FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0030551

Facility Name: Brightview Hlthcare & Rehab

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 2/1/1986

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,298	1,555	3,105	19,958	8
9	SNF/PED					9
10	ICF	19,470			19,470	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,768	1,555	3,105	39,428	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.54%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 143 and days of care provided 2,410

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	280,991	63,579	9,662	354,232		354,232	61	354,293			1
2	Food Purchase		218,581		218,581	(24,243)	194,338	(1,474)	192,864			2
3	Housekeeping	253,354	39,019		292,373		292,373	1,024	293,397			3
4	Laundry	99,664	8,940		108,604		108,604		108,604			4
5	Heat and Other Utilities			161,535	161,535		161,535	(11,985)	149,550			5
6	Maintenance	69,879	13,487	102,182	185,548		185,548	(9,377)	176,171			6
7	Other (specify):*											7
8	TOTAL General Services	703,888	343,606	273,379	1,320,873	(24,243)	1,296,630	(21,751)	1,274,878			8
	B. Health Care and Programs											
9	Medical Director			57,420	57,420		57,420	5,917	63,337			9
10	Nursing and Medical Records	2,317,597	164,579	155,731	2,637,907		2,637,907	39,391	2,677,298			10
10a	Therapy	5,659		545	6,204		6,204		6,204			10a
11	Activities	107,198	10,456	425	118,079		118,079	11	118,090			11
12	Social Services	114,381		10,967	125,348		125,348	4,018	129,366			12
13	CNA Training											13
14	Program Transportation			8,384	8,384		8,384	(1,175)	7,209			14
15	Other (specify):*							3,973	3,973			15
16	TOTAL Health Care and Programs	2,544,835	175,035	233,472	2,953,342		2,953,342	52,135	3,005,477			16
	C. General Administration											
17	Administrative	111,880		211,332	323,212		323,212	(52,416)	270,796			17
18	Directors Fees											18
19	Professional Services			431,901	431,901	(8,786)	423,115	(278,205)	144,910			19
20	Dues, Fees, Subscriptions & Promotions			132,171	132,171		132,171	(72,846)	59,325			20
21	Clerical & General Office Expenses	249,342	17,584	710,877	977,803		977,803	(549,001)	428,802			21
22	Employee Benefits & Payroll Taxes			590,833	590,833	24,243	615,076	(900)	614,177			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,737	1,737		1,737	119	1,856			24
25	Other Admin. Staff Transportation			4,662	4,662		4,662	2,919	7,581			25
26	Insurance-Prop.Liab.Malpractice			223,926	223,926		223,926	(77,966)	145,960			26
27	Other (specify):*							33,009	33,009			27
28	TOTAL General Administration	361,222	17,584	2,307,439	2,686,245	15,457	2,701,702	(995,288)	1,706,415			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,609,945	536,225	2,814,290	6,960,460	(8,786)	6,951,674	(964,904)	5,986,770			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Brightview Hlthcare & Rehab #0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,034	54,034		54,034	78,928	132,962			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,990	73,990		73,990	96,196	170,186			32
33	Real Estate Taxes			16,372	16,372	8,786	25,158	165,870	191,028			33
34	Rent-Facility & Grounds			518,617	518,617		518,617	(518,617)	0			34
35	Rent-Equipment & Vehicles							325	325			35
36	Other (specify):*							21,154	21,154			36
37	TOTAL Ownership			663,013	663,013	8,786	671,799	(156,144)	515,655			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		151,883	813,138	965,021		965,021	(5,014)	960,007			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			302,398	302,398		302,398		302,398			42
43	Other (specify):*	60,367		27,340	87,707		87,707	(87,707)	(0)			43
44	TOTAL Special Cost Centers	60,367	151,883	1,142,876	1,355,126		1,355,126	(92,722)	1,262,404			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,670,312	688,108	4,620,179	8,978,599		8,978,599	(1,213,769)	7,764,830			45

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,497)	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	(7,263)	30		9
10	Interest and Other Investment Income	(9,555)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(85)	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	(7,421)	21		18
19	Entertainment				19
20	Contributions	(37,039)	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	(574,502)	21		24
25	Fund Raising, Advertising and Promotional	(30,804)	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	(348,748)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,028,914)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(184,855)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (184,855)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,213,769)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Brightview Hlthcare & Rehab

