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.

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

I. IDPH License ID Number: 0030551

Facility Name: Brightview Care Center

Address: 4538 N. 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: 02/01/86

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 01/01/11 to 12/31/11 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: 01/01/11 Ending: 12/31/11

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	15,380	603	2,198	18,181	8
9	SNF/PED					9
10	ICF	26,370			26,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,750	603	2,198	44,551	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.35%

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 1,870

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: 12/31/2011 Fiscal Year: 12/31/2011

* 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: 01/01/11 Ending: 12/31/11

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	244,267	42,242	7,576	294,085		294,085		294,085			1
2	Food Purchase		253,073		253,073	(25,291)	227,782	(1,672)	226,110			2
3	Housekeeping	275,500	62,961		338,461		338,461	600	339,061			3
4	Laundry	82,155	8,397		90,552		90,552		90,552			4
5	Heat and Other Utilities			159,012	159,012		159,012	1,954	160,966			5
6	Maintenance	115,868	23,709	36,676	176,253		176,253	4,909	181,162			6
7	Other (specify):*											7
8	TOTAL General Services	717,790	390,382	203,264	1,311,436	(25,291)	1,286,145	5,791	1,291,936			8
	B. Health Care and Programs											
9	Medical Director			27,600	27,600		27,600		27,600			9
10	Nursing and Medical Records	2,139,748	184,679	52,554	2,376,981		2,376,981		2,376,981			10
10a	Therapy	145,030	16,662	90	161,782		161,782		161,782			10a
11	Activities	78,058	7,559	2,750	88,367		88,367		88,367			11
12	Social Services	129,172			129,172		129,172		129,172			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,492,008	208,900	82,994	2,783,902		2,783,902		2,783,902			16
	C. General Administration											
17	Administrative	134,986		211,332	346,318		346,318	(124,785)	221,533			17
18	Directors Fees											18
19	Professional Services			260,079	260,079	(4,857)	255,222	(217,129)	38,094			19
20	Dues, Fees, Subscriptions & Promotions			121,175	121,175		121,175	(79,005)	42,170			20
21	Clerical & General Office Expenses	161,562	38,876	355,758	556,196		556,196	(215,622)	340,574			21
22	Employee Benefits & Payroll Taxes			557,131	557,131	25,291	582,422		582,422			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,438	3,438		3,438	225	3,663			24
25	Other Admin. Staff Transportation			2,765	2,765		2,765	(460)	2,305			25
26	Insurance-Prop.Liab.Malpractice			1,680	1,680		1,680	127,258	128,938			26
27	Other (specify):*							48,283	48,283			27
28	TOTAL General Administration	296,548	38,876	1,513,358	1,848,782	20,434	1,869,216	(461,235)	1,407,981			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,506,346	638,158	1,799,616	5,944,120	(4,857)	5,939,263	(455,444)	5,483,819			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: 01/01/11 Ending: 12/31/11

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			39,451	39,451		39,451	69,039	108,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,137	31,137		31,137	225,606	256,743			32
33	Real Estate Taxes			15,414	15,414	4,857	20,271	154,356	174,627			33
34	Rent-Facility & Grounds			690,000	690,000		690,000	(690,000)	0			34
35	Rent-Equipment & Vehicles			8,340	8,340		8,340	(7,907)	433			35
36	Other (specify):*							20,750	20,750			36
37	**TOTAL Ownership**			784,342	784,342	4,857	789,199	(228,156)	561,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,119	370,816	586,935		586,935		586,935			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			250,566	250,566		250,566		250,566			42
43	Other (specify):*	116,082		21,758	137,840		137,840	(137,840)	(0)			43
44	**TOTAL Special Cost Centers**	116,082	216,119	643,140	975,341		975,341	(137,840)	837,501			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,622,428	854,277	3,227,098	7,703,803		7,703,803	(821,440)	6,882,363			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: 01/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,639)	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	(20,891)	30		9
10	Interest and Other Investment Income	(19,056)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	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	(50,650)	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	(319,931)	21		24
25	Fund Raising, Advertising and Promotional	(24,795)	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	(176,497)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (618,493)		$	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)	(202,948)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (202,948)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (821,440)		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: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (116,082)	43	1
2	Jury Duty	(34)	21	2
3	Bank Charges	(2,764)	21	3
4	Marketing Consultant	(21,758)	43	4
5	Non-Allowable Legal	(2,844)	19	5
6	Non-Allowable Travel	(498)	25	6
7	Additional R&M	1,317	06	7
8	Building Company - Legal & Professional Fees	(10,790)	19	8
9	Building Company - Amortization	(3,459)	36	9
10	Building Company - Other Costs	(100)	21	10
11	COPE Dues	(3,449)	20	11
12	Non-Allowable Accoutning Fees	(5,000)	19	12
13	Non-Allowable Auto Lease	(8,340)	35	13
14	Vending Income	(1,638)	02	14
15	Annual Fee	(643)	20	15
16	2010 Repl Tax	(414)	21	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				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**	(176,497)		49

