FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0030551

Facility Name: Brightview Care Center

Address: 4538 North Beacon (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 275-7200 **Fax #** (773) 275-7543

HFS ID Number:

Date of Initial License for Current Owners: 02/01/1986

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,588	738	2,780	20,106	8
9	SNF/PED					9
10	ICF	24,916			24,916	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,504	738	2,780	45,022	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.26%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/1986 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 143 and days of care provided 2,585

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,440	42,554	5,633	283,627		283,627		283,627			1
2	Food Purchase		233,521		233,521	(23,034)	210,487	(2,282)	208,205			2
3	Housekeeping	284,255	68,776		353,031		353,031	605	353,636			3
4	Laundry	65,662	10,071		75,733		75,733		75,733			4
5	Heat and Other Utilities			153,185	153,185		153,185	2,266	155,451			5
6	Maintenance	108,181	29,593	28,293	166,067		166,067	2,976	169,043			6
7	Other (specify):*											7
8	TOTAL General Services	693,538	384,515	187,111	1,265,164	(23,034)	1,242,130	3,565	1,245,695			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	2,077,913	152,312	50,219	2,280,444		2,280,444		2,280,444			10
10a	Therapy	133,056	13,642	1,170	147,868		147,868		147,868			10a
11	Activities	84,044	6,451	2,424	92,919		92,919		92,919			11
12	Social Services	127,516			127,516		127,516		127,516			12
13	CNA Training											13
14	Program Transportation			50	50		50		50			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,422,529	172,405	81,463	2,676,397		2,676,397		2,676,397			16
	C. General Administration											
17	Administrative	171,006		319,049	490,055		490,055	(241,800)	248,255			17
18	Directors Fees											18
19	Professional Services			264,838	264,838		264,838	(182,398)	82,440			19
20	Dues, Fees, Subscriptions & Promotions			101,983	101,983		101,983	(84,779)	17,204			20
21	Clerical & General Office Expenses	115,345	45,461	279,002	439,808		439,808	(176,851)	262,957			21
22	Employee Benefits & Payroll Taxes			553,088	553,088	23,034	576,122		576,122			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,479	2,479		2,479	319	2,798			24
25	Other Admin. Staff Transportation			2,849	2,849		2,849	(1,034)	1,815			25
26	Insurance-Prop.Liab.Malpractice			2,645	2,645		2,645	141,220	143,865			26
27	Other (specify):*							36,244	36,244			27
28	TOTAL General Administration	286,351	45,461	1,525,933	1,857,745	23,034	1,880,779	(509,079)	1,371,700			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,402,418	602,381	1,794,507	5,799,306		5,799,306	(505,514)	5,293,792			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Brightview Care Center #0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,286	34,286		34,286	84,539	118,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,952	14,952		14,952	215,043	229,995			32
33	Real Estate Taxes							156,735	156,735			33
34	Rent-Facility & Grounds			690,000	690,000		690,000	(690,000)	0			34
35	Rent-Equipment & Vehicles			8,049	8,049		8,049	(8,035)	14			35
36	Other (specify):*							20,987	20,987			36
37	TOTAL Ownership			747,287	747,287		747,287	(220,731)	526,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,320	543,585	864,905		864,905		864,905			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*	85,546		41,834	127,380		127,380	(127,380)				43
44	TOTAL Special Cost Centers	85,546	321,320	663,712	1,070,578		1,070,578	(127,380)	943,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,487,964	923,701	3,205,506	7,617,171		7,617,171	(853,625)	6,763,546			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,232)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(47,812)	30		9
10	Interest and Other Investment Income	(28,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(38)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(51,050)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(245,502)	21		24
25	Fund Raising, Advertising and Promotional	(29,258)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(519,489)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (924,334)		$	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)	70,709		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 70,709		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (853,625)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (85,546)	43	1
2	Other Taxes	(124)	21	2
3	Bank Charges	(1,022)	21	3
4	Theft & Loss	(70)	21	4
5	Marketing Consultant	(41,834)	43	5
6	Non-Alowable Legal	(3,512)	19	6
7	Non-Allowable Travel	(1,038)	25	7
8	Additional R&M	2,115	06	8
9	Building Company- Legal & Professional Fees	(19,137)	19	9
10	Building Company- Amortization	(3,459)	36	10
11	Building Company- Other Costs	(100)	21	11
12	COPE Dues	(5,139)	20	12
13	Non-Allowable Accounting Fees	(5,000)	19	13
14	Building Company Bad Debts	(343,746)	21	14
15	Non-Allowable Auto Lease	(8,049)	35	15
16	Vending Income	(2,244)	02	16
17	Prior Period Expense	(1,584)	21	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(519,489)		49

