

Facility Name & ID Number Brightview Care Center

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

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

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

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

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

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

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

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

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

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

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

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

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number **Brightview Care Center** # **0030551** Report Period Beginning: **01/01/12** Ending: **12/31/12**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

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

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,286)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,058)	30		9
10	Interest and Other Investment Income	(22,971)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,324)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(34)	21		18
19	Entertainment	(166)	21		19
20	Contributions	(58,575)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(442,634)	21		24
25	Fund Raising, Advertising and Promotional	(52,508)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(368,722)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (974,355)		\$	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)	145,748		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 145,748		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (828,607)		37

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

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

		1 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

Report Period Beginning:

Ending:

ID#0030551

01/01/12

12/31/12

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

ID#0030551

Report Period Beginning:01/01/12

Ending:12/31/12

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

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	17	ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 5,705	\$ 5,705	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	19	19	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	9	9	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	435	435	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			20
21	V	32	INTEREST EXPENSE		INTERCARE, LTD. C/O MANAGCARE	100.00%			21
22	V	35	EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%			22
23	V								23
24	V	17	MANAGEMENT FEES	211,332	INTERCARE, LTD. C/O MANAGCARE	100.00%		(211,332)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 211,332			\$ 6,168	\$ * (205,164)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	4600 TOUHY, LLC	100.00%	\$	\$	15
16	V	5	UTILITIES		4600 TOUHY, LLC				16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC				17
18	V	17	ADMIN.-M. WOLF		4600 TOUHY, LLC				18
19	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC		117	117	19
20	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC				20
21	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC				21
22	V	26	INSURANCE		4600 TOUHY, LLC				22
23	V	30	DEPRECIATION		4600 TOUHY, LLC		3,099	3,099	23
24	V	32	INTEREST EXPENSE		4600 TOUHY, LLC		4,147	4,147	24
25	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC		3,482	3,482	25
26	V								26
27	V								27
28	V								28
29	V	34	RENT	13,544	4600 TOUHY, LLC			(13,544)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 13,544			\$ 10,845	\$ * (2,699)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MOSHE WOLF	2.769%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	BRIGHTVIEW BUILDING COMPANY		BUILDING CO.	1
2	EDIE DAVIS	0.709%	MAYFIELD CARE CENTER, INC.	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3	STANLEY KLEM	2.767%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO	3
4	YOSEF DAVIS DELTA TRUST	93.755%			INTERCARE, LTD.C/O MANAGC	LINCOLNWOOD	MANAGEMENT CO	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Administrative	0.00%	See Attached	4.11	13.70%	Sal/Alloc Sal	\$ 5,705	17-7	1
2	Nesanel Davis	Relative	Administrative	0.00%	See Attached	6.86	14.29%	Sal/Alloc Sal	42,822	17-1,17-7	2
3	Moshe Wolf	Owner	Administrator	2.77%	See Attached	6.23	12.98%	Al Sal/Fees	13,628	17-7	3
4	Stanley Klem	Owner	Administrative	2.77%	See Attached	6.86	15.59%	Alloc Salary	22,447	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjstuted from the actual costs to reflect only amounts anticipated to be considered allowable										7
8	by the IL. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 84,602		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	278,486	4	\$	\$	43,391	\$	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	278,486	4			43,391		2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	278,486	4			43,391		3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	278,486	4			43,391		4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	278,486	4	750		43,391	117	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	278,486	4			43,391		6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	278,486	4			43,391		7
8	26	INSURANCE	MNGCR. PATIENT DAYS	278,486	4			43,391		8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS	278,486	4	19,887		43,391	3,099	9
10	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	278,486	4	26,618		43,391	4,147	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	278,486	4	22,347		43,391	3,482	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 69,602	\$		\$ 10,845	25

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,731 Line # 36

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 report.				\$	164,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	163,595	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(405)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	163,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	1,882	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 \$ 14,216 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	164,777	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007	151,976	8		
		2008	153,577	9		
		2009	154,095	10		
		2010	160,803	11		
		2011	160,113	12		
2012 Accrual = \$160,113 X 1.02= \$163,300 (Rounded)						
Allocated From 4600 Touhy LLC = \$3,482						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Brightview Care Center</u>	COUNTY	<u>Cook</u>
---------------	-------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

[illegible]