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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:** 01/01/11 **Ending:** 12/31/11

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	(1,672)											(1,672)	2
3	Housekeeping			575		25							600	3
4	Laundry													4
5	Heat and Other Utilities			1,074		880							1,954	5
6	Maintenance	(5,322)	1,850	7,793		588							4,909	6
7	Other (specify):*													7
8	**TOTAL General Services**	(6,994)	1,850	9,442		1,493							5,791	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			57,553	(182,757)	419							(124,785)	17
18	Directors Fees													18
19	Professional Services	(18,634)	15,647	(214,203)		61							(217,129)	19
20	Fees, Subscriptions & Promotions	(79,537)		514	18								(79,005)	20
21	Clerical & General Office Expenses	(323,243)	100	107,484	37								(215,622)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			225									225	24
25	Other Admin. Staff Transportation	(498)		38									(460)	25
26	Insurance-Prop.Liab.Malpractice		126,568	521		169							127,258	26
27	Other (specify):*			46,131	2,152								48,283	27
28	**TOTAL General Administration**	(421,912)	142,315	(1,737)	(180,550)	649							(461,235)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(428,906)	144,165	7,705	(180,550)	2,142							(455,444)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	(20,891)	87,030	2,675		225							69,039	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,056)	242,714	184		1,764							225,606	32
33	Real Estate Taxes		152,189			2,167							154,356	33
34	Rent-Facility & Grounds		(690,000)	8,620		(8,620)							(690,000)	34
35	Rent-Equipment & Vehicles	(8,340)		433									(7,907)	35
36	Other (specify):*	(3,459)	24,209										20,750	36
37	**TOTAL Ownership**	(51,746)	(183,858)	11,912		(4,464)							(228,156)	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):*	(137,840)											(137,840)	43
44	**TOTAL Special Cost Centers**	(137,840)											(137,840)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(618,493)	(39,693)	19,617	(180,550)	(2,322)							(821,440)	45

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	3,787	Brightview Building Company	100.00%	246,501	242,714	2
3	V	26	Insurance		Brightview Building Company	100.00%	126,568	126,568	3
4	V	19	Legal & Professional Fees		Brightview Building Company	100.00%	15,647	15,647	4
5	V	36	Mortgage Insurance		Brightview Building Company	100.00%	20,750	20,750	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%	152,189	152,189	7
8	V	30	Depreciation		Brightview Building Company	100.00%	87,030	87,030	8
9	V	21	Other Expenses		Brightview Building Company	100.00%	100	100	9
10	V	06	Repairs & Maintenance		Brightview Building Company	100.00%	1,850	1,850	10
11	V								11
12	V								12
13	V								13
14	Total			$ 693,787			$ 654,094	$ * (39,693)	14

* 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: 01/01/11 Ending: 12/31/11

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%	$ 575	$ 575	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,074	1,074	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	7,793	7,793	17
18	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	57,553	57,553	18
19	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	297	297	19
20	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	514	514	20
21	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	107,484	107,484	21
22	V	24	SEMINARS		MANAGCARE, INC.	100.00%	225	225	22
23	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	38	38	23
24	V	26	INSURANCE		MANAGCARE, INC.	100.00%	521	521	24
25	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	46,131	46,131	25
26	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	2,675	2,675	26
27	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	184	184	27
28	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	8,620	8,620	28
29	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	433	433	29
30	V								30
31	V	19	HOME OFFICE	214,500		100.00%		(214,500)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 214,500			$ 234,117	$ * 19,617	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: 01/01/11 Ending: 12/31/11

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%	$ 28,575	$ 28,575	15
16	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	18	18	16
17	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	37	37	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	2,152	2,152	18
19	V								19
20	V	17	MANAGEMENT FEES	211,332	INTERCARE, LTD. C/O MANAGCARE	100.00%		(211,332)	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			$ 211,332			$ 30,782	$ * (180,550)	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: 01/01/11 Ending: 12/31/11