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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													1
2	Food Purchase	(2,282)											(2,282)	2
3	Housekeeping			594		11							605	3
4	Laundry													4
5	Heat and Other Utilities			1,054		1,212							2,266	5
6	Maintenance	(117)		2,578		515							2,976	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,399)		4,226		1,738							3,565	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			48,031	(290,238)	407							(241,800)	17
18	Directors Fees													18
19	Professional Services	(27,649)	19,137	(173,946)		60							(182,398)	19
20	Fees, Subscriptions & Promotions	(85,447)		616	18	34							(84,779)	20
21	Clerical & General Office Expenses	(592,148)	343,846	71,150	285	16							(176,851)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			319									319	24
25	Other Admin. Staff Transportation	(1,038)		4									(1,034)	25
26	Insurance-Prop.Liab.Malpractice		140,823	234		163							141,220	26
27	Other (specify):*			32,950	3,294								36,244	27
28	**TOTAL General Administration**	(706,282)	503,806	(20,642)	(286,641)	680							(509,079)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(708,681)	503,806	(16,416)	(286,641)	2,418							(505,514)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Brightview Care Center** **#** **0030551** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(47,812)	129,068	3,109		174							84,539	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(28,953)	241,850	265		1,881							215,043	32
33	Real Estate Taxes		154,695			2,040							156,735	33
34	Rent-Facility & Grounds		(690,000)	8,913		(8,913)							(690,000)	34
35	Rent-Equipment & Vehicles	(8,049)		14									(8,035)	35
36	Other (specify):*	(3,459)	24,446										20,987	36
37	**TOTAL Ownership**	(88,273)	(139,941)	12,301		(4,818)							(220,731)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(127,380)											(127,380)	43
44	**TOTAL Special Cost Centers**	(127,380)											(127,380)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(924,334)	363,865	(4,115)	(286,641)	(2,400)							(853,625)	45

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Brightview Building Company		Building Co.

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 690,000	Brightview Building Company	100.00%	$	$ (690,000)	1
2	V	32	Interest	7,353	Brightview Building Company	100.00%	249,203	241,850	2
3	V	26	Insurance		Brightview Building Company	100.00%	140,823	140,823	3
4	V	19	Legal & Professional Fees		Brightview Building Company	100.00%	19,137	19,137	4
5	V	36	Mortgage Insurance		Brightview Building Company	100.00%	20,987	20,987	5
6	V	36	Amortization		Brightview Building Company	100.00%	3,459	3,459	6
7	V	33	Real Estate Taxes		Brightview Building Company	100.00%	154,695	154,695	7
8	V	30	Depreciation		Brightview Building Company	100.00%	129,068	129,068	8
9	V	21	Other Expenses		Brightview Building Company	100.00%	100	100	9
10	V	21	Bad Debt Expense		Brightview Building Company	100.00%	343,746	343,746	10
11	V								11
12	V								12
13	V								13
14	Total			$ 697,353			$ 1,061,218	$ * 363,865	14

