		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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0030551

Facility Name: Brightview Care Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,277	1,538	4,020	21,835	8
9	SNF/PED					9
10	ICF	20,716			20,716	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,993	1,538	4,020	42,551	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.52%

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 2,526

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	288,405	69,127	8,479	366,011		366,011	50	366,061			1
2	Food Purchase		222,921		222,921	(23,046)	199,875	(1,286)	198,588			2
3	Housekeeping	173,814	29,045	77,537	280,396		280,396	994	281,390			3
4	Laundry	83,154	18,434		101,588		101,588		101,588			4
5	Heat and Other Utilities			165,817	165,817		165,817	(11,509)	154,308			5
6	Maintenance	74,689	12,127	51,556	138,372		138,372	32,077	170,449			6
7	Other (specify):*											7
8	**TOTAL General Services**	620,062	351,654	303,389	1,275,105	(23,046)	1,252,059	20,326	1,272,385			8
	B. Health Care and Programs											
9	Medical Director			40,920	40,920		40,920	272	41,192			9
10	Nursing and Medical Records	2,426,702	138,016	87,027	2,651,745		2,651,745	33,640	2,685,385			10
10a	Therapy	20,208			20,208		20,208	4,653	24,861			10a
11	Activities	97,530	8,987		106,517		106,517	8	106,525			11
12	Social Services	123,366		9,434	132,800		132,800	4,879	137,679			12
13	CNA Training											13
14	Program Transportation			5,562	5,562		5,562	(263)	5,299			14
15	Other (specify):*							7,928	7,928			15
16	**TOTAL Health Care and Programs**	2,667,806	147,003	142,943	2,957,752		2,957,752	51,116	3,008,868			16
	C. General Administration											
17	Administrative	91,400		211,332	302,732		302,732	(165,367)	137,365			17
18	Directors Fees											18
19	Professional Services			553,378	553,378	(13,804)	539,574	(407,560)	132,014			19
20	Dues, Fees, Subscriptions & Promotions			148,128	148,128		148,128	(82,175)	65,953			20
21	Clerical & General Office Expenses	202,598	23,728	855,244	1,081,570		1,081,570	(604,722)	476,848			21
22	Employee Benefits & Payroll Taxes			563,312	563,312	23,046	586,358		586,358			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,121	1,121		1,121	48	1,169			24
25	Other Admin. Staff Transportation			3,078	3,078		3,078	2,433	5,511			25
26	Insurance-Prop.Liab.Malpractice			232,760	232,760		232,760	7,571	240,331			26
27	Other (specify):*							48,974	48,974			27
28	**TOTAL General Administration**	293,998	23,728	2,568,353	2,886,079	9,242	2,895,321	(1,200,799)	1,694,522			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,581,866	522,385	3,014,685	7,118,936	(13,804)	7,105,132	(1,129,357)	5,975,775			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 Care Center #0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			56,164	56,164		56,164	93,501	149,665			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			118,139	118,139		118,139	50,550	168,689			32
33	Real Estate Taxes			27,555	27,555	13,804	41,359	161,652	203,012			33
34	Rent-Facility & Grounds			477,479	477,479		477,479	(475,785)	1,694			34
35	Rent-Equipment & Vehicles							594	594			35
36	Other (specify):*							20,790	20,790			36
37	TOTAL Ownership			679,337	679,337	13,804	693,141	(148,697)	544,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		205,340	759,659	964,999		964,999		964,999			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			315,685	315,685		315,685		315,685			42
43	Other (specify):*	40,447		25,740	66,187		66,187	(66,187)				43
44	TOTAL Special Cost Centers	40,447	205,340	1,101,084	1,346,871		1,346,871	(66,187)	1,280,684			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,622,313	727,725	4,795,106	9,145,144		9,145,144	(1,344,241)	7,800,903			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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,566)	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	1,221	30		9
10	Interest and Other Investment Income	(11,407)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(53,590)	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	(716,600)	21		24
25	Fund Raising, Advertising and Promotional	(32,801)	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	(212,227)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,039,050)		$	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)	(305,192)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (305,192)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,344,241)		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