ID# **0030551**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period - A & G	$ (3,222)	21	1
2	Prior Period - Medical Supply	(2,415)	10	2
3	Prior Period - Uniforms	(900)	22	3
4	Prior Period - Centrad and Lifeline	(5,014)	39	4
5	Prior Period - Insurance	(84,943)	26	5
6	Prior Period - Legal Fees	(14,117)	19	6
7	Jury Duty	(17)	10	7
8	IIT Rebate	(112)	21	8
9	Vending Income	(1,389)	02	9
10	Marketing Consultant	(27,340)	43	10
11	Bank Charges	(7,240)	21	11
12	Marketing Salary	(60,367)	43	12
13	Theft and Loss	(1,654)	21	13
14	Sequestration	(42,747)	21	14
15	Building Company - Bank Charges	(581)	21	15
16	Building Company - Professional Fees	(11,975)	19	16
17	Building Company - Legal Fees	(4,895)	19	17
18	Building Company - Licenses Expense	(310)	20	18
19	Building Company - Amortization Expense	(2,245)	31	19
20	Non-allowable Legal Fees	(7,442)	19	20
21	PAC Dues	(8,116)	20	21
22	Capitalized R&M	(45,034)	06	22
23	Additional R&M	14,674	06	23
24	Non-allowable Interest	(31,348)	32	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(348,748)		49

Brightview Hlthcare & Rehab

ID# 0030551

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			61									61	1
2	Food Purchase	(1,474)											(1,474)	2
3	Housekeeping			1,024									1,024	3
4	Laundry													4
5	Heat and Other Utilities	(13,497)		1,085	427								(11,985)	5
6	Maintenance	(30,360)	16,978	3,840	165								(9,377)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(45,331)	16,978	6,010	592								(21,751)	8
	B. Health Care and Programs													
9	Medical Director			5,917									5,917	9
10	Nursing and Medical Records	(2,433)		41,824									39,391	10
10a	Therapy													10a
11	Activities			11									11	11
12	Social Services			4,018									4,018	12
13	CNA Training													13
14	Program Transportation							(1,175)					(1,175)	14
15	Other (specify):*			3,973									3,973	15
16	**TOTAL Health Care and Programs**	(2,433)		55,743				(1,175)					52,135	16
	C. General Administration													
17	Administrative			87,375		52,595	(192,386)						(52,416)	17
18	Directors Fees													18
19	Professional Services	(38,429)	16,870	(193,612)	358	(63,392)							(278,205)	19
20	Fees, Subscriptions & Promotions	(76,269)	310	3,103	9								(72,846)	20
21	Clerical & General Office Expenses	(637,478)	581	87,667	32	30	167						(549,001)	21
22	Employee Benefits & Payroll Taxes	(900)											(900)	22
23	Inservice Training & Education													23
24	Travel and Seminar			119									119	24
25	Other Admin. Staff Transportation			741		2,178							2,919	25
26	Insurance-Prop.Liab.Malpractice	(84,943)	6,450	334	193								(77,966)	26
27	Other (specify):*			33,009									33,009	27
28	**TOTAL General Administration**	(838,018)	24,211	18,736	592	(8,589)	(192,219)						(995,288)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(885,782)	41,189	80,488	1,184	(8,589)	(192,219)	(1,175)					(964,904)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Hlthcare & Rehab **#** 0030551 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(7,263)	79,602	4,662	1,927								78,928	30
31	Amortization of Pre-Op. & Org.	(2,245)	2,245											31
32	Interest	(40,903)	133,127	97	3,875								96,196	32
33	Real Estate Taxes		162,729		3,141								165,870	33
34	Rent-Facility & Grounds		(518,617)	13,836	(13,836)								(518,617)	34
35	Rent-Equipment & Vehicles			325									325	35
36	Other (specify):*		21,154										21,154	36
37	**TOTAL Ownership**	(50,411)	(119,760)	18,920	(4,893)								(156,144)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(5,014)											(5,014)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(87,707)											(87,707)	43
44	**TOTAL Special Cost Centers**	(92,722)											(92,722)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,028,914)	(78,571)	99,408	(3,709)	(8,589)	(192,219)	(1,175)					(1,213,769)	45