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 594	$ 594	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,054	1,054	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,578	2,578	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	48,031	48,031	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,086	1,086	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	616	616	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	71,150	71,150	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	319	319	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	4	4	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	234	234	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	32,950	32,950	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	3,109	3,109	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	265	265	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	8,913	8,913	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	14	14	30
31	V	19	HOME OFFICE	175,032	MANAGCARE, INC.	100.00%		(175,032)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,032			$ 170,917	$ * (4,115)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 28,811	$ 28,811	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	18	18	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	285	285	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	3,294	3,294	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			20
21	V	32	INVESTMENT		INTERCARE, LTD. C/O MANAGCARE	100.00%			21
22	V	35	EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%			22
23	V								23
24	V	17	MANAGEMENT FEES	319,049	INTERCARE, LTD. C/O MANAGCARE	100.00%		(319,049)	24
25	V								25
26	V								26
27	V								27
28	V								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			$ 319,049			$ 32,408	$ * (286,641)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MAZEL MANAGEMENT	100.00%	$ 11	$ 11	15
16	V	5	UTILITIES		MAZEL MANAGEMENT		1,212	1,212	16
17	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		515	515	17
18	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		407	407	19
20	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		60	60	20
21	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		34	34	21
22	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		16	16	22
23	V	26	INSURANCE		MAZEL MANAGEMENT		163	163	23
24	V	30	DEPRECIATION		MAZEL MANAGEMENT		174	174	24
25	V	31	AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		1,881	1,881	26
27	V	33	REAL ESTATE TAXES				2,040	2,040	27
28	V								28
29	V	34	RENT	8,913				(8,913)	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			$ 8,913			$ 6,513	$ * (2,400)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Owner	Administrative	90.93%	See Attached	4.32	14.40%	Sal/Alloc Sal	$ 43,811	17-1,17-7	1
2	Nesanel Davis	Relative	Administrative	0.00%	None	4.00	8.33%	Salary	38,828	17-1	2
3	Moshe Wolf	Relative	Administrator	0.00%	See Attached	35.87	74.73%	Sal/Al Sal/Fees	65,684	17-1, 17-7	3
4	Stanley Klem	Owner	Administrative	2.77%	See Attached	7.82	17.38%	Alloc Salary	23,606	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjsuted from the actual costs to reflect only amounts anticipated to be considered allowable										7
8	by the IL. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 171,929		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 Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	3	HOUSEKEEPING	PATIENT DAYS	259,131	3	$ 3,420	$	45,022	$ 594	1
2	5	UTILITIES	PATIENT DAYS	259,131	3	6,068		45,022	1,054	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	259,131	3	14,839		45,022	2,578	3
4	10	NURSING SALARIES	PATIENT DAYS	259,131	3			45,022		4
5	17	ADMINISTRATIVE	PATIENT DAYS	259,131	3	276,447	276,447	45,022	48,031	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	259,131	3	6,250		45,022	1,086	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	259,131	3	3,547		45,022	616	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	259,131	3	409,513	341,493	45,022	71,150	8
9	24	SEMINARS	PATIENT DAYS	259,131	3	1,835		45,022	319	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	259,131	3	22		45,022	4	10
11	26	INSURANCE	PATIENT DAYS	259,131	3	1,347		45,022	234	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	259,131	3	200,550		45,022	32,950	12
13	30	DEPRECIATION	PATIENT DAYS	259,131	3	17,897		45,022	3,109	13
14	32	INTEREST EXPENSE	PATIENT DAYS	259,131	3	1,526		45,022	265	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	259,131	3	51,300		45,022	8,913	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	259,131	3	81		45,022	14	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 994,642	$ 617,940		$ 170,917	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	17	ADMINISTRATIVE	AVG. HOURS WORKED	18	4	$ 120,000	$ 120,000	4	$ 28,811	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	18	4			4		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	75		4	18	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	1,189		4	285	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	13,719		4	3,294	5
6	30	DEPRECIATION	AVG. HOURS WORKED	18	4			4		6
7	32	INVESTMENT	AVG. HOURS WORKED	18	4			4		7
8	35	EQUIPMENT RENTAL	AVG. HOURS WORKED	18	4			4		8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 134,983	$ 120,000		$ 32,408	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	259,131	3	$ 62	$	45,022	$ 11	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	259,131	3	6,974		45,022	1,212	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	259,131	3	2,962		45,022	515	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	259,131	3			45,022		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	259,131	3	2,340		45,022	407	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	259,131	3	344		45,022	60	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	259,131	3	198		45,022	34	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	259,131	3	90		45,022	16	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	259,131	3	938		45,022	163	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	259,131	3	1,002		45,022	174	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	259,131	3			45,022		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	259,131	3	10,826		45,022	1,881	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	259,131	3	11,741		45,022	2,040	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 37,477	$		$ 6,513	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Midland		X	Mortgage	$24,481.00	6/1/2007	$	$ 4,203,238	7/1/2042	5.9000	$ 249,203	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit							8,037	6
7	Brightview Building Co.	X		Working Capital							6,915	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$24,481.00		$	$ 4,203,238			$ 264,155	9
	B. Non-Facility Related*											
10	Interest Income		X								(28,953)	10
11	Interest Income-Building Co.		X								(7,353)	11
12	Allocated From Managcare		X								265	12
13	See Supplemental Schedule										1,881	13
14	TOTAL Non-Facility Related						$	$			$ (34,160)	14
15	TOTALS (line 9+line14)						$	$ 4,203,238			$ 229,995	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 20,987 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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Allocated from Mazel Mgmt.		X				$	$			$ 1,881	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										1,881	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	156,600	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.)	$	156,135	2
3. Under or (over) accrual (line 2 minus line 1).	$	(465)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	157,200	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.	$	156,735	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	168,711	8
	2006	153,355	9
	2007	151,976	10
	2008	153,577	11
	2009	154,095	12