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	$	3553 WEST PETERSON AVE BLDG. PTR.	100.00%	$ 25	$ 25	15
16	V	5	UTILITIES		3553 WEST PETERSON AVE BLDG. PTR.		880	880	16
17	V	6	REPAIRS & MAINT.		3553 WEST PETERSON AVE BLDG. PTR.		588	588	17
18	V	17	ADMIN.-M. WOLF		3553 WEST PETERSON AVE BLDG. PTR.		419	419	18
19	V	19	PROFESSIONAL FEES		3553 WEST PETERSON AVE BLDG. PTR.		61	61	19
20	V	26	INSURANCE		3553 WEST PETERSON AVE BLDG. PTR.		169	169	20
21	V	30	DEPRECIATION		3553 WEST PETERSON AVE BLDG. PTR.		225	225	21
22	V	32	INTEREST EXPENSE		3553 WEST PETERSON AVE BLDG. PTR.		1,764	1,764	22
23	V	33	REAL ESTATE TAXES		3553 WEST PETERSON AVE BLDG. PTR.		2,167	2,167	23
24	V								24
25	V	34	RENT	8,620	3553 WEST PETERSON AVE BLDG. PTR.			(8,620)	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			$ 8,620			$ 6,298	$ * (2,322)	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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	EDIE DAVIS	0.71%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	BRIGHTVIEW BUILDING COMP		BUILDING CO.	1
2	STANLEY KLEM	2.77%	MAYFIELD CARE CENTER, INC.	CHICAGO	3553 WEST PETERSON AVE BLD		BUILDING CO.	2
3	YOSEF DAVIS DELTA TRUST	90.93%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.		MANAGEMENT CO.	3
4	MOSHE WOLF	2.77%			INTERCARE, LTD. C/O MANAG		MANAGEMENT CO.	4
5	CHAYA SMALL	2.83%						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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	4.29	14.30%	Sal/Alloc Sal	$ 43,575	17-1,17-7	1
2	Nesanel Davis	Relative	Administrative	0.00%	None	9.10	18.96%	Salary	34,253	17-1	2
3	Moshe Wolf	Owner	Administrator	2.77%	See Attached	6.72	14.00%	Al Sal/Fees	17,302	17-7	3
4	Stanley Klem	Owner	Administrative	2.77%	See Attached	7.39	16.80%	Alloc Salary	23,960	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	$ 119,090		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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	265,143	4	$ 3,420	$	44,551	$ 575	1
2	5	UTILITIES	PATIENT DAYS	265,143	4	6,395		44,551	1,074	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	265,143	4	46,378		44,551	7,793	3
4	17	ADMINISTRATIVE	PATIENT DAYS	265,143	4	342,522	342,522	44,551	57,553	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	265,143	4	1,765		44,551	297	5
6	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	265,143	4	3,059		44,551	514	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	265,143	4	639,686	395,180	44,551	107,484	7
8	24	SEMINARS	PATIENT DAYS	265,143	4	1,339		44,551	225	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	265,143	4	229		44,551	38	9
10	26	INSURANCE	PATIENT DAYS	265,143	4	3,101		44,551	521	10
11	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	265,143	4	274,547		44,551	46,131	11
12	30	DEPRECIATION	PATIENT DAYS	265,143	4	15,921		44,551	2,675	12
13	32	INTEREST EXPENSE	PATIENT DAYS	265,143	4	1,096		44,551	184	13
14	34	RENT - BUILDING (RELATED)	PATIENT DAYS	265,143	4	51,300		44,551	8,620	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	265,143	4	2,577		44,551	433	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,393,335	$ 737,703		$ 234,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 28,575	1
2	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	75		4	18	2
3	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	155		4	37	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	9,037		4	2,152	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					$ 129,267	$ 120,000		$ 30,782	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 3553 WEST PETERSON AVE BLDG. PTR.
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	265,143	4	$ 147	$	44,551	$ 25	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	265,143	4	5,239		44,551	880	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	265,143	4	3,498		44,551	588	3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	265,143	4	2,492		44,551	419	4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	265,143	4	363		44,551	61	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	265,143	4	1,007		44,551	169	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	265,143	4	1,338		44,551	225	7
8	31	INTEREST EXPENSE	MNGCR. PATIENT DAYS	265,143	4	10,498		44,551	1,764	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	265,143	4	12,899		44,551	2,167	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					$ 37,481	$		$ 6,298	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	$ 4,156,194	7/1/2042	5.9000	$ 246,501	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				1,000,000		4.2500	26,043	6
7	Brightview Building Co.	X		Working Capital							5,094	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$24,481.00		$	$ 5,156,194			$ 277,638	9
	B. Non-Facility Related*											
10	Interest Income		X								(19,056)	10
11	Interest Income-Building Co		X								(3,787)	11
12	Allocated from Managcare		X								184	12
13	Allocated from 3553 WEST PETERSO		X								1,764	13
14	TOTAL Non-Facility Related						$	$			$ (20,896)	14
15	TOTALS (line 9+line14)						$	$ 5,156,194			$ 256,742	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 20,750 **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: 01/01/11 Ending: 12/31/11