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 518,617	Brightview Building Company	100.00%	$	$ (518,617)	1
2	V	32	Interest Income	149	Brightview Building Company	100.00%		(149)	2
3	V	21	Bank Charges		Brightview Building Company	100.00%	581	581	3
4	V	30	Depreciation Expense		Brightview Building Company	100.00%	79,602	79,602	4
5	V	26	Insurance Expense		Brightview Building Company	100.00%	6,450	6,450	5
6	V	32	Interest Expense		Brightview Building Company	100.00%	133,276	133,276	6
7	V	19	Professional Fees		Brightview Building Company	100.00%	11,975	11,975	7
8	V	19	Legal Fees		Brightview Building Company	100.00%	4,895	4,895	8
9	V	06	Repairs and Maintenance		Brightview Building Company	100.00%	16,978	16,978	9
10	V	20	Licenses Expense		Brightview Building Company	100.00%	310	310	10
11	V	36	Mortgage Insurance		Brightview Building Company	100.00%	21,154	21,154	11
12	V	31	Amortization Expense		Brightview Building Company	100.00%	2,245	2,245	12
13	V	33	Real Estate Taxes		Brightview Building Company	100.00%	162,729	162,729	13
14	Total			$ 518,766			$ 440,195	$ * (78,571)	14

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 61	$ 61	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	1,024	1,024	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,085	1,085	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,840	3,840	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	5,917	5,917	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	41,824	41,824	20
21	V	11	ACTIVITIES		MANAGCARE, INC.	100.00%	11	11	21
22	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	4,018	4,018	22
23	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	3,973	3,973	23
24	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	87,375	87,375	24
25	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	3,728	3,728	25
26	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	3,103	3,103	26
27	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	81,726	81,726	27
28	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	5,941	5,941	28
29	V	24	SEMINARS		MANAGCARE, INC.	100.00%	119	119	29
30	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	741	741	30
31	V	26	INSURANCE		MANAGCARE, INC.	100.00%	334	334	31
32	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	33,009	33,009	32
33	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	4,662	4,662	33
34	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	97	97	34
35	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	13,836	13,836	35
36	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	325	325	36
37	V	19	BOOKKEEPING	163,020	MANAGCARE, INC.	100.00%		(163,020)	37
38	V	19	ADMINISTRATIVE CONSULTANT	34,320	MANAGCARE, INC.	100.00%		(34,320)	38
39	Total			$ 197,340			$ 296,748	$ * 99,408	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 427	$ 427	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	165	165	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	358	358	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	9	9	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	32	32	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	193	193	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,927	1,927	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	3,875	3,875	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	3,141	3,141	23
24	V								24
25	V	34	RENT	13,836	4600 TOUHY, LLC	100.00%		(13,836)	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			$ 13,836			$ 10,127	$ * (3,709)	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 16,183	$ 16,183	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	16,183	16,183	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	16,183	16,183	17
18	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	243	243	18
19	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	30	30	19
20	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2,178	2,178	20
21	V								21
22	V	19	ADMINISTRATIVE CONSULTANT	63,635	TETRAD MANAGEMENT, LLC	100.00%		(63,635)	22
23	V								23
24	V								24
25	V	17	ADMINISTRATIVE SALARY - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	4,046	4,046	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			$ 63,635			$ 55,046	$ * (8,589)	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 5,205	$ 5,205	15
16	V	17	COMMISSIONS AND FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	13,741	13,741	16
17	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	167	167	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,900		18
19	V								19
20	V								20
21	V	17	MANAGEMENT FEES	211,332	INTERCARE, LTD. C/O MANAGCARE	100.00%		(211,332)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 211,332			$ 21,013	$ * (192,219)	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	AMBULANCE	$ 5,062	LIFELINE AMBULANCE	100.00%	$ 3,887	$ (1,175)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,062			$ 3,887	$ * (1,175)	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2.77%	MAYFIELD CARE CENTER	CHICAGO	BRIGHTVIEW BUILDING COME	LINCOLNWOOD	BUILDING CO.	1
2	EDIE DAVIS	.71%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3	STANLEY KLEM	2.77%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO	3
4	YOSEF DAVIS DELTA TRUST	93.75%	CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD	INTERCARE, LTD.C/O MANAG	LINCOLNWOOD	MANAGEMENT CO	4
5			COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS	LIFELINE AMBULANCE	CHICAGO	AMBULANCE SERVICES	6
7			MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				7
8			MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				8
9			RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Administrative	0%	See Attached	1.46	4.87%	Alloc. Salary	$ 5,205	17-7	1
2	Moshe Davis	Relative	Administrative	0%	See Attached	3.56	8.09%	Alloc. Fees	16,183	17-7	2
3	Yehoshua Davis	Relative	Administrative	0%	See Attached	3.88	8.08%	Alloc. Fees	16,183	17-7	3
4	Nesanel Davis	Relative	Administrative	0%	See Attached	3.88	8.08%	Alloc. Fees	16,183	17-7	4
5	Eli Davis	Relative	Administrative	0%	See Attached	3.24	8.10%	Alloc. Fees	17,786	17-7	5
6	Stanley Klem	Owner	Administrative	2.77%	See Attached	3.56	8.09%	Alloc. Salary	11,335	17-7	6
7	Moshe Wolf	Owner	Administrative	2.77%	See Attached	3.88	8.08%	Alloc. Salary	8,029	17-7	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 90,904		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	487,280	10	$ 748	$	39,428	$ 61	1
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659		39,428	1,024	2
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409		39,428	1,085	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454		39,428	3,840	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125		39,428	5,917	5
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	39,428	41,824	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136		39,428	11	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	39,428	4,018	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107		39,428	3,973	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	39,428	87,375	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077		39,428	3,728	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354		39,428	3,103	12
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	39,428	81,726	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419		39,428	5,941	14
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473		39,428	119	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155		39,428	741	16
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123		39,428	334	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944		39,428	33,009	18
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614		39,428	4,662	19
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200		39,428	97	20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000		39,428	13,836	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015		39,428	325	22
23										23
24										24
25	TOTALS					$ 3,667,434	$ 2,656,422		$ 296,748	25