2010 Accrual = $154,095 X 1.02 = $157,200 (Rounded)

Allocated From Mazel Management: $2,040

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Long Term Care Property	$ 61,058.17	$ 61,058.17
2.	14-17-115-018-0000	Long Term Care Property	$ 58,412.13	$ 58,412.13
3.	14-17-115-030-0000	Long Term Care Property	$ 34,624.90	$ 34,624.90
4.	See Attached	Allocated from Mazel Management	$ 51,712.83	$ 2,059.86
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 205,808.03	$ 156,155.06

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? X YES _____ NO

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 73,992	1
2					2
3	TOTALS			$ 73,992	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306		20			10,284	9
10	Various			1987	4,719		20			4,712	10
11	Various			1988	2,895		20			2,891	11
12	Various			1989	67,265		20			67,250	12
13	Various			1991	22,384		20	1,119	1,119	19,835	13
14	Various			1992	17,019		20	143	143	15,181	14
15	Various			1993	44,200		20	1,940	1,940	38,277	15
16	Various			1994	63,594		20	3,180	3,180	52,553	16
17	Various			1995	7,105		20	355	355	5,539	17
18	Various			1996	37,640		20	1,882	1,882	27,859	18
19	Various			1997	17,411		20	871	871	11,392	19
20	Various			1998	49,850		20	2,493	2,493	30,802	20
21	Various			1999	215,484		20	10,774	10,774	124,581	21
22	Various			2000	47,834		20	2,392	2,392	25,071	22
23	Various			2001	35,034		20	2,167	2,167	20,704	23
24	Various			2002	33,534		20	2,615	2,615	24,136	24
25	Various			2003	21,000		20	1,356	1,356	10,221	25
26	Various			2004	67,457		20	5,352	5,352	40,508	26
27	Various			2005	20,650		20	1,669	1,669	9,681	27
28	Various			2006	19,318		20	1,455	1,455	6,428	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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 Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,910,789	129,068		50,573	(78,495)	2,202,675	67
68	Related Party Allocations (Pages 12H & 12I)		50,917	368		1,191	823	43,244	68
69	Financial Statement Depreciation			15,955			(15,955)		69
70	TOTAL (lines 4 thru 69)		$ 3,766,404	$ 145,391		$ 91,526	$ (53,865)	$ 2,793,823	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,766,404	$ 145,391		$ 91,526	$ (53,865)	$ 2,793,823	1
2	Elevator Repairs	2007	2,500		20	125	125	479	2
3	Elevator	2010	59,711		20	2,986	2,986	2,986	3
4	Elevator Repair	2010	2,500		20	125	125	125	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 3,831,115	$ 145,391		$ 94,762	$ (50,629)	$ 2,797,413	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information								1
2	Buildings:								2
3	Brightview Building Company	1968	1,899,326		35			1,899,326	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	2004 Improvements	2004	534,642	129,068	20	26,732	(102,336)	187,125	9
10	Bathroom Remodeling	2005	1,925		20	96	96	577	10
11	Gluedown Carpet In Conf. Room	2005	980		20	49	49	294	11
12	Laminating Desk In Reception Area	2005	8,016		20	401	401	2,405	12
13	Crown Molding	2005	1,183		20	59	59	355	13
14	Wall Covering	2005	2,044		20	102	102	613	14
15	Light Fixtures	2005	643		20	32	32	193	15
16	Drapery Panels	2005	1,340		20	67	67	402	16
17	Removal & Installation Of Vinyl In Lobby	2005	12,547		20	627	627	3,764	17
18	Crown Molding & Wood Fronts In Nurses Station	2005	19,159		20	958	958	5,748	18
19	Installation Of New Carpet & Cove Base	2005	892		20	45	45	268	19
20	Faux Wood Blinds	2005	283		20	14	14	85	20
21	Installation Of New VCT And Cove Base	2005	258		20	13	13	77	21
22	Ceramic Tile Installation In Bathroom	2005	816		20	41	41	245	22
23	Pedimat & Ceramic Tile In Vestibule	2005	3,829		20	191	191	1,149	23
24	Wall Covering & Repainting In Med Room	2005	5,630		20	282	282	1,689	24
25	Vestibule	2005	199,403		20	9,970	9,970	59,821	25
26	Bumpers, Corner Guards & Handrails	2005	3,998		20	200	200	1,199	26
27	Door Casings	2005	1,463		20	73	73	439	27
28	Elevator Wraps	2005	930		20	46	46	279	28
29	Resident Room Pvc Sheeting	2005	3,882		20	194	194	1,165	29
30	Bumpers, Corner Guards & Handrails	2005	2,442		20	122	122	733	30
31	Drywall & Framing For Sprinkler Piping	2005	1,872		20	94	94	561	31
