR & WALL TILE	2008	18,201	662	27.5	662		8,248	64
65	DOORS - per audit (1,645)	2008		60	27.5	60		747	65
66	BOILER	2008	5,104	185	27.5	185		2,305	66
67	DISH TV EQUIPMENT - per audit (1,575)	2009		57	27.5	57		653	67
68	PLUMBING WORK	2009	13,761	500	27.5	500		5,729	68
69	SHOWER ROOMS-DRYWALL,CEMENT BOARD,TILE,SINKS	2009	45,476	1,654	27.5	1,654		18,952	69
70	TOTAL (lines 4 thru 69)		\$ 5,688,232	\$ 148,051		\$ 150,611	\$ 2,560	\$ 3,445,754	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:

1/1/2020

Ending:

12/31/2020

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		\$ 5,688,232	\$ 148,051		\$ 150,611	\$ 2,560	\$ 3,445,754	1
2	FIRE ALARM SYSTEM	2009	107,498	3,909	27.5	3,909		44,791	2
3	DOORS & WINDOWS	2009	4,434	161	27.5	161		1,845	3
4	HEATING WORK	2009	9,475	345	27.5	345		3,953	4
5	TILE & CORRIDOR SIGNAGE	2009	10,786	392	27.5	392		4,492	5
6	BOILER -RESET CONTROL,CONVECTOR,COMPRESSOR -	2010	14,072	608	27.5	608		6,359	6
7	WALK IN FREEZER-NEW CONDENSOR, DEFROST TIMER	2010	5,300	193	27.5	193		2,018	7
8	3RD FLOOR SHOWER ROOM-NEW TILE,WALLS	2010	17,500	636	27.5	636		6,651	8
9	FRONT DOOR ALARM,SLIDING,ACCESS DOORS,KEY PAD	2010	6,328	230	27.5	230		2,405	9
10	REPLACE SEWER LINES HALLWAY AND KITCHEN	2010	34,102	1,240	27.5	1,240		12,968	10
11	REPAIRS ROOF-PENTHOUSE AND MAIN ROOF - per audit (1	2010	15,715	621	27.5	621		6,495	11
12	4TH FLOOR SHOWER ROOM-NEW WATER LINES, TILE	2010	16,782	610	27.5	610		6,380	12
13	LOCKER ROOM - TILE, PAINT AND CARPETING	2010	3,068	112	27.5	112		1,171	13
14	PACH PARKING LOT IN THE BACK OF BUILDING - per aud	2010	4,000	233	27.5	233		2,437	14
15	INSTALL NEW VINIL TILE IN THE BACK HALLWAY	2010	4,124	150	27.5	150		1,569	15
16	CABINETS,COUNTERTOP FOR KITCHEN,NEW FLOOR TIL	2010	5,691	207	27.5	207		2,165	16
17	CEILING PIPING	2010	2,825	103	27.5	103		1,077	17
18	AIR HANDLERS,HOT WATER COILS,MOTOR STARTER	2010	12,660	460	27.5	460		4,811	18
19	FIRE ALARM WORK, 72 SPRINKLER HEADS	2010	4,249	155	27.5	155		1,621	19
20	DVR RECORD,MONITOR, 2CAMERAS IN PARKING LOT	2010	2,500	91	27.5	91		952	20
21	BRICK WALL REPAIR	2010	2,900	105	27.5	105		1,098	21
22	DISH NETWORK SERVICE WORK, SECURITY SYSTEM - pe	2010		126	27.5	126		1,314	22
23	INSTALL NEW PIPE IN LAUNDRY ROOM - per audit (1,850)	2010		67	27.5	67		701	23
24	REHAB ROOM - ELECTRIC WORK - per audit (1,546)	2010		56	27.5	56		586	24
25	PLUMBING WORK, NEW DRAIN LINE IN KITCHEN AREA	2010	6,275	228	27.5	228		2,385	25
26	NEW RELAY ON COMPRESSOR,WATER TOWER MOTOR	2010	2,653	97	27.5	97		1,011	26
27	AIR CONDITIONING SYSTEM REPAIR - per audit (1,735)	2010		63	27.5	63		659	27
28	THERAPY ROOM - FLOORING	2011	13,166	479	27.5	479		4,530	28
29	THERAPY ROOM - WALLCOVERING/CEILING TILE	2011	19,219	699	27.5	699		6,611	29
30	THERAPY ROOM - ELECTRICAL WORK	2011	10,134	369	27.5	369		3,488	30
31	THERAPY ROOM - PLUMBING WORK	2011	22,879	832	27.5	832		7,869	31
32	THERAPY ROOM - DOORS	2011	12,009	437	27.5	437		4,133	32
33	THERAPY ROOM - INSTL OFFICES,FLOORING,DOORS - pe	2011	61,018	2,364	27.5	2,364		22,360	33
34	TOTAL (lines 1 thru 33)		\$ 6,119,593	\$ 164,429		\$ 166,989	\$ 2,560	\$ 3,616,659	34

