

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0030551</u></p> <p><b>Facility Name:</b> <u>Brightview Care Center</u></p> <p><b>Address:</b> <u>4538 N. Beacon</u> <u>Chicago</u> <u>60640</u>   Number  City  Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 275-7200</u>      <b>Fax #</b> <u>(773) 275-7543</u></p> <p><b>HFS ID Number:</b> <u>363408520001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/86</u></p> <p><b>Type of Ownership:</b></p> <table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td>    <input type="checkbox"/> Charitable Corp.</td><td>    <input type="checkbox"/> Individual</td><td>    <input type="checkbox"/> State</td></tr><tr><td>    <input type="checkbox"/> Trust</td><td>    <input type="checkbox"/> Partnership</td><td>    <input type="checkbox"/> County</td></tr><tr><td><b>IRS Exemption Code</b> _____</td><td>    <input type="checkbox"/> Corporation</td><td>    <input type="checkbox"/> Other _____</td></tr><tr><td></td><td>    <input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>    <input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td>    <input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td>    <input type="checkbox"/> Other _____</td><td></td></tr></table> <p><b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u>                      <b>Telephone Number:</b> <u>(847) 236-1111</u> <b>Email Address:</b> <u>slavenda@frccpas.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <p><b>Officer or Administrator of Provider</b></p> <p>(Signed) _____ (Date) _____</p> <p>(Type or Print Name) _____</p> <p>(Title) _____</p> <p><b>Paid Preparer</b></p> <p>(Signed) _____ (Date) _____</p> <p>(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u></p> <p>(Firm Name &amp; Address) <u>Frost, Rутtenberg &amp; Rothblatt, P.C.</u> <u>111 Pфngsten Road, Suite 300 Deerfield, IL 60015</u></p> <p>(Telephone) <u>(847) 236-1111</u>      <b>Fax #</b> <u>(847) 236-1155</u></p> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> 201 S. Grand Avenue East Springfield, IL 62763-0001      <b>Phone # (217) 782-1630</b></p>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																							
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																							
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																							
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																							
	<input checked="" type="checkbox"/> "Sub-S" Corp.																								
	<input type="checkbox"/> Limited Liability Co.																								
	<input type="checkbox"/> Trust																								
	<input type="checkbox"/> Other _____																								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,338	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	52,338	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	14,092	1,256	3,881	19,229	8	
9	SNF/PED					9	
10	ICF	24,162			24,162	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	38,254	1,256	3,881	43,391	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.91%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 143 and days of care provided 3,372

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

**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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	251,095	41,868	8,886	301,849		301,849	31	301,880		1
2	Food Purchase		269,027		269,027	(27,611)	241,416	(1,366)	240,050		2
3	Housekeeping	242,379	42,271		284,650		284,650	1,700	286,350		3
4	Laundry	122,620	12,230	2,359	137,209		137,209		137,209		4
5	Heat and Other Utilities			121,265	121,265		121,265	(7,971)	113,294		5
6	Maintenance	95,905	27,019	60,885	183,809		183,809	18,300	202,109		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	711,999	392,415	193,395	1,297,809	(27,611)	1,270,198	10,694	1,280,892		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			46,600	46,600		46,600	6,380	52,980		9
10	Nursing and Medical Records	2,303,226	142,985	22,153	2,468,364		2,468,364	(34)	2,468,330		10
10a	Therapy	155,986		450	156,436		156,436		156,436		10a
11	Activities	96,462	18,591	2,455	117,508		117,508		117,508		11
12	Social Services	192,951			192,951		192,951		192,951		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,748,625	161,576	71,658	2,981,859		2,981,859	6,346	2,988,205		16
	<b>C. General Administration</b>										
17	Administrative	132,612		211,332	343,944		343,944	(92,877)	251,067		17
18	Directors Fees										18
19	Professional Services			284,956	284,956	(1,882)	283,074	(228,818)	54,257		19
20	Dues, Fees, Subscriptions & Promotions			177,603	177,603		177,603	(114,955)	62,648		20
21	Clerical & General Office Expenses	181,886	36,441	502,241	720,568		720,568	(344,527)	376,041		21
22	Employee Benefits & Payroll Taxes			643,260	643,260	27,611	670,871		670,871		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,112	6,112		6,112	(2,531)	3,581		24
25	Other Admin. Staff Transportation			4,081	4,081		4,081	(1,036)	3,045		25
26	Insurance-Prop.Liab.Malpractice			6,474	6,474		6,474	124,740	131,214		26
27	Other (specify):*							42,651	42,651		27
28	<b>TOTAL General Administration</b>	314,498	36,441	1,836,059	2,186,998	25,729	2,212,727	(617,353)	1,595,375		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,775,122	590,432	2,101,112	6,466,666	(1,882)	6,464,784	(600,313)	5,864,471		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:

01/01/12

Ending:

12/31/12

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			23,008	23,008		23,008	93,737	116,745			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,511	49,511		49,511	325,823	375,334			32
33	Real Estate Taxes			14,216	14,216	1,882	16,098	148,679	164,777			33
34	Rent-Facility & Grounds			575,000	575,000		575,000	(575,000)				34
35	Rent-Equipment & Vehicles			12,547	12,547		12,547	(12,170)	377			35
36	Other (specify):*							8,731	8,731			36
37	<b>TOTAL Ownership</b>			674,282	674,282	1,882	676,164	(10,200)	665,964			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,979	707,645	895,624		895,624		895,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			321,423	321,423		321,423		321,423			42
43	Other (specify):*	210,467		7,627	218,094		218,094	(218,094)				43
44	<b>TOTAL Special Cost Centers</b>	210,467	187,979	1,036,695	1,435,141		1,435,141	(218,094)	1,217,047			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,985,589	778,411	3,812,089	8,576,089		8,576,089	(828,607)	7,747,482			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:

**01/01/12**

Ending:

**12/31/12**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(9,286)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,058)	30		9
10	Interest and Other Investment Income	(22,971)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,324)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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	(34)	21		18
19	Entertainment	(166)	21		19
20	Contributions	(58,575)	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	(442,634)	21		24
25	Fund Raising, Advertising and Promotional	(52,508)	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	(368,722)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (974,355)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	145,748		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 145,748		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (828,607)		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

**Brightview Care Center**

**ID#** 0030551  
**Report Period Beginning:** 01/01/12  
**Ending:** 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,289)	02	1
2	Marketing Consultant	(7,627)	43	2
3	Bank Charges	(4,810)	21	3
4	Marketing Salary	(210,467)	43	4
5	Theft & Loss	(328)	21	5
6	COPE Dues	(6,150)	20	6
7	Non-Allowable Accounting Fees	(5,000)	19	7
8	Non-Allowable Auto Lease	(12,546)	35	8
9	Non-Allowable Travel	(1,229)	25	9
10	Non-Allowable Seminar	(2,908)	24	10
11	Non-Allowable Legal	(1,263)	19	11
12	Additional R&M	6,811	06	12
13	Building Company Legal & Professional Fees	(15,949)	19	13
14	Building Company Amortization	(105,630)	36	14
15	Building Company Other Expenses	(303)	21	15
16	Jury Duty Income	(34)	10	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(368,722)		49

Brightview Care Center

Report Period Beginning:                     01/01/12                      
 Ending:   12/31/12  