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							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 157,200	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.)		$ 162,970	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,770	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 164,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$ 4,857	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** $ 15,414 **For** 01/07 **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.		$ 174,627	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	153,355	8
	2007	151,976	9
	2008	153,577	10
	2009	154,095	11
	2010	160,803	12

2011 Accrual = $157,200 X 1.04= $164,000 (Rounded)

Allocated From 3553 WEST PETERSON AVE BLDG. PTR.: $2,167

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) 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	$ 63,716.31	$ 63,716.31
2.	14-17-115-018-0000	Long Term Care Property	$ 60,955.05	$ 60,955.05
3.	14-17-115-030-0000	Long Term Care Property	$ 36,131.35	$ 36,131.35
4.	See Attached	Allocated from 3553 WEST PETERS(	$ 53,964.18	$ 2,078.82
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 214,766.89	$ 162,881.53

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

C. **Tax Bills**

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143			1968	$ 1,899,326	$	35	$	$	$ 1,899,326	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	619	619	20,454	13
14	Various			1992	17,019		20	143	143	15,324	14
15	Various			1993	44,200		20	1,940	1,940	40,217	15
16	Various			1994	63,594		20	3,180	3,180	55,733	16
17	Various			1995	7,105		20	355	355	5,895	17
18	Various			1996	37,640		20	1,882	1,882	29,741	18
19	Various			1997	17,411		20	871	871	12,263	19
20	Various			1998	49,850		20	2,493	2,493	33,294	20
21	Various			1999	215,484		20	10,774	10,774	135,355	21
22	Various			2000	47,834		20	2,392	2,392	27,463	22
23	Various			2001	35,034		20	1,680	1,680	22,384	23
24	Various			2002	33,534		20	2,615	2,615	26,750	24
25	Various			2003	21,000		20	1,356	1,356	11,578	25
26	Various			2004	67,457		20	5,352	5,352	45,860	26
27	Various			2005	20,650		20	1,669	1,669	11,350	27
28	Various			2006	19,318		20	1,455	1,455	7,883	28
29	Various			2007	2,500		20	125	125	604	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		1,090,630	64,781		54,532	(10,249)	360,993	67
68	Related Party Allocations (Pages 12H & 12I)		50,060	361		1,202	841	43,032	68
69	Financial Statement Depreciation			39,451			(39,451)		69
70	TOTAL (lines 4 thru 69)		$ 3,847,215	$ 104,593		$ 94,634	$ (9,959)	$ 2,890,634	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,847,215	$ 104,593		$ 94,634	$ (9,959)	$ 2,890,634	1
2	Wall-Mounted Sign	2011	9,417		20	314	314	314	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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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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)		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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)		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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)		$ 3,856,632	$ 104,593		$ 94,948	$ (9,645)	$ 2,890,948	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	2004 Improvements	2004	534,642	64,781	20	26,732	(38,049)	213,857	9
10	2005 Improvements	2005	314,875		20	15,744	15,744	110,207	10
11	2007 Improvements	2007	19,048		20	952	952	4,762	11
12	150 AMP Volt Feeder	2008	2,000		20	100	100	400	12
13	Sprinkler System Repair	2008	2,520		20	126	126	504	13
14	Roofing and Tuckpointing	2008	5,000		20	250	250	1,000	14
15	Elevator	2008	17,000		20	850	850	3,400	15
16	Water Tube for Boiler	2008	2,800		20	140	140	560	16
17	Hot Water Storage Tank	2008	14,727		20	736	736	2,945	17
18	OEM Pump and Coil	2008	14,865		20	743	743	2,973	18
19	Cooling Tower	2008	5,250		20	263	263	1,050	19
20	Security Cameras	2008	9,090		20	455	455	1,818	20
21	Brick & Cement Repair	2009	6,200		20	310	310	930	21
22	Custom Carpetry	2009	5,140		20	257	257	771	22