32	Time & Materials For Invoice Period	2005	309		20	15	15	93	32
33	Demolition Of Medication & Linen Rooms	2005	3,453		20	173	173	1,036	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information Continued		$	$		$	$	$	1
2	Electrical For Receptacles & Lights	2005	2,129		20	106	106	639	2
3	Concrete Flatwork	2005	978		20	49	49	294	3
4	Sliding Doors	2005	7,654		20	383	383	2,296	4
5	Installation Of New Window Opening	2005	3,039		20	152	152	912	5
6	HVAC, Sprinkler, Fire Alarm	2005	17,141		20	857	857	5,142	6
7	Fireproofing Of Existing Steel Beams	2005	403		20	20	20	121	7
8	New Ceilings & Lighting	2005	2,129		20	106	106	639	8
9	Cabinets, Countertops, & Plumbing	2005	1,093		20	55	55	328	9
10	New Shelving For DON Office Closet	2005	460		20	23	23	138	10
11	Plumbing	2005	1,496		20	75	75	449	11
12	Faux Food Blinds	2005	1,055		20	53	53	317	12
13	A/C Compressor	2007	6,886		20	344	344	1,377	13
14	Wiring - 2 Rooms	2007	8,100		20	405	405	1,620	14
15	2 Smoke Detectors	2007	4,062		20	203	203	812	15
16	150 AMP Volt Feeder	2008	2,000		20	100	100	300	16
17	Sprinkler System Repair	2008	2,520		20	126	126	378	17
18	Roofing and Tuckpointing	2008	5,000		20	250	250	750	18
19	Elevator	2008	17,000		20	850	850	2,550	19
20	Water Tube for Boiler	2008	2,800		20	140	140	420	20
21	Hot Water Storage Tank	2008	14,727		20	736	736	2,209	21
22	OEM Pump and Coil	2008	14,865		20	743	743	2,230	22
23	Cooling Tower	2008	5,250		20	263	263	788	23
24	Security Cameras	2008	9,090		20	455	455	1,364	24
25	Brick & Cement Repair	2009	6,200		20	310	310	620	25
26	Custom Carpetry	2009	5,140		20	257	257	514	26
27	Window Repairs	2009	4,500		20	225	225	450	27
28	Copper Fittings & Valves	2009	5,693		20	285	285	569	28
29	Boiler Gas Valve Motor & Temp Control	2009	2,542		20	127	127	254	29
30	Sewer Access	2010	3,750		20	188	188	375	30
31	Basement Flooring	2010	12,700		20	635	635	1,270	31
32	Basement Door & Wall	2010	17,120		20	856	856	1,712	32
33	Wood Flooring	2010	12,000		20	600	600	1,200	33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 2,910,789	$ 129,068		$ 50,573	$ (78,495)	$ 2,202,675	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Mazel Management	1985	17,925		39	597	597	15,087	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2008	2,430	186	20	243	57	709	9
10	Allocated From Managcare	1997	2,090		20			2,090	10
11	Allocated From Managcare	1993	164		20	8	8	144	11
12	Allocated From Managcare	1988	256	8	20		(8)	256	12
13	Allocated From Managcare	1986	19,385		20			19,384	13
14									14
15	Allocated From Mazel Management	2007	1,055	27	20	53	26	187	15
16	Allocated From Mazel Management	2006	566	14	20	28	14	127	16
17	Allocated From Mazel Management	2005	423	38	20	42	4	232	17
18	Allocated From Mazel Management	2001	376	10	20	19	9	179	18
19	Allocated From Mazel Management	2000	190	5	20	10	5	98	19
20	Allocated From Mazel Management	1998	671	22	20	34	12	426	20
21	Allocated From Mazel Management	1997	625	16	20	31	15	417	21
22	Allocated From Mazel Management	1996	426	5	20	21	16	311	22
23	Allocated From Mazel Management	1995	96	2	20	5	3	75	23
24	Allocated From Mazel Management	1994	381	7	20	19	12	294	24
25	Allocated From Mazel Management	1993	225	7	20	11	4	196	25
26	Allocated From Mazel Management	1991	168	5	20	8	3	156	26
27	Allocated From Mazel Management	1990	262	5	20	4	(1)	257	27
28	Allocated From Mazel Management	1989	164	4	20	5	1	145	28
29	Allocated From Mazel Management	1987	372	7	20		(7)	372	29
30	Allocated From Mazel Management	1986	1,502		20			1,502	30
31	Allocated From Mazel Management	1985	105		20			105	31
32									32
33	Allocated From Intercare	2001	1,060		20	53	53	495	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 50,917	$ 368		$ 1,191	$ 823	$ 43,244	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 270,648	$ 2,928	$ 17,129	$ 14,201	10	$ 223,443	71
72	Current Year Purchases	41,330	15,640	4,296	(11,344)	10	4,296	72
73	Fully Depreciated Assets	344,820				10	344,820	73
74								74
75	TOTALS	$ 656,798	$ 18,568	$ 21,425	$ 2,857		$ 572,559	75