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
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67			18
68			19
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97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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			31									31	1
2	Food Purchase	(1,366)											(1,366)	2
3	Housekeeping			1,700									1,700	3
4	Laundry													4
5	Heat and Other Utilities	(9,286)		1,315									(7,971)	5
6	Maintenance	6,811		11,489									18,300	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(3,841)</b>		<b>14,535</b>									<b>10,694</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director			6,380									6,380	9
10	Nursing and Medical Records	(34)											(34)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(34)</b>		<b>6,380</b>									<b>6,346</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			112,750	(205,627)								(92,877)	17
18	Directors Fees													18
19	Professional Services	(22,212)	15,949	(222,672)		117							(228,818)	19
20	Fees, Subscriptions & Promotions	(117,233)		2,259	19								(114,955)	20
21	Clerical & General Office Expenses	(449,599)	303	104,760	9								(344,527)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,908)		377									(2,531)	24
25	Other Admin. Staff Transportation	(1,229)		193									(1,036)	25
26	Insurance-Prop.Liab.Malpractice		124,540	200									124,740	26
27	Other (specify):*			42,216	435								42,651	27
28	<b>TOTAL General Administration</b>	<b>(593,181)</b>	<b>140,792</b>	<b>40,083</b>	<b>(205,164)</b>	<b>117</b>							<b>(617,353)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(597,056)</b>	<b>140,792</b>	<b>60,998</b>	<b>(205,164)</b>	<b>117</b>							<b>(600,313)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	(18,058)	87,322	21,374		3,099							93,737	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(22,971)	344,175	472		4,147							325,823	32
33	Real Estate Taxes		145,197			3,482							148,679	33
34	Rent-Facility & Grounds		(575,000)	13,544		(13,544)							(575,000)	34
35	Rent-Equipment & Vehicles	(12,546)		376									(12,170)	35
36	Other (specify):*	(105,630)	114,361										8,731	36
37	<b>TOTAL Ownership</b>	<b>(159,205)</b>	<b>116,055</b>	<b>35,766</b>		<b>(2,816)</b>							<b>(10,200)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(218,094)											(218,094)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(218,094)</b>											<b>(218,094)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(974,355)	256,847	96,764	(205,164)	(2,699)							(828,607)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 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.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Rent	\$ 575,000	Brightview Building Company	100.00%	\$	(575,000)	1	
2	V	32 Interest	2,826	Brightview Building Company	100.00%	347,001	344,175	2	
3	V	26 Insurance		Brightview Building Company	100.00%	124,540	124,540	3	
4	V	19 Legal & Professional Fees		Brightview Building Company	100.00%	15,949	15,949	4	
5	V	36 Mortgage Insurance		Brightview Building Company	100.00%	8,731	8,731	5	
6	V	36 Amortization		Brightview Building Company	100.00%	105,630	105,630	6	
7	V	33 Real Estate Taxes		Brightview Building Company	100.00%	145,197	145,197	7	
8	V	30 Depreciation		Brightview Building Company	100.00%	87,322	87,322	8	
9	V	21 Other Expenses		Brightview Building Company	100.00%	303	303	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 577,826			\$ 834,673	\$ *	256,847	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>DIETARY</u>	\$	<u>MANAGCARE, INC.</u>	100.00%	\$ 31	\$	31	15
16	V	3 <u>HOUSEKEEPING</u>		<u>MANAGCARE, INC.</u>	100.00%	1,700		1,700	16
17	V	5 <u>UTILITIES</u>		<u>MANAGCARE, INC.</u>	100.00%	1,315		1,315	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>MANAGCARE, INC.</u>	100.00%	11,489		11,489	18
19	V	9 <u>MEDICAL DIRECTOR</u>		<u>MANAGCARE, INC.</u>	100.00%	6,380		6,380	19
20	V	17 <u>ADMINISTRATIVE</u>		<u>MANAGCARE, INC.</u>	100.00%	112,750		112,750	20
21	V	19 <u>PROFESSIONAL FEES</u>		<u>MANAGCARE, INC.</u>	100.00%				21
22	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>MANAGCARE, INC.</u>	100.00%	2,259		2,259	22
23	V	21 <u>CLERICAL AND GENERAL</u>		<u>MANAGCARE, INC.</u>	100.00%	104,760		104,760	23
24	V	24 <u>SEMINARS</u>		<u>MANAGCARE, INC.</u>	100.00%	377		377	24
25	V	25 <u>ADMIN. STAFF TRANS.</u>		<u>MANAGCARE, INC.</u>	100.00%	193		193	25
26	V	26 <u>INSURANCE</u>		<u>MANAGCARE, INC.</u>	100.00%	200		200	26
27	V	27 <u>GEN. ADMIN. EMP. BEN.</u>		<u>MANAGCARE, INC.</u>	100.00%	42,216		42,216	27
28	V	30 <u>DEPRECIATION</u>		<u>MANAGCARE, INC.</u>	100.00%	21,374		21,374	28
29	V	32 <u>INTEREST EXPENSE</u>		<u>MANAGCARE, INC.</u>	100.00%	472		472	29
30	V	34 <u>RENT - BUILDING (RELATED)</u>		<u>MANAGCARE, INC.</u>	100.00%	13,544		13,544	30
31	V	35 <u>EQUIPMENT RENTAL</u>		<u>MANAGCARE, INC.</u>	100.00%	376		376	31
32	V								32
33	V	19 <u>BOOKKEEPING/STRATEGIC CONSLT</u>	222,672	<u>MANAGCARE, INC.</u>	100.00%			(222,672)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 222,672			\$ 319,436	\$ *	96,764	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 5,705	\$	5,705	15
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%				16
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	19		19	17
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	9		9	18
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	435		435	19
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%				20
21	V	32 INTEREST EXPENSE		INTERCARE, LTD. C/O MANAGCARE	100.00%				21
22	V	35 EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%				22
23	V								23
24	V	17 MANAGEMENT FEES	211,332	INTERCARE, LTD. C/O MANAGCARE	100.00%			(211,332)	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			\$ 6,168	\$ *	(205,164)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 HOUSEKEEPING	\$	4600 TOUHY, LLC	100.00%	\$	\$	15
16	V	5 UTILITIES		4600 TOUHY, LLC				16
17	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC				17
18	V	17 ADMIN.-M. WOLF		4600 TOUHY, LLC				18
19	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC		117	117	19
20	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC				20
21	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC				21
22	V	26 INSURANCE		4600 TOUHY, LLC				22
23	V	30 DEPRECIATION		4600 TOUHY, LLC		3,099	3,099	23
24	V	32 INTEREST EXPENSE		4600 TOUHY, LLC		4,147	4,147	24
25	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC		3,482	3,482	25
26	V							26
27	V							27
28	V							28
29	V	34 RENT	13,544	4600 TOUHY, LLC			(13,544)	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		\$ 13,544			\$ 10,845	\$ * (2,699)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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