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	487,280	10	$ 5,277	$	39,428	$ 427	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	487,280	10	2,035		39,428	165	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	487,280	10	4,429		39,428	358	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	487,280	10	148		39,428	9	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	487,280	10	391		39,428	32	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	487,280	10	2,388		39,428	193	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	487,280	10	23,819		39,428	1,927	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	487,280	10	47,891		39,428	3,875	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	487,280	10	38,818		39,428	3,141	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					$ 125,196	$		$ 10,127	25

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: TETRAD MANAGEMENT, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	$ 200,000	$ 200,000	39,428	$ 16,183	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	39,428	16,183	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	39,428	16,183	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	3,000		39,428	243	4
5	21	OFFICE EXPENSE	PATIENT DAYS	487,280	10	374		39,428	30	5
6	25	TRAVEL	PATIENT DAYS	487,280	10	26,914		39,428	2,178	6
7										7
8	17	ADMINISTRATIVE SALARY - I	PATIENT DAYS	487,280	10	50,000	50,000	39,428	4,046	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					$ 680,288	$ 650,000		$ 55,046	25

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	189,385	3	$ 25,000	$ 25,000	39,428	$ 5,205	1
2	17	COMMISSIONS AND FEES	AVG. HOURS WORKED	189,385	3	66,000		39,428	13,741	2
3	21	CLERICAL & GENERAL	AVG. HOURS WORKED	189,385	3	801		39,428	167	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	189,385	3	9,127		39,428	1,900	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					$ 100,928	$ 25,000		$ 21,013	25

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: LIFELINE AMBULANCE
Street Address: 2424 S. WABASH AVENUE
City / State / Zip Code: CHICAGO, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	AMBULANCE	DIRECT COSTS			$	$		$ 3,887	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					$	$		$ 3,887	25

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Midland		X	Mortgage	$24,481.00	6/1/2007	$	$ 4,197,998	7/1/2042	5.9000	$ 133,276	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				1,294,898			35,455	6
7	Allocated from Managcare		X								97	7
8	See Supplemental Schedule										3,875	8
9	TOTAL Facility Related				$24,481.00		$	$ 5,492,896			$ 172,703	9
	B. Non-Facility Related*											
10	Interest Income - Bldg. Co.		X								(149)	10
11	Interest Income		X								(2,368)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,517)	14
15	TOTALS (line 9+line14)						$	$ 5,492,896			$ 170,186	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 21,154 Line # 36