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,207)	02	1
2	Medical Records Income	(252)	10	2
3	Marketing Consultant	(25,740)	43	3
4	Bank Charges	(5,863)	21	4
5	Marketing Salary	(40,447)	43	5
6	Theft and Loss	(1,994)	21	6
7	Sequestration	(31,990)	21	7
8	Prior period Expense	(3,484)	21	8
9	Non-Allowable Interest Expense	(73,099)	32	9
10	Marketing Travel	(238)	25	10
11	Non-Allowable Legal Fees	(6,730)	19	11
12	Building Company - Bank Charges	(989)	21	12
13	Building Company - Professional Fees	(15,100)	19	13
14	Building Company - Legal Fees	(2,750)	19	14
15	Building Company - Licenses & Permits	(100)	20	15
16	Building Company - Amortization Expense	(2,245)	31	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(212,227)		49

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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			50									50	1
2	Food Purchase	(1,286)											(1,286)	2
3	Housekeeping			984	9								994	3
4	Laundry													4
5	Heat and Other Utilities	(13,566)		1,748	309								(11,509)	5
6	Maintenance		21,012	10,273	449			343					32,077	6
7	Other (specify):*													7
8	**TOTAL General Services**	(14,852)	21,012	13,056	767			343					20,326	8
	B. Health Care and Programs													
9	Medical Director			272									272	9
10	Nursing and Medical Records	(252)		33,892									33,640	10
10a	Therapy						4,653						4,653	10a
11	Activities			8									8	11
12	Social Services			4,879									4,879	12
13	CNA Training													13
14	Program Transportation								(263)				(263)	14
15	Other (specify):*			7,928									7,928	15
16	**TOTAL Health Care and Programs**	(252)		46,979			4,653		(263)				51,116	16
	C. General Administration													
17	Administrative			24,171			(189,538)						(165,367)	17
18	Directors Fees													18
19	Professional Services	(24,580)	17,850	(315,156)	108	(63,229)		(22,553)					(407,560)	19
20	Fees, Subscriptions & Promotions	(86,491)	100	4,210	5								(82,175)	20
21	Clerical & General Office Expenses	(760,920)	989	124,522	60			30,626					(604,722)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			48									48	24
25	Other Admin. Staff Transportation	(238)		373		2,298							2,433	25
26	Insurance-Prop.Liab.Malpractice		7,025	344	202								7,571	26
27	Other (specify):*			44,976			458	3,540					48,974	27
28	**TOTAL General Administration**	(872,228)	25,964	(116,512)	376	(60,931)	(189,080)	11,612					(1,200,799)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(887,333)	46,976	(56,477)	1,143	(60,931)	(184,427)	11,955	(263)				(1,129,357)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	1,221	84,291	5,931	2,057								93,501	30
31	Amortization of Pre-Op. & Org.	(2,245)	2,245											31
32	Interest	(84,506)	130,954		4,102								50,550	32
33	Real Estate Taxes		157,806		3,846								161,652	33
34	Rent-Facility & Grounds		(477,479)	8,713	(8,713)			1,694					(475,785)	34
35	Rent-Equipment & Vehicles			594									594	35
36	Other (specify):*		20,790										20,790	36
37	**TOTAL Ownership**	(85,529)	(81,393)	15,238	1,293			1,694					(148,697)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(66,187)											(66,187)	43
44	**TOTAL Special Cost Centers**	(66,187)											(66,187)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,039,050)	(34,417)	(41,239)	2,436	(60,931)	(184,427)	13,649	(263)				(1,344,241)	45

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 477,479	Brightview Building Company		$	$ (477,479)	1
2	V	32	Interest Income	45	Brightview Building Company			(45)	2
3	V	21	Bank Charges		Brightview Building Company		989	989	3
4	V	30	Depreciation Expense		Brightview Building Company		84,291	84,291	4
5	V	26	Insurance Expense		Brightview Building Company		7,025	7,025	5
6	V	32	Interest Expense		Brightview Building Company		130,999	130,999	6
7	V	19	Professional Fees		Brightview Building Company		15,100	15,100	7
8	V	19	Legal Fees		Brightview Building Company		2,750	2,750	8
9	V	06	Repairs and Maintenance		Brightview Building Company		21,012	21,012	9
10	V	20	Licenses & Permits		Brightview Building Company		100	100	10
11	V	36	Mortgage Insurance		Brightview Building Company		20,790	20,790	11
12	V	31	Amortization Expense		Brightview Building Company		2,245	2,245	12
13	V	33	Real Estate Taxes		Brightview Building Company		157,806	157,806	13
14	Total			$ 477,524			$ 443,107	$ * (34,417)	14