**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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	MOSHE WOLF	2.769%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	BRIGHTVIEW BUILDING COMPANY		BUILDING CO.	1
2	EDIE DAVIS	0.709%	MAYFIELD CARE CENTER, INC.	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3	STANLEY KLEM	2.767%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO	3
4	YOSEF DAVIS DELTA TRUST	93.755%			INTERCARE, LTD.C/O MANAGC	LINCOLNWOOD	MANAGEMENT CO	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

SEE ACCOUNTANTS' COMPILATION REPORT

**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 &amp; ID Number

Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Administrative	0.00%	See Attached	4.11	13.70%	Sal/Alloc Sal	\$ 5,705	17-7	1
2	Nesanel Davis	Relative	Administrative	0.00%	See Attached	6.86	14.29%	Sal/Alloc Sal	42,822	17-1,17-7	2
3	Moshe Wolf	Owner	Administrator	2.77%	See Attached	6.23	12.98%	AI Sal/Fees	13,628	17-7	3
4	Stanley Klem	Owner	Administrative	2.77%	See Attached	6.86	15.59%	Alloc Salary	22,447	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted 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	\$ 84,602		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 MANAGCARE, INC.  
 Street Address 4600 W. TOUHY AVENUE, SUITE 200  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	278,486	4	\$ 201	\$ 43,391	\$ 31	1	
2	3	HOUSEKEEPING	PATIENT DAYS	278,486	4	10,914	43,391	1,700	2	
3	5	UTILITIES	PATIENT DAYS	278,486	4	8,439	43,391	1,315	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	278,486	4	73,740	43,391	11,489	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	278,486	4	40,948	43,391	6,380	5	
6	17	ADMINISTRATIVE	PATIENT DAYS	278,486	4	723,635	723,635	43,391	112,750	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	278,486	4		43,391		7	
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	278,486	4	14,497	43,391	2,259	8	
9	21	CLERICAL AND GENERAL	PATIENT DAYS	278,486	4	672,355	453,150	43,391	104,760	9
10	24	SEMINARS	PATIENT DAYS	278,486	4	2,422	43,391	377	10	
11	25	ADMIN. STAFF TRANS.	PATIENT DAYS	278,486	4	1,240	43,391	193	11	
12	26	INSURANCE	PATIENT DAYS	278,486	4	1,286	43,391	200	12	
13	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	278,486	4	270,942	43,391	42,216	13	
14	30	DEPRECIATION	PATIENT DAYS	278,486	4	137,841	43,391	21,374	14	
15	32	INTEREST EXPENSE	PATIENT DAYS	278,486	4	3,032	43,391	472	15	
16	34	RENT - BUILDING (RELATED)	PATIENT DAYS	278,486	4	86,925	43,391	13,544	16	
17	35	EQUIPMENT RENTAL	PATIENT DAYS	278,486	4	2,412	43,391	376	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,050,829	\$ 1,176,785	\$ 319,436	25	