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	143			1968	\$ 1,899,326	\$ 87,322	35	\$	\$ (87,322)	\$ 1,899,326	4
5											5
6											6
7											7
8											8
	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	15,466	14
15	Various			1993	44,200		20	1,939	1,939	42,156	15
16	Various			1994	63,594		20	3,180	3,180	58,913	16
17	Various			1995	7,105		20	355	355	6,250	17
18	Various			1996	37,640		20	1,882	1,882	31,623	18
19	Various			1997	17,411		20	871	871	13,133	19
20	Various			1998	49,850		20	2,493	2,493	35,787	20
21	Various			1999	215,484		20	10,774	10,774	146,129	21
22	Various			2000	47,834		20	2,392	2,392	29,855	22
23	Various			2001	35,034		20	1,337	1,337	23,721	23
24	Various			2002	33,534		20	1,535	1,535	28,285	24
25	Various			2003	21,000		20	1,356	1,356	12,934	25
26	Various			2004	67,457		20	5,352	5,352	51,213	26
27	Various			2005	20,650		20	1,669	1,669	13,019	27
28	Various			2006	19,318		20	1,454	1,454	9,338	28
29	Various			2007	2,500		20	125	125	729	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

Facility Name & ID Number **Brightview Care Center**# **0030551**

Report Period Beginning:

01/01/12

Ending:

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

1 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)		1,098,380			54,920	54,920	415,914	67
68	Related Party Allocations (Pages 12H & 12I)		192,550	8,949		5,891	(3,058)	6,405	68
69	Financial Statement Depreciation			10,051			(10,051)		69
70	TOTAL (lines 4 thru 69)		\$ 3,997,455	\$ 106,322		\$ 97,667	\$ (8,655)	\$ 2,945,785	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,997,455	\$ 106,322		\$ 97,667	\$ (8,655)	\$ 2,945,785	1
2	Wall-Mounted Sign	2011	9,417		20	942	942	1,256	2
3	Fire Alarm Devices	2012	4,474		20				3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1 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		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,011,346	\$ 106,322		\$ 98,609	\$ (7,713)	\$ 2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$4,011,346	\$106,322		\$98,609	\$ (7,713)	\$2,947,041	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,011,346	\$106,322		\$98,609	\$ (7,713)	\$2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$4,011,346	\$106,322		\$98,609	\$ (7,713)	\$2,947,041	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,011,346	\$106,322		\$98,609	\$ (7,713)	\$2,947,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company Information								1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 2004 Improvements	2004	534,642		20	26,732	26,732	240,589	9
10 2005 Improvements	2005	314,875		20	15,744	15,744	125,951	10
11 2007 Improvements	2007	19,048		20	952	952	5,714	11
12 2008 Improvements	2008	73,252		20	3,663	3,663	18,313	12
13 Brick & Cement Repair	2009	6,200		20	310	310	1,240	13
14 Custom Carpentry	2009	5,140		20	257	257	1,028	14
15 Window Repairs	2009	4,500		20	225	225	900	15
16 Copper Fittings & Valves	2009	5,693		20	285	285	1,139	16
17 Boiler Gas Valve Motor & Temp Control	2009	2,542		20	127	127	508	17
18 Sewer Access	2010	3,750		20	188	188	751	18
19 Basement Flooring	2010	12,700		20	635	635	2,540	19
20 Basement Door & Wall	2010	17,120		20	856	856	3,424	20
21 Wood Flooring	2010	12,000		20	600	600	2,400	21
22 Elevator	2010	59,711		20	2,986	2,986	8,958	22
23 Elevator Repair	2010	2,500		20	125	125	375	23
24 Fire Alarm	2011	13,957		20	698	698	1,396	24
25 Tile Flooring	2011	3,000		20	150	150	300	25
26 Generator Outlets	2012	7,750		20	388	388	388	26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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 (12F & 12G lines 1 thru 33)		\$1,098,380	\$		\$54,920	\$54,920	\$415,914	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Brightview Care Center**# **0030551**

Report Period Beginning:

01/01/12

Ending:

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	80,002	728	30	2,667	1,939	2,667	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated From Managcare	2012	16,703	5,850	20	803	(5,047)	796	10
11									11
12	Allocated From Intercare	2001	1,007		20	50	50	571	12
13									13
14	Allocaated from 4600 Touhy LLC	2012	94,838	2,371	20	2,371		2,371	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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 (12H & 12I lines 1 thru 33)		\$ 192,550	\$ 8,949		\$ 5,891	\$ (3,058)	\$ 6,405	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$294,044	\$8,211	\$8,830	\$619	10	\$216,534	71
72	Current Year Purchases	128,976	17,154	6,292	(10,862)	10	6,292	72
73	Fully Depreciated Assets	367,522		24	24	10	367,446	73
74								74
75	TOTALS	\$790,542	\$25,365	\$15,146	\$(10,219)		\$590,273	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Managcare	2012	\$21,808	\$3,117	\$2,991	\$(126)	5	\$15,100	76
77										77
78										78
79										79
80	TOTALS			\$21,808	\$3,117	\$2,991	\$(126)		\$15,100	80

E. Summary of Care-Related Assets

	1	2	
		Reference	Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,897,689
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$134,804
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$116,746
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(18,058)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,552,414

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 377
- 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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678											
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	198,938	\$		\$ 198,938	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				84,244			84,244	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				243,208			243,208	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts				170,303			170,303	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): See Supplemental						181,255	17,676		198,931	13
14	TOTAL			\$		\$	707,645	\$ 187,979	\$	895,624	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 242,696	\$ 399,281	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,743,483	2,059,832	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,040	177,044	6
7	Other Prepaid Expenses	5,965	5,965	7
8	Accounts Receivable (owners or related parties)	809,236	1,056,867	8
9	Other(specify): See Attached Schedule	70,239	287,762	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,966,659	\$ 3,986,751	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	634,633	851,330	15
16	Equipment, at Historical Cost	612,600	825,458	16
17	Accumulated Depreciation (book methods)	(822,083)	(3,674,605)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		94,944	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 425,150	\$ 1,126,217	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,391,809	\$ 5,112,968	25

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$360,203	1
2	Restatements (describe):		2
3	Rounding Adjustment	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$360,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(245,160)	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)	\$(245,160)	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)	\$115,047	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

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

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

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

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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

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

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Brightview Care Center		STATE OF ILLINOIS		Report Period Beginning:		01/01/12		Page 21	
				# 0030551				Ending:		12/31/12	
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Mark Murphy		Administrator	0.00%	\$ 117,097	Workers' Compensation Insurance		\$ 88,355	IDPH License Fee		\$	
Nesanel Davis		Administrative	0.00%	15,515	Unemployment Compensation Insurance		39,645	Advertising: Employee Recruitment		35,625	
					FICA Taxes		297,825	Health Care Worker Background Check			
					Employee Health Insurance		185,692	(Indicate # of checks performed)			
					Employee Meals		27,611	Patient Background Checks		438	4,383
					Illinois Municipal Retirement Fund (IMRF)*			Licence & Fees		3,925	
					Disability Insurance		5,279	Dues & Subscriptions		16,437	
TOTAL (agree to Schedule V, line 17, col. 1)					Chicago Head Tax		2,560	Advertising & Promotions		52,508	
(List each licensed administrator separately.)				\$ 132,612	Pension Expense		5,550				
B. Administrative - Other								See Supplemental Schedule			
Description				Amount				Less: Public Relations Expense		(	
Management Fees- Intercare, Ltd.				\$ 211,332				Non-allowable advertising		(52,508)	
								Yellow page advertising		(	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 211,332	TOTAL (agree to Schedule V, line 22, col.8)		\$ 670,871	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 62,648	
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
Comprehensive Reimbursement		Reimbursement Consult		\$ 13,896				\$	Out-of-State Travel		\$
Michigan Peer Review Org		Conflict Resolution		510							
Managcare, Inc		Strategic Consulting		8,172							
American Data		Computer Services		4,201					In-State Travel		
E-Health Data		Computer Services		4,782							
Adar LLC		Computer Services		10,439							
Ivans		Computer Services		495							
Personnel Planners		Unemployment Consult		1,717					Seminar Expense		3,204
Honkamp Kreuger		Unemployment Consult		360					Allocated From Managcare		377
Frost, Ruttenberg & Rothblatt		Accounting		20,250							
See Attached		Legal		3,134							
See Supplemental Schedule				217,000					Entertainment Expense		(
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 284,956					TOTAL		\$ 3,581
* Attach copy of IMRF notifications											
SEE ACCOUNTANTS' COMPILATION REPORT											
**See instructions.											

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC- \$13,845
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,146 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 321,423
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 27,611 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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