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

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 12B, Carried Forward		\$ 6,119,593	\$ 164,429		\$ 166,989	\$ 2,560	\$ 3,616,659	1
2	ROOF DRAINS	2011	5,150	187	27.5	187		1,769	2
3	SHOWER ROOM FLOOR,DRAIN,TILE	2011	30,945	1,125	27.5	1,125		10,641	3
4	ROOF REPAIR	2011	5,920	215	27.5	215		2,034	4
5	SECURITY/FIRE SYSTEM REPAIR	2011	8,320	303	27.5	303		2,866	5
6	COMPRESSOR INSTALL REPAIR	2011	18,703	680	27.5	680		6,432	6
7	SCANNER	2011	35,598	1,294	27.5	1,294		12,239	7
8	FLOORING/TACKBOARD/LIGHT fixtures	2011	2,809	102	27.5	102		966	8
9									9
10									10
11									11
12									12
13	RELATED PARTY - LANDLORD:								13
14	COVE BASE, FLOORING	2002	64,984	860	39	860		45,794	14
15	HANDRAILS, BUMPERS, CORNER GUARDS	2002	56,219	744	39	744		39,617	15
16	WALLCOVERING,BORDER,MOLDING,WINDOW TREATMI	2002	125,676	1,663	39	1,663		88,562	16
17	CLOSET DOORS & TRACKS	2002	39,288	520	39	520		27,687	17
18	LIGHTING, CEILING TILES	2002	38,204	506	39	506		26,926	18
19	NURSE STATION	2002	17,320	229	39	229		12,203	19
20	ASPHALT PAVING	2002	57,615	4,409	15	4,409		62,024	20
21	PATIO, FENCING, ROOFING	2002	20,804	275	39	275		14,657	21
22	NURSE STATION	2004	27,559	707	39	707		11,636	22
23	CARPET, TILE, WALLCOVERING	2004	42,388					42,388	23
24	MODERNIZE ELEVATORS	2007	175,828	4,508	39	4,508		60,670	24
25	WINDOWS	2006	83,000	2,128	39	2,128		27,575	25
26									26
27	DOORS & WINDOWS	2012	4,075	153	27.5	153		1,292	27
28	PLUMBING WORK	2012	11,639	433	27.5	433		3,658	28
29	SPRINKLER & FIRE SYSTEM WORK	2012	26,504	968	27.5	968		8,184	29
30	FLOORING	2012	8,640	306	27.5	306		2,592	30
31	SECURITY SYSTEM WORK	2012	5,130	178	27.5	178		1,510	31
32	ROOF REPAIR	2012	1,595	51	27.5	51		434	32
33	NURSE CALL SYSTEM WORK	2012	1,488	51	27.5	51		433	33
34	TOTAL (lines 1 thru 33)		\$ 7,034,994	\$ 187,024		\$ 189,584	\$ 2,560	\$ 4,131,448	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:

1/1/2020

Ending:

12/31/2020

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 12C, Carried Forward		\$ 7,034,994	\$ 187,024		\$ 189,584	\$ 2,560	\$ 4,131,448	1
2	CEILING REPAIR	2012	2,145	76	27.5	76		644	2
3	ELECTRIC WORK	2012	2,825	102	27.5	102		863	3
4	HANDRAIL SPACERS	2012	2,800	102	27.5	102		863	4
5	CYLINDER FOR ELEVATOR & HEAT MOTOR	2012	3,208	127	27.5	127		1,070	5
6	SPRINKLER & SECURITY SYSTEM	2013	13,953	507	27.5	507		3,785	6
7	DOORS & HARDWARE	2013	6,459	235	27.5	235		1,757	7
8	BATHROOM SINKS, FAUCETS & DRYWALL	2013	15,179	552	27.5	552		4,113	8
9	OFFICE WALL REPAIR	2013	4,383	160	27.5	160		1,195	9
10	AC REPAIR & ROOF FAN INSTALL	2013	8,750	318	27.5	318		2,375	10
11	COMPRESSORS, BREAKERS HEAT COIL	2013	21,983	799	27.5	799		5,953	11
12	WALK IN FREEZER REPAIR	2013	1,055	38	27.5	38		278	12
13	FENCE INSTALL	2013	2,800	102	27.5	102		764	13
14	REPAIRED ELEVATOR DOOR ON THE SECOND FLOOR	2014	5,274	192	27.5	192		1,240	14
15	WATER HEATERS-TWO RAYPAK MVB MODEL	2014	35,148	1,278	27.5	1,278		8,254	15
16	EMERGENCY ROOF INSPECTION & ANALYSIS	2014	11,040	401	27.5	401		2,590	16
17	PASSENGER ELEVATOR-REPLACE DETECTOR EDGES	2014	2,136	78	27.5	78		504	17
18	WALK IN FREEZER-REPLACEMENT SYSTEM	2014	5,310	193	27.5	193		1,247	18
19	SECURITY SYSTEM WORK-INSTALLED WIRELESS DOOR,								19
20	REPLACED CAMERA'S AND DOORS	2014	4,610	168	27.5	168		1,085	20
21	INSTALL 7 EYEWASH STATIONS	2014	5,100	185	27.5	185		1,195	21
22	1ST FLOOR AIRCONDITION REPAIR	2014	4,050	147	27.5	147		949	22
23	PLUMBING SUPPLIES	2014	2,969	108	27.5	108		697	23
24	GLASS BLOCK AND GLASS DOORS	2014	5,706	207	27.5	207		1,337	24
25	INSTALLED SPRINKLER & SATELLITE HEADEND SYSTEM	2014	4,057	148	27.5	148		956	25
26	FIRE RATED DOORS & HARDWARE, SVR EXIT DEVICE	2014	6,739	245	27.5	245		1,582	26
27	RESIDENT BATHROOMS: FLOOR TILES, SINKS, FAUCETS,								27
28	LIGHTING FIXTURES, WALL AND CEILING TITLES	2014	29,926	1,088	27.5	1,088		7,027	28
29	DIETARY ROOM: ICE MELT, TILES, DROP CEILING	2014	2,193	80	27.5	80		516	29
30	DRYWALL FOR PENTHOUSE; STEEL STORAGE SHELVRG								30
31	UNIT; FIX WALLPAPER IN BASEMENT	2014	4,098	149	27.5	149		962	31
32	MANSARD METAL ROOF REPAIR	2015	3,960	102	39	102		561	32