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$	MOSAIC HEALTHCARE	100.00%	$ 50	$ 50	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	984	984	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	1,748	1,748	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	10,273	10,273	18
19	V	9	MEDICAL DIRECTOR		MOSAIC HEALTHCARE	100.00%	272	272	19
20	V	10	NURSING SALARIES	17,160	MOSAIC HEALTHCARE	100.00%	51,052	33,892	20
21	V	11	ACTIVITIES		MOSAIC HEALTHCARE	100.00%	8	8	21
22	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	4,879	4,879	22
23	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	7,928	7,928	23
24	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	24,171	24,171	24
25	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	(2,816)	(2,816)	25
26	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	4,210	4,210	26
27	V	21	CLERICAL AND GENERAL SALARIES	51,480	MOSAIC HEALTHCARE	100.00%	159,030	107,550	27
28	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE	100.00%	16,972	16,972	28
29	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	48	48	29
30	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	373	373	30
31	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	344	344	31
32	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	44,976	44,976	32
33	V	30	DEPRECIATION		MOSAIC HEALTHCARE	100.00%	5,931	5,931	33
34	V	32	INTEREST EXPENSE		MOSAIC HEALTHCARE	100.00%			34
35	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	8,713	8,713	35
36	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	594	594	36
37	V	19	BOOKKEEPING	153,020	MOSAIC HEALTHCARE	100.00%		(153,020)	37
38	V	19	ADMIN / MGMT CONSULTANT	159,320	MOSAIC HEALTHCARE	100.00%		(159,320)	38
39	Total			$ 380,980			$ 339,741	$ * (41,239)	39

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSKEEPING	$	4600 TOUHY, LLC	100.00%	$ 9	$ 9	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	309	309	16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	449	449	17
18	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	108	108	18
19	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	5	5	19
20	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	60	60	20
21	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	202	202	21
22	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	2,057	2,057	22
23	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	4,102	4,102	23
24	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	3,846	3,846	24
25	V								25
26	V	34	RENT	8,713	4600 TOUHY, LLC	100.00%		(8,713)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,713			$ 11,149	$ * 2,436	39

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	405	$ 405	15
16	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2,298	2,298	16
17	V								17
18	V	19	ADMINISTRATIVE CONSULTANT	63,634	TETRAD MANAGEMENT, LLC	100.00%		(63,634)	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			$ 63,634			$ 2,703	$ * (60,931)	39

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 5,646	$ 5,646	15
16	V	17	COMMISSIONS AND FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	16,148	16,148	16
17	V	10A	THERAPY CONSULTATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	4,653	4,653	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	458	458	18
19	V								19
20	V	17	MANAGEMENT FEES	211,332	INTERCARE, LTD. C/O MANAGCARE	100.00%		(211,332)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 211,332			$ 26,905	$ * (184,427)	39

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	LEGAL & PROFESSIONAL		PLATINUM BILLING SOLUTIONS	30.00%	2,251	$ 2,251	15
16	V	6	REPAIRS & MAINTENANCE		PLATINUM BILLING SOLUTIONS	30.00%	343	343	16
17	V	21	CLERICAL & GENERAL EXPENSE		PLATINUM BILLING SOLUTIONS	30.00%	6,718	6,718	17
18	V	21	CLERICAL & GENERAL SALARY		PLATINUM BILLING SOLUTIONS	30.00%	23,908	23,908	18
19	V	27	EMPLOYEE BENEFITS		PLATINUM BILLING SOLUTIONS	30.00%	3,540	3,540	19
20	V	34	RENT EXPENSE		PLATINUM BILLING SOLUTIONS	30.00%	1,694	1,694	20
21	V								21
22	V	19	PROFESSIONAL FEES	24,804	PLATINUM BILLING SOLUTIONS	30.00%		(24,804)	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			$ 24,804			$ 38,453	$ * 13,649	39