D. Vehicle Depreciation (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		Allocated From Managcare	2010	$ 19,825	$ 2,679	$ 2,639	$ (40)	5	$ 9,889	76
77										77
78										78
79										79
80	TOTALS			$ 19,825	$ 2,679	$ 2,639	$ (40)		$ 9,889	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)	$ 4,581,730	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 166,638	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,826	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (47,812)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,379,861	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

STATE OF ILLINOIS
0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 - 03	hrs	$		$ 198,609	$		$ 198,609	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			117,679			117,679	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			227,162			227,162	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				140,305		140,305	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					135	181,015		181,150	13
14	TOTAL			$		$ 543,585	$ 321,320		$ 864,905	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Brightview Care Center **#** 0030551 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 724,019	$ 885,579	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	359,918	870,101	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,827	110,126	6
7	Other Prepaid Expenses	5,911	5,911	7
8	Accounts Receivable (owners or related parties)	39,732	39,732	8
9	Other(specify): See Attached Schedule	562	369,630	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,191,969	$ 2,284,079	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	617,979	809,969	15
16	Equipment, at Historical Cost	490,416	703,274	16
17	Accumulated Depreciation (book methods)	(728,069)	(3,406,239)	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): See Attached Schedule		108,668	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 380,326	$ 1,244,762	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,572,295	$ 3,528,841	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 610,614	$ 645,662	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,019	43,019	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	105,723	105,723	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,071	12,071	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,200	32
33	Accrued Interest Payable	158,183	178,849	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	291,961	291,961	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,221,571	$ 1,434,485	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,203,238	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,203,238	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,221,571	$ 5,637,723	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 350,724	$ (2,108,882)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,572,295	$ 3,528,841	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 331,587	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	(5)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 331,582	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	19,142	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 19,142	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)**	$ 350,724	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,009,433	1
2	Discounts and Allowances for all Levels	(604,704)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,404,729	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	873,220	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 873,220	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	151,888	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,871	19
20	Radiology and X-Ray	2,195	20
21	Other Medical Services	29,452	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 194,406	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,953	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,953	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	135,005	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 135,005	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,636,313	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,265,164	31
32	Health Care	2,676,397	32
33	General Administration	1,857,745	33
	B. Capital Expense		
34	Ownership	747,287	34
	C. Ancillary Expense		
35	Special Cost Centers	992,285	35
36	Provider Participation Fee	78,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,617,171	40
41	**Income before Income Taxes (line 30 minus line 40)****	19,142	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 19,142	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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.** SEE ACCOUNTANTS' COMPILATION REPORT