33	MAIN OFFICE CORRIDOR WALLCOVERING/HANDRAIL	2015	824	21	39	21		116	33
34	TOTAL (lines 1 thru 33)		\$ 7,253,674	\$ 194,932		\$ 197,492	\$ 2,560	\$ 4,185,926	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:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,253,674	\$ 194,932		\$ 197,492	\$ 2,560	\$ 4,185,926	1
2	HOT WATER HEATER/BOILER	2015	14,546	373	39	186	(187)	1,116	2
3	BOOSTER HEATER FOR DISHMACHINE & SUPPLIES	2015	3,751	96	39	48	(48)	288	3
4	EXHAUST FAN IN MECHANICAL ROOM	2015	12,344	316	39	158	(158)	948	4
5	COMPRESSOR 1ST FLOOR AC UNIT/COIL REPAIR	2015	7,055	181	39	90	(91)	540	5
6	1 HEAT MUA UNIT	2015	1,354	35	39	17	(18)	102	6
7	ROOFTOP EXHAUST VENTILATOR	2015	6,767	174	39	87	(87)	522	7
8	NALCO WATER TREATMENT	2015	4,316	111	39	55	(56)	330	8
9	5 ROOMS, DEMO FLOOR BASEBOARD, PATCH, PRIME, PAINT,INSTALL VINYL FLOOR, BASEBOARDS								9
10		2015	11,750	301	39	151	(150)	906	10
11	3 SECURITY CAMERAS BY ELEVATOR	2015	1,470	38	39	19	(19)	114	11
12	SECURITY CAMERAS, DOOR OPENER	2016	1,665	43	39	43		206	12
13	FLOORING	2016	6,158	158	39	158		712	13
14	ELEVATOR ELECTRONIC DETECTOR EDGE	2016	2,136	55	39	55		248	14
15	CUBICLE CURTAINS, PICTURES, MIRRORS	2016	6,238	23	39	23		115	15
16	FIRE DOOR	2016	358	9	39	9		33	16
17	AIR HANDLER/DUCT WORK	2016	17,531	160	39	160		800	17
18	ROOF REPAIR	2016	3,080	79	39	79		296	18
19	FLOORING 1ST - 3RD FLOOR	2016	26,991	88	39	88		440	19
20	FENCING	2016	9,114	608	15	608		2,025	20
21	RESIDENT BATHROOMS TILE, DRYWALL, PAINT	2016	34,181	114	39	114		570	21
22	OVERBED LIGHTS	2016	9,330	28	39	28		140	22
23	WALL GUARDS	2016	8,741	12	39	12		60	23
24	3rd FLOOR PATIENT RMS, BATHROOMS-FLOORING, WALLS FIXTURES								24
25		2017	15,240		39	391	391	1,564	25
26	FENCING	2017	9,084		15	606	606	2,424	26
27	BASEMENT FLOORING, WALL REPAIR	2017	509		39	13	13	52	27
28	AC REPAIR,STARTER MOTOR, COMPRESSOR	2017	11,710		39	300	300	1,200	28
29	ELEVATOR DOOR OPERATOR	2017	8,395		39	215	215	860	29
30	LANDLORD								30
31	3rd FLOOR PATIENT RMS, BATHROOMS-FLOORING, WALLS FIXTURES								31
32		2017	257,688		39	6,607	6,607	26,428	32
33	ASBESTOR REMOVEL	2017	40,745		39	1,045	1,045	4,180	33
34	TOTAL (lines 1 thru 33)		\$ 7,785,921	\$ 197,934		\$ 208,857	\$ 10,923	\$ 4,233,145	34