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 3,432	LIFELINE AMBULANCE	100.00%	$ 3,169	$ (263)	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			$ 3,432			$ 3,169	$ * (263)	39

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 COMP	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 MANAGC	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	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	MEDICAL BILLING CO	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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1.56	5.20%	Alloc. Salary	$ 5,646	17-7	1
2	Eli Davis	Relative	Administrative	0%	See Attached	3.46	8.65%	Alloc. Fees	16,148	17-7	2
3	Moshe Wolf	Owner	Administrative	2.77%	See Attached	4.15	8.65%	Alloc. Salary	8,529	17-7	3
4	Stanley Klem	Owner	Administrative	2.77%	See Attached	3.81	8.66%	Alloc. Salary	12,751	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,074		13

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MOSAIC HEALTHCARE
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	491,775	10	$ 583	$	42,551	$ 50	1
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376		42,551	984	2
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206		42,551	1,748	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728		42,551	10,273	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145		42,551	272	5
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	42,551	51,052	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95		42,551	8	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	42,551	4,879	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625		42,551	7,928	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	42,551	24,171	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)		42,551	(2,816)	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662		42,551	4,210	12
13	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	491,775	10	1,837,959	1,837,959	42,551	159,030	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155		42,551	16,972	14
15	24	SEMINARS	PATIENT DAYS	491,775	10	556		42,551	48	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308		42,551	373	16
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971		42,551	344	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798		42,551	44,976	18
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552		42,551	5,931	19
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10			42,551		20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700		42,551	8,713	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863		42,551	594	22
23										23
24										24
25	TOTALS					$ 3,926,495	$ 2,763,717		$ 339,741	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3	HOUSKEEPING	MNGCR. PATIENT DAYS	491,775	10	$ 107	$	42,551	$ 9	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	491,775	10	3,569		42,551	309	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	491,775	10	5,190		42,551	449	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	491,775	10	1,250		42,551	108	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	491,775	10	63		42,551	5	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	491,775	10	698		42,551	60	6
7	26	INSURANCE	MNGCR. PATIENT DAYS	491,775	10	2,336		42,551	202	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS	491,775	10	23,779		42,551	2,057	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	491,775	10	47,406		42,551	4,102	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	491,775	10	44,453		42,551	3,846	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					$ 128,850	$		$ 11,149	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682		42,551	405	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559		42,551	2,298	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					$ 31,241	$		$ 2,703	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	188,403	3	$ 25,000	$ 25,000	42,551	$ 5,646	1
2	17	COMMISSIONS AND FEES	AVG. HOURS WORKED	188,403	3	71,500		42,551	16,148	2
3	10A	THERAPY CONSULTATION	AVG. HOURS WORKED	188,403	3	20,600		42,551	4,653	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	188,403	3	2,026		42,551	458	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					$ 119,126	$ 25,000		$ 26,905	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: PLATINUM BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
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	19	LEGAL & PROFESSIONAL	PATIENT DAYS	188,403	3	9,965		42,551	2,251	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	188,403	3	1,518		42,551	343	2
3	21	CLERICAL & GENERAL EXPE	PATIENT DAYS	188,403	3	29,745		42,551	6,718	3
4	21	CLERICAL & GENERAL SALA	PATIENT DAYS	188,403	3	105,856	105,856	42,551	23,908	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	188,403	3	15,673		42,551	3,540	5
6	34	RENT EXPENSE	PATIENT DAYS	188,403	3	7,500		42,551	1,694	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					$ 170,257	$ 105,856		$ 38,453	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 3,169	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					$	$		$ 3,169	25

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$	$ 4,124,143	7/1/2042	5.9000	$ 130,999	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				949,898			45,040	6
7	Allocated from 4600 Touhy, LLC		X								4,102	7
8												8
9	TOTAL Facility Related				$24,481.00		$	$ 5,074,041			$ 180,141	9
	B. Non-Facility Related*											
10	Interest Income - Bldg. Co.										(45)	10
11	Interest Income										(11,407)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,452)	14
15	TOTALS (line 9+line14)						$	$ 5,074,041			$ 168,689	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 20,790 **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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	180,300	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.)	$	183,975	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,675	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	185,532	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.**	$	13,804	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** $ 41,359 **For** 2011 and 2012 **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.	$	203,011	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	160,803	8
2011	160,113	9
2012	174,535	10
2013	176,802	11
2014	180,128	12