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from 4600 Touhy, LLC		X				$	$			$ 3,875	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,875	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 178,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 179,943	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,943	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 180,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 8,786	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 26,331 **For** 2010 & 2011 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 191,029	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	154,095	8
	2010	160,803	9
	2011	160,113	10
	2012	174,535	11
	2013	176,802	12

2014 Accrual = $176,805 x 1.02 = $180,300 (Rounded)

Allocated from 4600 Touhy, LLC - $3,141

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Hlthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Long Term Care Property	$ 70,204.20	$ 70,204.20
2.	14-17-115-018-0000	Long Term Care Property	$ 67,117.91	$ 67,117.91
3.	14-17-115-030-0000	Long Term Care Property	$ 39,479.46	$ 39,479.46
4.	See Attached	Alloc. From 4600 Touhy, LLC	$ 84,567.54	$ 3,421.37
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 261,369.11	$ 180,222.94

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Hlthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143			1968	$ 1,899,326	$ 79,602	35	$	$ (79,602)	$ 1,899,326	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306		20			10,284	9
10	Various			1987	4,719		20			4,712	10
11	Various			1988	2,895		20			2,891	11
12	Various			1989	67,265		20			67,250	12
13	Various			1991	22,384		20			20,454	13
14	Various			1992	17,019		20	143	143	15,752	14
15	Various			1993	44,200		20			43,379	15
16	Various			1994	33,607		20	628	628	33,604	16
17	Various			1995	7,105		20	355	355	6,960	17
18	Various			1996	32,680		20	1,634	1,634	30,860	18
19	Various			1997	17,411		20	871	871	14,874	19
20	Various			1998	41,967		20	2,098	2,098	34,368	20
21	Various			1999	205,495		20	10,275	10,275	160,017	21
22	Various			2000	44,219		20	2,211	2,211	31,926	22
23	Various			2001	32,791		20	1,225	1,225	24,922	23
24	Various			2002	31,703		20	641	641	27,745	24
25	Various			2003	17,283		20	1,171	1,171	13,503	25
26	Various			2004	67,457		20	3,063	3,063	59,628	26
27	Various			2005	20,650		20	1,669	1,669	16,357	27
28	Various			2006	12,318		20	988	988	8,338	28
29	Various			2007	2,500		20	125	125	979	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,177,980			58,901	58,901	526,024	67
68	Related Party Allocations (Pages 12H & 12I)		85,750	2,732		3,596	864	10,835	68
69	Financial Statement Depreciation			54,034			(54,034)		69
70	TOTAL (lines 4 thru 69)		$ 3,899,030	$ 136,368		$ 89,592	$ (46,775)	$ 3,064,988	70

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,899,030	$ 136,368		$ 89,592	$ (46,775)	$ 3,064,988	1
2	Wall-Mounted Sign	2011	9,417		20	942	942	3,139	2
3	Fire Alarm Devices	2012	4,474		20	639	639	1,332	3
4	Water Chiller	2013	37,500		20	2,501	2,501	3,750	4
5	Fence	2013	5,000		20	334	334	500	5
6	Installation Of Pump Power Monitor For Fire Alarm Devices	2014	5,123		20	192	192	192	6
7	Installed 9 Victaulic Gaskets In Passenger Elevator	2014	2,520		20	126	126	126	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	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)		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	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)		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	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)		$ 3,963,065	$ 136,368		$ 94,326	$ (42,042)	$ 3,074,027	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	2004 Improvements	2004	534,642		20	26,732	26,732	294,053	9
10	2005 Improvements	2005	314,875		20	15,744	15,744	157,439	10
11	2007 Improvements	2007	28,893		20	952	952	7,618	11
12	2008 Improvements	2008	63,407		20	3,663	3,663	25,639	12
13	Brick & Cement Repair	2009	6,200		20	310	310	1,860	13
14	Custom Carpetry	2009	5,140		20	257	257	1,542	14
15	Window Repairs	2009	4,500		20	225	225	1,350	15
16	Copper Fittings & Valves	2009	5,693		20	285	285	1,709	16
17	Boiler Gas Valve Motor & Temp Control	2009	2,542		20	127	127	762	17
18	Sewer Access	2010	3,750		20	188	188	1,127	18
19	Basement Flooring	2010	12,700		20	635	635	3,810	19
20	Fire Alarm	2010	13,957		20	698	698	2,792	20
21	Wood Flooring	2010	12,000		20	600	600	3,600	21
22	Elevator	2010	59,711		20	2,986	2,986	14,930	22
23	Elevator Repair	2010	2,500		20	125	125	625	23
24	Tile Flooring	2011	3,000		20	150	150	838	24
25	Generator Outlets	2012	7,750		20	388	388	1,494	25
26	Asphalt Resurface 9,246 sq. ft.	2013	14,360		20	718	718	718	26
27	Designed New Therapy Gym & Renov. 1st FL Dining/Lounge								27
28	Room - Remove & Replace Floor, Wallpaper, Painting	2014	82,360		20	4,118	4,118	4,118	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,177,980	$		$ 58,901	$ 58,901	$ 526,024	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 1,177,980	$		$ 58,901	$ 58,901	$ 526,024	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,177,980	$		$ 58,901	$ 58,901	$ 526,024	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy, LLC	2012	41,546	1,065	30	1,385	320	4,155	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare, Inc	2013	698	185	20	35	(150)	70	9
10	Allocated from Managcare, Inc	2012	8,674	620	20	434	(186)	1,301	10
11									11
12									12
13	Allocated from 4600 Touhy, LLC	2012	26,756	693	20	1,338	645	4,013	13
14	Allocated from 4600 Touhy, LLC	2013	6,510	153	20	326	173	651	14
15	Allocated from 4600 Touhy, LLC	2014	647	16	20	32	16	32	15
16									16
17	Allocated from Inter Care, LTD	2001	919		20	46	46	613	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)		$ 85,750	$ 2,732		$ 3,596	$ 864	$ 10,835	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 85,750	$ 2,732		$ 3,596	$ 864	$ 10,835	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 85,750	$ 2,732		$ 3,596	$ 864	$ 10,835	34