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

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 12E, Carried Forward		\$ 7,785,921	\$ 197,934		\$ 208,857	\$ 10,923	\$ 4,233,145	1
2	LANDLORD CONTINUED								2
3	3RD FLOOR CORRIDOR, DINING RM, DON OFFICE, THERAPY RM - FLOORING, WALLPAPER, CORNER GUARDS, MILLWORK								3
4		2017	82,867		39	2,125	2,125	8,500	4
5	PARKING LOT SEALING	2017	6,800		15	453	453	1,812	5
6	MILWORK 2ND FLR DON,DINING,4TH FLR RESTORTATIVE								6
7		2018	8,675						7
8	3RD FLR RESIDENT ROOM WALL PROTECTION,ADMINISTRATOR,ADMISSION & BUSINESS MGR OFFICE WALL COVERING, WINDOW T								8
9		2018	7,783						9
10	2ND FLOOR RESIDENT BATHROOMS, BUID AROUND PIPE SOFFIT,DRYWALL,PLASTER,PRIME,PAINT & ELECTRICAL & LIGHTS IN CEH								10
11		2018	37,750						11
12	3RD FLOOR NURSE STATION & ELEVATOR INTERIOR	2018	26,763						12
13	2ND FLOOR NURSE STATION	2018	18,800						13
14	STANDARD & SERVICE ELEVATOR CLADDING	2018	14,900						14
15	PAINT 46 BATHROOMS AND INSTALL ELECTRICAL FOR LIGHTS, INSTALL NEW FLOORING IN ELEVATOR, REMOVE TILE & FLOOR IN								15
16	CORRIDOR BATHROOM,DRYWALL, PRIME,PAINT,SINK,TOILET,MIRROW,1ST & 2ND FLOOR OFFICE REMOVE WALLPAPER								16
17	PRIME,PAINT,NEW FLOORS	2018	26,370						17
18	1ST FLOOR MILLWORK	2018	29,400						18
19	1ST & 2ND FLOOR-REMOVE WALLPAPER,BUID SFFIT,PLASTER,PRIME,PAINT,SAND & INSTALL COVER ON 68 BATHROOM & RESIDENT								19
20	1ST & 2ND FLR DOORS,PLATER,PRIME,PAINT CORRIDOR	2018	23,825						20
21	3RD FLOOR DINING ROOM WALLPROTECTION	2018	1,764						21
22	1ST & 2ND FLR 26 BRAIL WALL SIGNS 1ST & 2ND FLOOR	2018	1,422						22
23	1ST FLOOR HANDRAIL & WALLGUARD FOR CORRIDOR	2018	10,387						23
24	1ST & 2ND FLR 20 BATHROOMS, TILE,DRYWALL,FIXTURES,COVER DOORS WITH PANELING								24
25		2018	39,595						25
26	INSTALL NEW GLASS WINDOWS IN CONFERENCE ROOM	2018	2,436		39	62	62	124	26
27	REPLACE MOTOR STARTER AND FILTER DRYER	2018	2,917		39	75	75	150	27
28	1ST AND 2ND FLOOR REMODELING-INSTALL NEW FIRE BOXES AROUND ALL LIGHTS, BUILD NEW SOFFITS AROUND PIPES, NEW								28
29	RAILINGS & BUMPERS, NEW WALLPAPER, CORNER GUARDS, PAINTING, PROTECTION SYTEM, WINDOW TREATMENT, FLOORING								29
30		2019	207,274						30
31	INSTALL 2 NURSES STATIONS	2019	39,050						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,374,699	\$ 197,934		\$ 211,572	\$ 13,638	\$ 4,243,731	34

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

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 12F, Carried Forward		\$ 8,374,699	\$ 197,934		\$ 211,572	\$ 13,638	\$ 4,243,731	1
2	SERVICE SEWER LINE THROUGHOUT THE BUILDING AND								2
3	IN THE PARKING LOT	2019	11,850	431	27.5	431		467	3
4	ASPHALT REPAIRS IN SOUTH REAR PARKING LOT	2019	4,800	320	15	320		347	4
5	INSTALL NEW SECTIOS OF 2" HOT WATER LINE, RESTORE								5
6	PRESSURE TO SYSTEM	2019	3,200	118	27.5	118		137	6
7	INSTALL NEW SECTIONS OF PIPE	2019	3,250	118	27.5	118		197	7
8	INSTALL CARPET, PREP & BASE FOR 1ST FLOOR OFFICE	2019	18,160	908	5	908		1,816	8
9	2ND FLOOR ASBESTOS ABATEMENT	2019	41,700	1,516	27.5	1,516		1,895	9
10	BELL & GOSSETT	2019	4,373	27	27.5	27		54	10
11	SERVICE ON AIR CONDITIONER	2020	3,230	49	27.5	49		49	11
12	INSTALLED NEW SEAL KIT/FSG RELAY AND AMPLIFIER	2020	2,606	24	27.5	24		24	12
13	CUT/THREADED WATER LINE	2020	3,478	32	27.5	32		32	13
14	INSTALL NEW EDGE ON ELEVATOR CAR	2020	2,569	8	27.5	8		8	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				27,164			(27,164)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,473,915	\$ 228,649		\$ 215,123	\$ (13,526)	\$ 4,248,757	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	\$ 659,595	\$ 39,979	\$ 65,960	\$ 25,981	10	\$ 423,619	71
72	Current Year Purchases	15,849	3,170	792	(2,378)	10	792	72
73	Fully Depreciated Assets	562,566					562,566	73
74	RELATED PARTY			475	475			74
75	TOTALS	\$ 1,238,010	\$ 43,149	\$ 67,227	\$ 24,078		\$ 986,977	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78	RELATED PARTY									78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,015,925	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 271,798	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 282,350	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,552	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,235,734	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: N/A RELATED PARTY
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.