2015 Accrual = $180,128 x 1.03 = $185,532 (Rounded)

Allocated from 4600 Touhy, LLC $3,846

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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	$ 71,618.39	$ 71,618.39
2.	14-17-115-018-0000	Long Term Care Property	$ 68,469.96	$ 68,469.96
3.	14-17-115-030-0000	Long Term Care Property	$ 40,040.10	$ 40,040.10
4.	See Attached	Alloc. From 4600 Touhy, LLC	$ 86,316.15	$ 3,734.27
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 266,444.60	$ 183,862.72

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT 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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Allocated from 4600 Touhy LLC			7,787	2
3	TOTALS			$ 81,779	3

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 84,291	35	$	$ (84,291)	$ 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	15,895	14
15	Various			1993	44,200		20			43,379	15
16	Various			1994	33,607		20			33,604	16
17	Various			1995	7,105		20	144	144	7,104	17
18	Various			1996	32,680		20	1,634	1,634	32,494	18
19	Various			1997	17,411		20	871	871	15,745	19
20	Various			1998	41,967		20	2,098	2,098	36,466	20
21	Various			1999	205,495		20	10,275	10,275	170,292	21
22	Various			2000	44,219		20	2,211	2,211	34,137	22
23	Various			2001	32,791		20	1,225	1,225	26,147	23
24	Various			2002	31,703		20	532	532	28,278	24
25	Various			2003	17,283		20	851	851	14,354	25
26	Various			2004	67,457		20	1,076	1,076	60,704	26
27	Various			2005	20,650		20	1,669	1,669	18,026	27
28	Various			2006	12,318		20	988	988	9,325	28
29	Various			2007	2,500		20	125	125	1,104	29
30	Various			2011	9,417		20	942	942	4,081	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		1,251,031			62,554	62,554	588,578	67
68	Related Party Allocations (Pages 12H & 12I)		91,711	2,609		3,896	1,287	15,490	68
69	Financial Statement Depreciation			56,164			(56,164)		69
70	TOTAL (lines 4 thru 69)		$ 3,987,459	$ 143,064		$ 91,233	$ (51,831)	$ 3,160,119	70

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,987,459	$ 143,064		$ 91,233	$ (51,831)	$ 3,160,119	1
2	Fire Alarm Devices	2012	4,474		20	639	639	1,971	2
3	Water Chiller	2013	37,500		20	2,501	2,501	6,251	3
4	Fence	2013	5,000		20	334	334	834	4
5	Installation Of Pump Power Monitor For Fire Alarm Devices	2014	5,123		20	256	256	448	5
6	Installed 9 Victoulic Gaskets In Elevator	2014	2,520		20	126	126	210	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,042,077	$ 143,064		$ 95,089	$ (47,975)	$ 3,169,833	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	2004 Improvements	2004	511,497		20	25,575	25,575	319,628	9
10	2005 Improvements	2005	314,875		20	15,744	15,744	173,183	10
11	2007 Improvements	2007	28,893		20	952	952	8,570	11
12	2008 Improvements	2008	63,407		20	3,663	3,663	29,302	12
13	Brick & Cement Repair	2009	6,200		20	310	310	2,170	13
14	Custom Carpetry	2009	5,140		20	257	257	1,799	14
15	Window Repairs	2009	4,500		20	225	225	1,575	15
16	Copper Fittings & Valves	2009	5,693		20	285	285	1,994	16
17	Boiler Gas Valve Motor & Temp Control	2009	2,542		20	127	127	889	17
18	Sewer Access	2010	3,750		20	188	188	1,315	18
19	Basement Flooring	2010	12,700		20	635	635	4,445	19
20	Fire Alarm	2010	13,957		20	698	698	3,490	20
21	Wood Flooring	2010	12,000		20	600	600	4,200	21
22	Elevator	2010	59,711		20	2,986	2,986	17,916	22
23	Elevator Repair	2010	2,500		20	125	125	750	23
24	Tile Flooring	2011	3,000		20	150	150	988	24
25	Generator Outlets	2012	7,750		20	388	388	1,882	25
26	Asphalt Resurface 9,246 sq. ft.	2013	14,360		20	718	718	1,436	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	8,236	28
29	1st Fl Corridor-Walcovering,Handrails,Bumpers,Corner Guards	2015	44,135		20	2,207	2,207	2,207	29
30	Full Elevator Rehab	2015	8,650		20	433	433	433	30
31	Wireless Network	2015	43,411		20	2,171	2,171	2,171	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,251,031	$		$ 62,554	$ 62,554	$ 588,578	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 1,251,031	$		$ 62,554	$ 62,554	$ 588,578	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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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)		$ 1,251,031	$		$ 62,554	$ 62,554	$ 588,578	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy, LLC	2012	44,427	1,139	30	1,481	342	5,924	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2013	746	143	20	37	(106)	112	9
10	Allocated from Mosaic Healthcare	2012	9,276	409	20	464	55	1,855	10
11									11
12									12
13	Allocated from 4600 Touhy, LLC	2012	28,611	737	20	1,481	744	5,722	13
14	Allocated from 4600 Touhy, LLC	2013	6,962	163	20	348	185	1,044	14
15	Allocated from 4600 Touhy, LLC	2014	692	18	20	35	17	69	15
16									16
17	Allocated from Inter Care, LTD	2001	997		20	50	50	764	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)		$ 91,711	$ 2,609		$ 3,896	$ 1,287	$ 15,490	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 91,711	$ 2,609		$ 3,896	$ 1,287	$ 15,490	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
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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)		$ 91,711	$ 2,609		$ 3,896	$ 1,287	$ 15,490	34