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,480	1,528	$ 55,123	$ 36.08	1
2	Assistant Director of Nursing	1,807	2,071	66,340	32.03	2
3	Registered Nurses	12,267	13,600	416,606	30.63	3
4	Licensed Practical Nurses	30,553	32,922	750,229	22.79	4
5	CNAs & Orderlies	70,290	75,833	765,330	10.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,314	9,309	133,056	14.29	8
9	Activity Director	1,405	1,453	24,763	17.04	9
10	Activity Assistants	6,684	7,101	59,281	8.35	10
11	Social Service Workers	7,118	7,458	127,516	17.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,190	20,280	235,440	11.61	15
16	Dishwashers					16
17	Maintenance Workers	5,754	6,395	108,181	16.92	17
18	Housekeepers	22,993	25,439	284,255	11.17	18
19	Laundry	6,610	7,194	65,662	9.13	19
20	Administrator	1,865	1,865	60,000	32.17	20
21	Assistant Administrator	2,048	2,160	57,178	26.47	21
22	Other Administrative	832	832	53,828	64.70	22
23	Office Manager					23
24	Clerical	8,690	9,539	115,345	12.09	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	952	1,040	24,285	23.35	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,056	2,064	85,546	41.45	33
34	TOTAL (lines 1 - 33)	209,908	228,083	$ 3,487,964 *	$ 15.29	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	107	$ 5,633	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant	99	4,554	10-03	37
38	Nurse Consultant	Monthly	6,218	10-03	38
39	Pharmacist Consultant	Monthly	7,447	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	26	1,170	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	2,424	11-03	44
45	Social Service Consultant				45
46	Other(specify) Rehab Medical Dir.	Monthly	18,000	10-03	46
47	Geriatric Program Director	Monthly	8,000	10-03	47
48	Psychiatric Medical Director	Monthly	6,000	09-03	48
49	TOTAL (lines 35 - 48)	258	$ 87,046		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Moshe Wolf	Administrator	0.00%	$ 60,000
Shai Berdugo	Asst. Admin	0.00%	57,178
Yosef Davis	Administrative	90.93%	15,000
Nesanel Davis	Administrative	0.00%	38,828
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 171,006

B. Administrative - Other

Description	Amount
Management Fees- Intercare, Ltd.	$ 319,049
TOTAL (agree to Schedule V, line 17, col. 3)	$ 319,049
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 20,250
Managcare, Inc	Bookkeeping	175,032
E-Health Data Solutions	Computer Services	5,217
American Data	Computer Services	4,079
Kipp Computer Solutions	Computer Services	2,700
Kronos	Computer Services	380
Cimpar Consulting	Strategic Consulting	1,400
Personnel Planners	Unemployment Tax Consult	1,344
Honkamp Krueger	Unemployment Tax Consult	516
See Attached	Legal	53,920
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 264,838

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,994
Unemployment Compensation Insurance	27,141
FICA Taxes	258,916
Employee Health Insurance	180,106
Employee Meals	23,034
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	5,432
Dental Insurance	461
Other Employee Benefits	4,410
Holiday Expense	9,873
Pension Expense	7,125
Disability Insurance	4,106
See Supplemental Schedule	2,524
TOTAL (agree to Schedule V, line 22, col.8)	$ 576,122

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	$ 995
Advertising: Employee Recruitment	275
Health Care Worker Background Check	
(Indicate # of checks performed 66)	661
Patient Background Checks 89	889
Licenses, Permits, Inspections	1,878
Annual Fee	643
Advertising & Promotions	29,258
Dues & Subscriptions	11,195
See Supplemental Schedule	668
Less: Public Relations Expense	( )
Non-allowable advertising	(29,258)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,204

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,479
Allocated From Managcare	319
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,798

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC- $12,226**

(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? **N/A**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,941** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **78,293**
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. $ **23,034** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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