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 427,502	$ 3,383	$ 31,826	$ 28,443	10	$ 262,879	71
72	Current Year Purchases	63,544		5,700	5,700	10	5,700	72
73	Fully Depreciated Assets	361,945				10	361,945	73
74								74
75	TOTALS	$ 852,991	$ 3,383	$ 37,526	$ 34,143		$ 630,524	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	2013	$ 9,779	$ 474	$ 1,110	$ 636	5	$ 8,942	76
77										77
78										78
79										79
80	TOTALS			$ 9,779	$ 474	$ 1,110	$ 636		$ 8,942	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)	$ 4,899,827	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 140,225	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,962	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,263)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,713,493	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	Architectural Services	$ 11,795	92
93			93
94			94
95		$ 11,795	95

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 325 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 269,904	$		$ 269,904	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			153,814			153,814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			335,456			335,456	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				132,001		132,001	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					53,964	19,882		73,846	13
14	TOTAL			$		$ 813,138	$ 151,883		$ 965,021	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.

STATE OF ILLINOIS

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,710	$ 32,829	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,542,486	2,694,486	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,660	124,604	6
7	Other Prepaid Expenses	25,617	25,617	7
8	Accounts Receivable (owners or related parties)	559,128	1,024,108	8
9	Other(specify):	95,466	95,466	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,345,067	$ 3,997,110	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	677,133	986,511	15
16	Equipment, at Historical Cost	670,621	896,328	16
17	Accumulated Depreciation (book methods)	(922,354)	(3,936,476)	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):	4,757	308,833	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 430,157	$ 1,284,286	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,775,224	$ 5,281,396	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,771,873	$ 1,781,679	26
27	Officer's Accounts Payable	120,000	120,000	27
28	Accounts Payable-Patient Deposits	17,872	17,872	28
29	Short-Term Notes Payable	1,294,898	1,294,898	29
30	Accrued Salaries Payable	230,339	230,339	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,437	35,437	31
32	Accrued Real Estate Taxes(Sch.IX-B)		180,300	32
33	Accrued Interest Payable	9,068	20,088	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,882,372	1,690,422	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,361,859	$ 5,371,035	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,197,998	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,197,998	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,361,859	$ 9,569,033	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,586,635)	$ (4,287,637)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,775,224	$ 5,281,396	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (318,174)	1
2	Restatements (describe):		2
3	**Prior Period**	14,439	3
4	**Interest**	2,052	4
5	**Rent / Insurance**	(132,473)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (434,156)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,152,479)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,152,479)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,586,635)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,309,845	1
2	Discounts and Allowances for all Levels	(2,381,730)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,928,115	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,723,572	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,723,572	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,168	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,974	19
20	Radiology and X-Ray	1,810	20
21	Other Medical Services	9,836	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,788	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,555	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,555	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	26,090	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,090	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,826,120	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,320,873	31
32	Health Care	2,953,342	32
33	General Administration	2,686,245	33
	B. Capital Expense		
34	Ownership	663,013	34
	C. Ancillary Expense		
35	Special Cost Centers	1,052,728	35
36	Provider Participation Fee	302,398	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,978,599	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,152,479)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,152,479)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,710,796	44
45	Private Pay - Net Inpatient Revenue	364,815	45
46	Medicare - Net Inpatient Revenue	726,839	46
47	Other-(specify) Hospice	2,345	47
48	Other-(specify) Insurance	123,320	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,928,115	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.**