23	Window Repairs	2009	4,500		20	225	225	675	23
24	Copper Fittings & Valves	2009	5,693		20	285	285	854	24
25	Boiler Gas Valve Motor & Temp Control	2009	2,542		20	127	127	381	25
26	Sewer Access	2010	3,750		20	188	188	563	26
27	Basement Flooring	2010	12,700		20	635	635	1,905	27
28	Basement Door & Wall	2010	17,120		20	856	856	2,568	28
29	Wood Flooring	2010	12,000		20	600	600	1,800	29
30	Elevator	2010	59,711		20	2,986	2,986	5,972	30
31	Elevator Repair	2010	2,500		20	125	125	250	31
32	Fire Alarm	2011	13,957		20	698	698	698	32
33	Tile Flooring	2011	3,000		20	150	150	150	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company 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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,090,630	$ 64,781		$ 54,532	$ (10,249)	$ 360,993	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1985	17,335		39	578	578	15,168	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2008	2,350	128	20	235	107	920	9
10	Allocated From Managcare	1997	2,021		20			2,021	10
11	Allocated From Managcare	1993	159		20	8	8	147	11
12	Allocated From Managcare	1988	247	8	20		(8)	247	12
13	Allocated From Managcare	1986	18,747		20			18,746	13
14									14
15	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2011	794	56	20	53	(3)	53	15
16	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2007	1,020	26	20	51	25	232	16
17	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2006	547	14	20	27	13	150	17
18	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2005	409	37	20	41	4	265	18
19	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2001	364	9	20	18	9	191	19
20	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	2000	184	5	20	9	4	104	20
21	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1998	649	21	20	32	11	444	21
22	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1997	605	16	20	30	14	433	22
23	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1996	412	5	20	21	16	321	23
24	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1995	93	2	20	5	3	77	24
25	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1994	368	7	20	18	11	303	25
26	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1993	217	6	20	11	5	201	26
27	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1991	163	5	20	7	2	158	27
28	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1990	253	5	20		(5)	249	28
29	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1989	158	4	20	5	1	145	29
30	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1987	360	7	20		(7)	360	30
31	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1986	1,453		20			1,453	31
32	Allocated From 3553 WEST PETERSON AVE BLDG. PTR.	1985	101		20			101	32
33	Allocated From Intercare	2011	1,051		20	53	53	543	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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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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)		$ 50,060	$ 361		$ 1,202	$ 841	$ 43,032	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 298,410	$ 22,376	$ 9,163	$ (13,213)	10	$ 221,159	71
72	Current Year Purchases	10,301	1,161	1,218	57	10	1,218	72
73	Fully Depreciated Assets	356,746		59	59	10	356,653	73
74								74
75	TOTALS	$ 665,458	$ 23,537	$ 10,440	$ (13,097)		$ 579,030	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Managecare	2011	$ 19,173	$ 1,251	$ 3,102	$ 1,851	5	$ 12,665	76
77										77
78										78
79										79
80	TOTALS			$ 19,173	$ 1,251	$ 3,102	$ 1,851		$ 12,665	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)	$ 4,615,255	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 129,381	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 108,490	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,891)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,482,643	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	Improvements	$ 7,038	92
93			93
94			94
95		$ 7,038	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: 01/01/11 Ending: 12/31/11