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 496,825	$ 5,088	$ 48,112	$ 43,024	10	$ 309,963	71
72	Current Year Purchases	56,491		6,464	6,464	10	6,464	72
73	Fully Depreciated Assets	366,635				10	366,635	73
74								74
75	TOTALS	$ 919,951	$ 5,088	$ 54,576	$ 49,488		$ 683,062	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 Mosaic	2015	$ 8,219	$ 292	$	$ (292)	5	$ 8,219	76
77										77
78										78
79										79
80	TOTALS			$ 8,219	$ 292	$	$ (292)		$ 8,219	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)	$ 5,052,026	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,444	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,665	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,221	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,861,113	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Platinum Billing Solutions				1,694			5
6								6
7	TOTAL				$ 1,694 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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

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

16. Rental Amount for movable equipment: $ 594 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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 243,846	$		$ 243,846	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			146,168			146,168	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			273,582			273,582	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				164,853		164,853	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					96,063	40,487		136,550	13
14	TOTAL			$		$ 759,659	$ 205,340		$ 964,999	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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 197,106	$ 210,457	1
2	Cash-Patient Deposits	21,903	21,903	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,673,966	2,825,966	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,603	118,188	6
7	Other Prepaid Expenses	9,027	9,027	7
8	Accounts Receivable (owners or related parties)	481,671	1,153,210	8
9	Other(specify):	73,375	73,375	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,550,651	$ 4,412,126	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	679,402	1,029,138	15
16	Equipment, at Historical Cost	687,419	989,162	16
17	Accumulated Depreciation (book methods)	(978,518)	(4,076,931)	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):		226,787	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 388,303	$ 1,197,246	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,938,954	$ 5,609,372	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,431,157	$ 1,474,548	26
27	Officer's Accounts Payable	120,000	120,000	27
28	Accounts Payable-Patient Deposits	21,903	21,903	28
29	Short-Term Notes Payable	949,898	949,898	29
30	Accrued Salaries Payable	249,544	249,544	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,510	21,510	31
32	Accrued Real Estate Taxes(Sch.IX-B)		185,532	32
33	Accrued Interest Payable	4,897	15,739	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,105,736	3,078,832	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,904,645	$ 6,117,506	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,124,143	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)**	$	$ 4,124,143	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,904,645	$ 10,241,649	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,965,691)	$ (4,632,277)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,938,954	$ 5,609,372	48

*(See instructions.)