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

	Fiscal Year Ending	Annual Rent
12.		\$
13.		\$
14.		\$

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 34,200 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	ADMINISTRATIVE	2017 LEXUS	\$ 601.58	\$ 7,219	17
18	FACILITY	2020 BUICK	440.16	1,761	18
19					19
20					20
21	TOTAL		\$ #####	\$ 8,980	21

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

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

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

C. CONTRACTUAL INCOME

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)	\$			

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	\$		\$ 392,990	\$		\$ 392,990	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			131,550			131,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			465,045			465,045	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				113,439		113,439	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY								0	
	Other (specify): RENTALS	39-2					66,160		66,160	13
14	TOTAL			\$		\$ 989,585	\$ 179,599		\$ 1,169,184	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	\$ 393,052	\$ 1,123,835	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 13,694)	5,461,287	5,461,287	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	146,110	146,110	6
7	Other Prepaid Expenses	8,417	8,417	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SECURITY DEPOSITS	28,877	28,877	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,037,743	\$ 6,768,526	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,356	13
14	Buildings, at Historical Cost		5,483,213	14
15	Leasehold Improvements, at Historical Cost	1,699,810	3,720,942	15
16	Equipment, at Historical Cost	1,238,013	2,033,130	16
17	Accumulated Depreciation (book methods)	(1,663,029)	(6,826,045)	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): LOAN COSTS		14,218	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,274,794	\$ 4,752,814	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,312,537	\$ 11,521,340	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 918,594	\$ 918,594	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,434,686	2,434,686	29
30	Accrued Salaries Payable	360,138	360,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,097	16,097	31
32	Accrued Real Estate Taxes(Sch.IX-B)		793,750	32
33	Accrued Interest Payable	2,663	32,663	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)	\$ 3,732,178	\$ 4,555,928	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,673,386	39
40	Mortgage Payable		7,772,354	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)	\$	\$ 9,445,740	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,732,178	\$ 14,001,668	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,580,359	\$ (2,480,328)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,312,537	\$ 11,521,340	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,459,543	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,459,543	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,242,416	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	(121,600)	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)	\$ 1,120,816	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)	\$ 3,580,359	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CTR

0037358

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,722,157	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,722,157	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	528,651	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 528,651	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***	3,361	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,361	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	953,253	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 953,253	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,207,422	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,545,870	31
32	Health Care	4,937,217	32
33	General Administration	3,562,144	33
	B. Capital Expense		
34	Ownership	1,479,190	34
	C. Ancillary Expense		
35	Special Cost Centers	1,169,184	35
36	Provider Participation Fee	271,401	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,965,006	40
41	Income before Income Taxes (line 30 minus line 40)**	1,242,416	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,242,416	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,242,637	44
45	Private Pay - Net Inpatient Revenue	608,440	45
46	Medicare - Net Inpatient Revenue	5,871,080	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,722,157	49