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization INTERCARE, LTD. C/O MANAGCARE  
 Street Address 4600 W. TOUHY AVENUE, SUITE 200  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED 18	4	\$ 25,000	\$ 25,000	4	\$ 5,705	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 18	4			4		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED 18	4	85		4	19	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED 18	4	38		4	9	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 18	4	1,905		4	435	5
6	30	DEPRECIATION	AVG. HOURS WORKED 18	4			4		6
7	32	INTEREST EXPENSE	AVG. HOURS WORKED 18	4			4		7
8	35	EQUIPMENT RENTAL	AVG. HOURS WORKED 18	4			4		8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 27,028	\$ 25,000		\$ 6,168	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 4600 TOUHY, LLC  
 Street Address 4600 W. TOUHY AVENUE, SUITE 200  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS 278,486	4	\$	\$	43,391	\$	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 278,486	4			43,391		2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 278,486	4			43,391		3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS 278,486	4			43,391		4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 278,486	4	750		43,391	117	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 278,486	4			43,391		6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 278,486	4			43,391		7
8	26	INSURANCE	MNGCR. PATIENT DAYS 278,486	4			43,391		8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS 278,486	4	19,887		43,391	3,099	9
10	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 278,486	4	26,618		43,391	4,147	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 278,486	4	22,347		43,391	3,482	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				\$ 69,602	\$		\$ 10,845	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending: 12/31/12

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number

Brightview Care Center

# 0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Midland		X	Mortgage	\$24,481.00	6/1/2007	\$	\$ 4,338,919	7/1/2042	5.9000	\$ 347,001	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
<b>Working Capital</b>																			
6	MB Financial		X	Line Of Credit				750,000		4.2500	39,897	6							
7	Brightview Bldg. Co.	X		Working Capital							9,614	7							
8	See Supplemental Schedule										4,619	8							
9	TOTAL Facility Related				\$24,481.00		\$	\$ 5,088,919			\$ 401,131	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(22,971)	10							
11	Interest Income- Bldg. Co.		X								(2,826)	11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ (25,797)	14							
15	TOTALS (line 9+line14)						\$	\$ 5,088,919			\$ 375,334	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,731 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:

01/01/12

Ending:

12/31/12

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$				\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8	Allocated From Managcare		X			\$				\$	472	8						
9	Allocated from 4600 Touhy LLC		X								4,147	9						
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>										4,619	14						
<b>B. Non-Facility Related*</b>																		
15						\$				\$		15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>										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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2011 report.		\$	<b>164,000</b>		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.)		\$	<b>163,595</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(405)</b>		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>163,300</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>1,882</b>		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. <b>TOTAL REFUND \$ 14,216 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>164,777</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<b>151,976</b>			8
	2008	<b>153,577</b>			9
	2009	<b>154,095</b>			10
	2010	<b>160,803</b>			11
	2011	<b>160,113</b>			12
<b>2012 Accrual = \$160,113 X 1.02= \$163,300 (Rounded)</b>					
<b>Allocated From 4600 Touhy LLC = \$3,482</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

# 2011 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>14-17-115-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>63,451.31</u>	\$ <u>63,451.31</u>
2.	<u>14-17-115-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>60,701.55</u>	\$ <u>60,701.55</u>
3.	<u>14-17-115-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>35,960.10</u>	\$ <u>35,960.10</u>
4.	<u>See Attached</u>	<u>All:3553 WEST PETERSON AVE BLDG. PTR.</u>	\$ <u>44,694.00</u>	\$ <u>3,481.90</u>
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u>204,806.96</u>	\$ <u>163,594.86</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?  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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

**IMPORTANT NOTICE**

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

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

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

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

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

**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:

01/01/12

Ending:

12/31/12

**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  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>73,992</u>	1
2					2
3	TOTALS			\$ <u>73,992</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	143		1968	\$ 1,899,326	\$ 87,322	35	\$	\$(87,322)	\$ 1,899,326	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
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			20,454	13
14	Various		1992	17,019		20	143	143	15,466	14
15	Various		1993	44,200		20	1,939	1,939	42,156	15
16	Various		1994	63,594		20	3,180	3,180	58,913	16
17	Various		1995	7,105		20	355	355	6,250	17
18	Various		1996	37,640		20	1,882	1,882	31,623	18
19	Various		1997	17,411		20	871	871	13,133	19
20	Various		1998	49,850		20	2,493	2,493	35,787	20
21	Various		1999	215,484		20	10,774	10,774	146,129	21
22	Various		2000	47,834		20	2,392	2,392	29,855	22
23	Various		2001	35,034		20	1,337	1,337	23,721	23
24	Various		2002	33,534		20	1,535	1,535	28,285	24
25	Various		2003	21,000		20	1,356	1,356	12,934	25
26	Various		2004	67,457		20	5,352	5,352	51,213	26
27	Various		2005	20,650		20	1,669	1,669	13,019	27
28	Various		2006	19,318		20	1,454	1,454	9,338	28
29	Various		2007	2,500		20	125	125	729	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  
SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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		1,098,380			54,920	54,920	415,914	67
68		192,550	8,949		5,891	(3,058)	6,405	68
69			10,051			(10,051)		69
70		\$ 3,997,455	\$ 106,322		\$ 97,667	\$ (8,655)	\$ 2,945,785	70

SEE ACCOUNTANTS' COMPILATION REPORT

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



**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,997,455	\$ 106,322		\$ 97,667	\$ (8,655)	\$ 2,945,785	1
2	Wall-Mounted Sign	2011	9,417		20	942	942	1,256	2
3	Fire Alarm Devices	2012	4,474		20				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)		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	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
31								31
32								32
33								33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	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:

01/01/12

Ending:

12/31/12**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>2004 Improvements</b>	2004	534,642		20	26,732	26,732	240,589	9
10	<b>2005 Improvements</b>	2005	314,875		20	15,744	15,744	125,951	10
11	<b>2007 Improvements</b>	2007	19,048		20	952	952	5,714	11
12	<b>2008 Improvements</b>	2008	73,252		20	3,663	3,663	18,313	12
13	<b>Brick &amp; Cement Repair</b>	2009	6,200		20	310	310	1,240	13
14	<b>Custom Carpentry</b>	2009	5,140		20	257	257	1,028	14
15	<b>Window Repairs</b>	2009	4,500		20	225	225	900	15
16	<b>Copper Fittings &amp; Valves</b>	2009	5,693		20	285	285	1,139	16
17	<b>Boiler Gas Valve Motor &amp; Temp Control</b>	2009	2,542		20	127	127	508	17
18	<b>Sewer Access</b>	2010	3,750		20	188	188	751	18
19	<b>Basement Flooring</b>	2010	12,700		20	635	635	2,540	19
20	<b>Basement Door &amp; Wall</b>	2010	17,120		20	856	856	3,424	20
21	<b>Wood Flooring</b>	2010	12,000		20	600	600	2,400	21
22	<b>Elevator</b>	2010	59,711		20	2,986	2,986	8,958	22
23	<b>Elevator Repair</b>	2010	2,500		20	125	125	375	23
24	<b>Fire Alarm</b>	2011	13,957		20	698	698	1,396	24
25	<b>Tile Flooring</b>	2011	3,000		20	150	150	300	25
26	<b>Generator Outlets</b>	2012	7,750		20	388	388	388	26
27									27
28									28
29									29
30									30
31									31
32									32
33									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:

01/01/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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
31								31
32								32
33								33
34	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>	\$	\$		\$	\$	\$	34
			1,098,380		54,920	54,920	415,914	