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

16. Rental Amount for movable equipment: $ 433 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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	$		$ 134,969	$		$ 134,969	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			72,490			72,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			141,970			141,970	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				63,090		63,090	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					21,387	153,029		174,416	13
14	TOTAL			$		$ 370,816	$ 216,119		$ 586,935	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: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 33,599	$ 166,896	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,407,161	2,920,780	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,991	135,198	6
7	Other Prepaid Expenses	9,955	9,955	7
8	Accounts Receivable (owners or related parties)	360,475	360,475	8
9	Other(specify): See Attached Schedule	7,189	326,061	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,907,370	$ 3,922,365	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	627,396	836,343	15
16	Equipment, at Historical Cost	500,873	713,731	16
17	Accumulated Depreciation (book methods)	(767,520)	(3,532,720)	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		112,248	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 360,749	$ 1,158,692	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,268,119	$ 5,081,057	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,072,605	$ 1,084,827	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,352	33,352	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,440	128,440	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,679	11,679	31
32	Accrued Real Estate Taxes(Sch.IX-B)		164,000	32
33	Accrued Interest Payable	164,747	185,182	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	497,093	497,093	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,907,916	$ 2,104,573	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000	1,000,000	39
40	Mortgage Payable		4,156,194	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)**	$ 1,000,000	$ 5,156,194	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,907,916	$ 7,260,767	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 360,203	$ (2,179,710)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,268,119	$ 5,081,057	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 350,724	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)**	$ 350,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	9,484	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)**	$ 9,484	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)**	$ 360,203	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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	$ 7,216,594	1
2	Discounts and Allowances for all Levels	(392,221)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,824,373	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	581,233	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 581,233	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	75,042	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,204	19
20	Radiology and X-Ray	820	20
21	Other Medical Services	17,292	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 99,358	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,056	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,056	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	189,267	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 189,267	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,713,287	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,311,436	31
32	Health Care	2,783,902	32
33	General Administration	1,848,782	33
	B. Capital Expense		
34	Ownership	784,342	34
	C. Ancillary Expense		
35	Special Cost Centers	724,775	35
36	Provider Participation Fee	250,566	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,703,803	40
41	**Income before Income Taxes (line 30 minus line 40)****	9,484	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 9,484	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	1,960	2,068	$ 76,757	$ 37.12	1
2	Assistant Director of Nursing	928	1,147	35,821	31.23	2
3	Registered Nurses	14,675	15,236	486,123	31.91	3
4	Licensed Practical Nurses	32,289	34,942	794,025	22.72	4
5	CNAs & Orderlies	65,642	71,046	719,835	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,195	10,143	145,030	14.30	8
9	Activity Director	1,169	1,200	16,723	13.94	9
10	Activity Assistants	6,541	6,839	61,335	8.97	10
11	Social Service Workers	7,690	8,257	129,172	15.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,199	20,445	244,267	11.95	15
16	Dishwashers					16
17	Maintenance Workers	6,000	6,750	115,868	17.17	17
18	Housekeepers	21,879	24,256	275,500	11.36	18
19	Laundry	7,914	8,676	82,155	9.47	19
20	Administrator	2,040	2,080	82,175	39.51	20
21	Assistant Administrator					21
22	Other Administrative	2,120	2,120	52,811	24.91	22
23	Office Manager					23
24	Clerical	11,534	12,713	161,562	12.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,012	1,148	27,187	23.68	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,248	3,296	116,082	35.22	33
34	TOTAL (lines 1 - 33)	214,035	232,362	$ 3,622,428 *	$ 15.59	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	149	$ 7,576	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant	32	1,504	10-03	37
38	Nurse Consultant	Monthly	6,745	10-03	38
39	Pharmacist Consultant	Monthly	8,305	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	90	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,750	11-03	44
45	Social Service Consultant				45
46	Other(specify) Rehab Medical Drt	Monthly	18,000	10-03	46
47	Geratric Program Director	Monthly	12,000	10-03	47
48	Psychiatric Medical Center	Monthly	6,000	10-03	48
49	TOTAL (lines 35 - 48)	231	$ 90,570		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%	$
Shai Berdugo	Asst. Admin	0.00%	3,558
Yosef Davis	Administrative	90.93%	15,000
Nesanel Davis	Administrative	0.00%	34,253
Scott Schayer	Administrator	0.00%	82,175
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,986

B. Administrative - Other

Description	Amount
Management Fees- Intercare, Ltd.	$ 211,332
TOTAL (agree to Schedule V, line 17, col. 3)	$ 211,332
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 20,250
Managcare, Inc	Bookkeeping	215,119
E-Health Data Solutions	Computer Services	5,217
American Data	Computer Services	4,333
Adar, LLC	Computer Services	1,655
Cimpar Consulting	Strategic Consulting	4,060
Personnel Planners	Unemployment Tax Consult	2,105
MPRO	Conflict Resolution	1,715
Legal	See Attached	5,626
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 260,080

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,591
Unemployment Compensation Insurance	29,263
FICA Taxes	256,040
Employee Health Insurance	169,894
Employee Meals	25,291
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,056
Dental Insurance	363
Other Employee Benefits	3,290
Holiday Expense	4,754
Pension Expense	6,506
Disability Insurance	4,374
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,422

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,231
Health Care Worker Background Check	
(Indicate # of checks performed 627)	
Patient Background Checks	6,278
Licenses, Permits, Inspections	2,842
Advertising & Promotions	24,795
Dues & Subscriptions	18,287
Allocated From Managcare	514
Allocated From Intercare	18
Less: Public Relations Expense	( )
Non-allowable advertising	(24,795)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,170

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,438
Allocated From Managcare	225
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,663

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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 - $13,584**

(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. $ **23,963** 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. $ **250,566**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **25,291** 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.