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

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

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

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

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	2,032	2,080	\$ 115,397	\$ 55.48	1
2	Assistant Director of Nursing	1,960	2,200	102,489	46.59	2
3	Registered Nurses	13,961	15,475	709,285	45.83	3
4	Licensed Practical Nurses	33,441	37,877	1,356,710	35.82	4
5	CNAs & Orderlies	59,599	65,529	1,376,473	21.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,160	49,573	22.95	9
10	Activity Assistants	14,226	15,345	232,942	15.18	10
11	Social Service Workers	2,863	3,922	98,362	25.08	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,139	42,601	19.92	13
14	Head Cook	5,788	6,410	118,074	18.42	14
15	Cook Helpers/Assistants	12,366	13,102	213,069	16.26	15
16	Dishwashers					16
17	Maintenance Workers	5,971	6,427	169,501	26.37	17
18	Housekeepers	17,457	18,623	272,250	14.62	18
19	Laundry	3,139	3,583	56,269	15.70	19
20	Administrator	2,040	2,264	101,047	44.63	20
21	Assistant Administrator	824	840	29,672	35.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,460	9,440	264,070	27.97	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	1,377	1,618	41,947	25.93	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Direct	1,888	2,080	84,839	40.79	33
34	TOTAL (lines 1 - 33)	191,259	211,114	\$ 5,434,570 *	\$ 25.74	34

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

** See instructions.

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	\$ 23,888	1-3	35
36	Medical Director	O	13,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,431	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	1,632	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,751		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	15,613	405,927	10-3	52
53	TOTAL (lines 50 - 52)	15,613	\$ 405,927		53

Facility Name & ID Number

BRIDGEVIEW HEALTH CARE CTR

STATE OF ILLINOIS

0037358

Report Period Beginning:

1/1/2020

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Ending: 12/31/2020

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		
MARTHA PECK		ADMINISTRATOR	0	\$ 101,047	Workers' Compensation Insurance		\$ 162,872	IDPH License Fee		\$ 1,990		
ELIZABETH WALL		ASSISTANT ADMIN	0	29,672	Unemployment Compensation Insurance		26,737	Advertising: Employee Recruitment		23,569		
					FICA Taxes		411,565	Health Care Worker Background Check		545		
					Employee Health Insurance		255,561	(Indicate # of checks performed)				
					Employee Meals		14,420	Patient Background Checks		1,424		
					Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		17,796		
					EMPLOYEE BENEFITS - OTHER		85,737	MARKETING/ADV/PROMO		36,587		
							0	LICENSES/DUES/SUBSCRIPTIONS		24,934		
							0	MGMT CO ALLOC		2,567		
							0	TRUST/FRANCHISE/CONTRIB/ETC		(17,796)		
								Less: Public Relations Expense		(0)		
								Non-allowable advertising		(36,587)		
							0	Yellow page advertising		(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 130,719	TOTAL (agree to Schedule V, line 22, col.8)				\$ 956,892	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 55,029
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount		
DYNAMIC HEALTHCARE CONSULT MANAGEMENT FEES			\$ 126,000					Out-of-State Travel		\$		
								In-State Travel				
										12,588		
								MGMT CO ALLOC		336		
								Seminar Expense		0		
								Entertainment Expense		()		
								(agree to Sch. V, line 24, col. 8)				
								TOTAL		\$ 12,924		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 126,000	TOTAL				\$			
C. Professional Services												
Vendor/Payee		Type	Amount									
			\$									
SEE SCHEDULE ATTACHED			280,027									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 280,027								