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<u>Allocated from 4600 Touhy LLC</u>	<u>2012</u>	<u>80,002</u>	<u>728</u>	<u>30</u>	<u>2,667</u>	<u>1,939</u>	<u>2,667</u>	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10	<u>Allocated From Managcare</u>	<u>2012</u>	<u>16,703</u>	<u>5,850</u>	<u>20</u>	<u>803</u>	<u>(5,047)</u>	<u>796</u>	10
11									11
12	<u>Allocated From Intercare</u>	<u>2001</u>	<u>1,007</u>		<u>20</u>	<u>50</u>	<u>50</u>	<u>571</u>	12
13									13
14	<u>Allocaated from 4600 Touhy LLC</u>	<u>2012</u>	<u>94,838</u>	<u>2,371</u>	<u>20</u>	<u>2,371</u>		<u>2,371</u>	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									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								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
31								31
32								32
33								33
34		\$ 192,550	\$ 8,949		\$ 5,891	\$ (3,058)	\$ 6,405	34

SEE ACCOUNTANTS' COMPILATION REPORT

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



XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 294,044	\$ 8,211	\$ 8,830	\$ 619	10	\$ 216,534	71
72	Current Year Purchases	128,976	17,154	6,292	(10,862)	10	6,292	72
73	Fully Depreciated Assets	367,522		24	24	10	367,446	73
74								74
75	TOTALS	\$ 790,542	\$ 25,365	\$ 15,146	\$ (10,219)		\$ 590,273	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 Managcare	2012	\$ 21,808	\$ 3,117	\$ 2,991	\$ (126)	5	\$ 15,100	76
77										77
78										78
79										79
80	TOTALS			\$ 21,808	\$ 3,117	\$ 2,991	\$ (126)		\$ 15,100	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)	\$ 4,897,689	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,804	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,746	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,058)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,552,414	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 377 Description: See Attached Schedule  YES  NO

(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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2013 \$ \_\_\_\_\_

13. \_\_\_\_\_/2014 \$ \_\_\_\_\_

14. \_\_\_\_\_/2015 \$ \_\_\_\_\_

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

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

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 198,938	\$		\$ 198,938	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			84,244			84,244	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			243,208			243,208	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				170,303		170,303	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					181,255	17,676		198,931	13
14	TOTAL			\$		\$ 707,645	\$ 187,979		\$ 895,624	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

Facility Name & ID Number **Brightview Care Center**# **0030551**Report Period Beginning: **01/01/12**Ending: **12/31/12****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/12**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 242,696	\$ 399,281	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,743,483	2,059,832	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,040	177,044	6
7	Other Prepaid Expenses	5,965	5,965	7
8	Accounts Receivable (owners or related parties)	809,236	1,056,867	8
9	Other(specify): <u>See Attached Schedule</u>	70,239	287,762	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,966,659	\$ 3,986,751	10
<b>B. Long-Term Assets</b>				
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	634,633	851,330	15
16	Equipment, at Historical Cost	612,600	825,458	16
17	Accumulated Depreciation (book methods)	(822,083)	(3,674,605)	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): <u>See Attached Schedule</u>		94,944	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 425,150	\$ 1,126,217	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,391,809	\$ 5,112,968	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 960,537	\$ 964,845	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,761	34,761	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	235,319	235,319	30
31	Accrued Taxes Payable (excluding real estate taxes)	153,957	153,957	31
32	Accrued Real Estate Taxes(Sch.IX-B)		163,300	32
33	Accrued Interest Payable	2,095	13,485	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	1,140,093	1,140,093	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,276,762	\$ 3,455,760	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,338,919	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,338,919	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,276,762	\$ 7,794,679	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 115,047	\$ (2,681,711)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,391,809	\$ 5,112,968	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>360,203</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding Adjustment</b>	<b>4</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>360,207</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(245,160)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(245,160)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>115,047</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Brightview Care Center**

# 0030551

Report Period Beginning: 01/01/12

Ending:

12/31/12

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,328,699	1
2	Discounts and Allowances for all Levels	(1,239,074)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,089,625	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	958,029	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 958,029	8
<b>C. Other Operating Revenue</b>			
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	192,606	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,581	19
20	Radiology and X-Ray	2,450	20
21	Other Medical Services	33,804	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 243,441	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	22,971	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 22,971	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	16,863	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 16,863	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,330,929	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,297,809	31
32	Health Care	2,981,859	32
33	General Administration	2,186,998	33
<b>B. Capital Expense</b>			
34	Ownership	674,282	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,113,718	35
36	Provider Participation Fee	321,423	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,576,089	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(245,160)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (245,160)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,613,551	44
45	Private Pay - Net Inpatient Revenue	230,840	45
46	Medicare - Net Inpatient Revenue	1,173,035	46
47	Other-(specify)	72,199	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,089,625	49

\* 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.