Facility Name & ID Number Brightview Care Center # 0030551 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,586,635)	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,586,631)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(379,060)	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)**	$ (379,060)	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)**	$ (1,965,691)	24 *

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 8,981,406	1
2	Discounts and Allowances for all Levels	(1,910,036)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,071,370	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,502,554	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,502,554	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	106,552	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,757	19
20	Radiology and X-Ray	2,120	20
21	Other Medical Services	8,594	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 129,023	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,407	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	51,730	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,730	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,766,084	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,275,105	31
32	Health Care	2,957,752	32
33	General Administration	2,886,079	33
	B. Capital Expense		
34	Ownership	679,337	34
	C. Ancillary Expense		
35	Special Cost Centers	1,031,186	35
36	Provider Participation Fee	315,685	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,145,144	40
41	**Income before Income Taxes (line 30 minus line 40)****	(379,060)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (379,060)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,757,624	44
45	Private Pay - Net Inpatient Revenue	434,222	45
46	Medicare - Net Inpatient Revenue	609,655	46
47	Other-(specify) Hospice	77,285	47
48	Other-(specify) Insurance	192,584	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,071,370	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 Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,824	1,960	$ 79,820	$ 40.72	1
2	Assistant Director of Nursing	2,032	2,153	76,445	35.51	2
3	Registered Nurses	17,552	18,623	563,903	30.28	3
4	Licensed Practical Nurses	31,887	34,153	863,327	25.28	4
5	CNAs & Orderlies	68,399	74,724	813,243	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	661	762	20,208	26.52	8
9	Activity Director	1,912	2,012	36,144	17.96	9
10	Activity Assistants	5,841	6,429	61,386	9.55	10
11	Social Service Workers	6,183	6,583	123,366	18.74	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	45,452	21.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,237	19,450	242,953	12.49	15
16	Dishwashers					16
17	Maintenance Workers	3,993	4,232	74,689	17.65	17
18	Housekeepers	14,140	15,598	173,814	11.14	18
19	Laundry	6,918	7,700	83,154	10.80	19
20	Administrator	1,968	2,080	91,400	43.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,328	9,946	202,598	20.37	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	2,040	2,088	29,964	14.35	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,176	1,275	40,447	31.72	33
34	TOTAL (lines 1 - 33)	195,091	211,848	$ 3,622,313 *	$ 17.10	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	167	$ 8,479	01-03	35
36	Medical Director	Monthly	40,920	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	34,320	10-03	38
39	Pharmacist Consultant	Monthly	13,204	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	9,434	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	17,160	10-03	47
48	Orthopedic Care Director	Monthly	13,500	10-03	48
49	TOTAL (lines 35 - 48)	167	$ 137,017		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	81	$ 8,843	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	81	$ 8,843		53

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ryan Schwamlien	Administrator	0	$ 91,400
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,400

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 6,964
FR&R/Marcum LLP	Accounting	22,740
Legal Fees	See Attached	29,900
Mosaic Healthcare	Bookkeeping	153,020
Platinum Billing	Billing Services	24,804
Galaxy Hosted Software	Clinical & Financial Software	1,672
ADAR	Cloud-based IT Solutions	11,775
HealthMEDX	EMR Software	26,919
Ability Network, Inc	Billing Software	4,741
American Data	Electronic Charting System	3,377
eHealth Data Solutions	MDS Software	2,800
See Supplemental Schedule		264,666
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 553,378

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,437
Unemployment Compensation Insurance	64,860
FICA Taxes	268,877
Employee Health Insurance	136,678
Employee Meals	23,046
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	732
Other Employee Benefits	24,307
Safe Harbor Match Expense	7,788
Disability Insurance	1,315
Holiday Expense	1,317
TOTAL (agree to Schedule V, line 22, col.8)	$ 586,358

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	29,390
Health Care Worker Background Check	2,763
(Indicate # of checks performed 276)	
Patient Background Checks	
Licenses & Permits	6,725
Dues and Subscriptions	22,859
Allocated from Mosaic Healthcare	4,210
Allocated from 4600 Touhy, LLC	5
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,953

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,121
Allocated from Mosaic Healthcare	48
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,169

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/15 Ending: 12/31/15

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													
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10													
11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Brightview Care Center **#** 0030551 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $19,710**

(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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,427** 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. $ **315,685**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **23,046** 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 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.