* Attach copy of IMRF notifications

**See instructions.

**BRIDGEVIEW HEALTH CARE CTR
SCHEDULE - LEGAL**

12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
8/31/2020	BANK LEUMI	Field Exam	1,700.00
6/30/2020	CLARK HILL, PLC	ESTATE OF JUDY BUTLER,ALLEGED PERSON W/ DISABILIT	385.00
8/31/2020	CLARK HILL, PLC	ESTATE OF JUDY BUTLER,ALLEGED PERSON W/ DISABILIT	1,760.00
11/30/2020	FMS LAW GROUP LLC	Estate of Luneal Brown, A Disabled Person	3,822.50
10/29/2020	MARGARET ANN O'SULLVAN	ESTATE: LOUVENIA MCCATHY	2,956.25
1/1/2020	MUCH SHELIST, P.C	Dec2020 Services	220.00
1/1/2020	MUCH SHELIST, P.C	Dec2020 Services	1,170.00
3/1/2020	MUCH SHELIST, P.C.	General Counseling	205.00
4/1/2020	MUCH SHELIST, P.C.	FMLA Issues	507.40
4/1/2020	MUCH SHELIST, P.C.	General Counseling	697.00
5/1/2020	MUCH SHELIST, P.C.	COVID-19 Related	1,476.00
6/1/2020	MUCH SHELIST, P.C.	Regarding COVID-19	246.00
7/29/2020	MUCH SHELIST, P.C.	Annual Corporation Report	350.00
11/1/2020	MUCH SHELIST, P.C.	General Counseling	533.00
6/15/2020	SPIELBERGER LAW GROUP	Employment Issues	2,395.00
1/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	1,199.81
3/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	3,970.07
3/2/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	4,231.49
4/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	3,013.67
5/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	2,646.09
6/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	2,504.06
7/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	2,280.80
8/31/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	2,220.38
9/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	7,251.75
11/30/2020	STONE POGRUND & KOREY LLC	General Litigation & Collection	2,359.67
1/15/2020	VON BRIESEN & ROPER, S.C.	Dec2020 Services	1,040.00
1/15/2020	VON BRIESEN & ROPER, S.C.	Dec2020 Services	364.00
1/15/2020	VON BRIESEN & ROPER, S.C.	DESTINY DEUERLING MATTER	676.00
2/17/2020	VON BRIESEN & ROPER, S.C.	DESTINY DEUERLING MATTER	4,746.00
2/17/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	4,042.41
2/29/2020	VON BRIESEN & ROPER, S.C.	IDHR CHARGE (DISABILITY)	196.00
2/29/2020	VON BRIESEN & ROPER, S.C.	DESTINY DEUERLING MATTER	560.00
3/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	962.50
3/31/2020	VON BRIESEN & ROPER, S.C.	DESTINY DEUERLING MATTER	336.00
4/21/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	98.00
4/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	1,198.60
4/30/2020	VON BRIESEN & ROPER, S.C.	DEUERLING EEOC CHARGE	1,676.00
4/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	8,000.00
4/30/2020	VON BRIESEN & ROPER, S.C.	TAINIKA SOMERVILLE MATTER	3,165.50
5/31/2020	VON BRIESEN & ROPER, S.C.	TAINIKA SOMERVILLE MATTER	5,835.00
6/30/2020	VON BRIESEN & ROPER, S.C.	DESTINY DEUERLING MATTER	336.00
5/31/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	175.00
6/30/2020	VON BRIESEN & ROPER, S.C.	TAINIKA SOMERVILLE MATTER	357.50
5/31/2020	VON BRIESEN & ROPER, S.C.	DESTINY DEUERLING MATTER	196.00
6/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	385.00
7/31/2020	VON BRIESEN & ROPER, S.C.	TAINIKA SOMERVILLE MATTER	1,237.50
6/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	133.00
8/31/2020	VON BRIESEN & ROPER, S.C.	TAINIKA SOMERVILLE MATTER	1,062.50
9/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	110.00
9/30/2020	VON BRIESEN & ROPER, S.C.	TAINIKA SOMERVILLE MATTER	522.50
9/30/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	280.00
11/23/2020	VON BRIESEN & ROPER, S.C.	Labor & Employment	365.63
11/23/2020	VON BRIESEN & ROPER, S.C.	HARRIS OSHA COMP	364.00
TOTAL			<u>88,521.58</u>

XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>YES</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>YES</u>
If YES, give association name and amount. <u>ICLTC-\$ 10,400</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>YES</u> If YES, have these costs been properly adjusted out of the cost report? <u>YES</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u>
What was the average life used for new equipment added during this period? <u>10 YR</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>34,129</u> Line <u>10-2</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>271,401</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>YES</u></p> <p>(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? <u>NO</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>14,420</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>NO</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> 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? <u>5%</u>
d. Have vehicle usage logs been maintained? <u>NO</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>NO</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>YES</u>
g. Does the facility transport residents to and from day training? <u>NO</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>NO</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. <u>YES</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|---|--|