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,488	1,700	$ 68,867	$ 40.51	1
2	Assistant Director of Nursing	1,368	1,440	51,635	35.86	2
3	Registered Nurses	22,160	23,524	643,666	27.36	3
4	Licensed Practical Nurses	26,611	28,166	747,125	26.53	4
5	CNAs & Orderlies	68,495	74,069	772,669	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	599	613	5,659	9.23	8
9	Activity Director	1,780	1,948	31,194	16.01	9
10	Activity Assistants	7,720	8,390	76,004	9.06	10
11	Social Service Workers	6,005	6,220	114,381	18.39	11
12	Dietician					12
13	Food Service Supervisor	1,892	1,956	40,975	20.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,705	19,798	240,016	12.12	15
16	Dishwashers					16
17	Maintenance Workers	3,649	3,853	69,879	18.14	17
18	Housekeepers	19,261	21,693	253,354	11.68	18
19	Laundry	8,792	9,714	99,664	10.26	19
20	Administrator	2,104	2,252	111,880	49.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,684	13,581	249,342	18.36	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	1,849	2,029	33,635	16.58	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	1,920	2,082	60,367	28.99	33
34	TOTAL (lines 1 - 33)	206,082	223,028	$ 3,670,312 *	$ 16.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	190	$ 9,662	01-03	35
36	Medical Director	Monthly	57,420	09-03	36
37	Medical Records Consultant	Monthly	3,528	10-03	37
38	Nurse Consultant	Monthly	45,425	10-03	38
39	Pharmacist Consultant	Monthly	15,542	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Visit	64	10a-03	43
44	Activity Consultant	4	425	11-03	44
45	Social Service Consultant	Monthly	10,967	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	17,160	10-03	47
48	Renal Therapy	Visit	481	10a-03	48
49	TOTAL (lines 35 - 48)	194	$ 160,674		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	676	$ 74,076	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	676	$ 74,076		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Jenkins	Administrator	0	$ 17,901
Christopher Kropp	Administrator	0	14,545
Gina McCarthy	Administrator	0	39,717
Ryan Schwamlien	Administrator	0	39,717
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 111,880

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 4,283
Frost, Ruttenberg & Rothblatt	Accounting	23,352
Legal Fees	See Attached	72,864
Managcare, Inc.	Bookkeeping	163,020
Managcare, Inc.	Administrative Consulting	34,320
Tetrad Management	Administrative Consulting	63,635
Achieve Accreditation	Accreditation Services	15,500
Joint Commission	Accreditation Services	6,673
Kronos	Workforce Management	128
American Data	Electronic Charting System	4,803
eHealth Data Solutions	MDS Software	2,500
See Supplemental Schedule		40,821
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 431,898

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,248
Unemployment Compensation Insurance	65,005
FICA Taxes	280,779
Employee Health Insurance	149,527
Employee Meals	24,243
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	714
Other Employee Benefits	11,539
Safe Harbor Match Expense	15,557
Disbility Insurance	1,251
Holiday Expense	3,312
TOTAL (agree to Schedule V, line 22, col.8)	$ 614,174

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	33,575
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 254	2,535
Licenses & Permits	2,834
Dues and Subscriptions	15,278
Allocated from Managcare	3,103
Allocated from 4600 Touhy, LLC	9
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,325

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,737
Allocated from Managcare	119
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,856

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Brightview Hlthcare & Rehab # 0030551 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. **ICLTC $21,115**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,778** Line **10**

(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. $ **302,398**
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. $ **24,243** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.