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **Brightview Care Center**

# **0030551**

Report Period Beginning:

**01/01/12**

Ending:

**12/31/12**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,002	2,039	\$ 75,405	\$ 36.98	1
2	Assistant Director of Nursing	2,008	2,049	74,020	36.12	2
3	Registered Nurses	23,916	25,028	700,042	27.97	3
4	Licensed Practical Nurses	26,406	27,719	689,656	24.88	4
5	CNAs & Orderlies	67,017	72,652	737,419	10.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,632	10,399	155,986	15.00	8
9	Activity Director	2,870	3,040	42,987	14.14	9
10	Activity Assistants	5,603	5,816	53,475	9.19	10
11	Social Service Workers	11,419	11,970	192,951	16.12	11
12	Dietician					12
13	Food Service Supervisor	1,905	2,130	46,852	22.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,474	18,252	204,243	11.19	15
16	Dishwashers					16
17	Maintenance Workers	5,998	6,605	95,905	14.52	17
18	Housekeepers	18,989	20,877	242,379	11.61	18
19	Laundry	10,984	11,385	122,620	10.77	19
20	Administrator	2,080	2,080	117,097	56.30	20
21	Assistant Administrator					21
22	Other Administrative	276	276	15,515	56.21	22
23	Office Manager					23
24	Clerical	13,992	15,195	181,886	11.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,016	1,190	26,684	22.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,373	5,373	210,467	39.17	33
34	TOTAL (lines 1 - 33)	227,960	244,076	\$ 3,985,589 *	\$ 16.33	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	175	\$ 8,886	01-03	35
36	Medical Director	Monthly	46,600	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	49	10,610	10-03	38
39	Pharmacist Consultant	Monthly	7,319	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	450	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	2,455	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	261	\$ 80,544		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/12

Ending: 12/31/12

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mark Murphy	Administrator	0.00%	\$ 117,097	Workers' Compensation Insurance	\$ 88,355	IDPH License Fee	\$	
Nesanel Davis	Administrative	0.00%	15,515	Unemployment Compensation Insurance	39,645	Advertising: Employee Recruitment	35,625	
				FICA Taxes	297,825	Health Care Worker Background Check		
				Employee Health Insurance	185,692	(Indicate # of checks performed )		
				Employee Meals	27,611	Patient Background Checks	438 4,383	
				Illinois Municipal Retirement Fund (IMRF)*		Licence & Fees	3,925	
				Disability Insurance	5,279	Dues & Subscriptions	16,437	
				Chicago Head Tax	2,560	Advertising & Promotions	52,508	
				Pension Expense	5,550			
				Holiday Expense	10,789	See Supplemental Schedule	2,278	
				Other Employee Benefits	7,179	Less: Public Relations Expense	( )	
				Dental Insurance	386	Non-allowable advertising	(52,508)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 132,612	TOTAL (agree to Schedule V, line 22, col.8)	\$ 670,871	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 62,648	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees- Intercare, Ltd.			\$ 211,332			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 211,332				Seminar Expense	3,204
(Attach a copy of any management service agreement)							Allocated From Managcare	377
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Comprehensive Reimbursement	Reimbursement Consult		\$ 13,896					
Michigan Peer Review Org	Conflict Resolution		510					
Managcare, Inc	Strategic Consulting		8,172					
American Data	Computer Services		4,201					
E-Health Data	Computer Services		4,782					
Adar LLC	Computer Services		10,439					
Ivans	Computer Services		495					
Personnel Planners	Unemployment Consult		1,717					
Honkamp Kreuger	Unemployment Consult		360					
Frost, Ruttenberg & Rothblatt	Accounting		20,250					
See Attached	Legal		3,134					
See Supplemental Schedule			217,000					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 284,956					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>			\$	\$	\$	\$	\$	\$	\$	\$	\$								

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12**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- \$13,845
- (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. \$ 24,146 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. \$ 321,423  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 27,611 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% Ln14
- 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**