

		FOR BHF USE					

LL1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**I. IDPH Facility ID Number:** 0030551

**Facility Name:** Brightview Care Center

**Address:** 4538 North Beacon Chicago 60640  
 Number City Zip Code

**County:** Cook

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

**HFS ID Number:** 363408520001

**Date of Initial License for Current Owners:** 02/01/86

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center# 0030551 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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 bedsN/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>52,195</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>52,195</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>27,924</u>	<u>408</u>	<u>2,424</u>	<u>30,756</u>	8
9	SNF/PED					9
10	ICF	<u>15,261</u>	<u>121</u>		<u>15,382</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,185</u>	<u>529</u>	<u>2,424</u>	<u>46,138</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 88.40%

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)

N/AF. Does the facility maintain a daily midnight census? YesG. 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 2,424Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	199,247	35,287	5,400	239,934		239,934	(34)	239,900		1
2	Food Purchase		187,607		187,607	(16,630)	170,977	(21)	170,956		2
3	Housekeeping	232,321	46,178		278,499		278,499	1,211	279,710		3
4	Laundry	83,677	6,875		90,552		90,552		90,552		4
5	Heat and Other Utilities			151,756	151,756		151,756	2,796	154,552		5
6	Maintenance	25,926	17,365	42,356	85,647		85,647	5,923	91,570		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	541,171	293,312	199,512	1,033,995	(16,630)	1,017,365	9,875	1,027,240		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,800	27,800		27,800		27,800		9
10	Nursing and Medical Records	1,643,089	108,230	210,049	1,961,368		1,961,368	(17)	1,961,351		10
10a	Therapy	108,936	900	5,081	114,917		114,917	(64)	114,853		10a
11	Activities	58,029	4,692	4,214	66,935		66,935		66,935		11
12	Social Services	110,649		150	110,799		110,799		110,799		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,920,703	113,822	247,294	2,281,819		2,281,819	(81)	2,281,738		16
	<b>C. General Administration</b>										
17	Administrative	255,549		114,000	369,549		369,549	(30,974)	338,575		17
18	Directors Fees										18
19	Professional Services			287,032	287,032	(2,500)	284,532	(210,490)	74,042		19
20	Dues, Fees, Subscriptions & Promotions			55,617	55,617		55,617	(30,613)	25,004		20
21	Clerical & General Office Expenses	120,603	36,471	215,208	372,282		372,282	(112,067)	260,215		21
22	Employee Benefits & Payroll Taxes			449,701	449,701	16,630	466,331		466,331		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,033	3,033		3,033	321	3,354		24
25	Other Admin. Staff Transportation			2,833	2,833		2,833	(698)	2,135		25
26	Insurance-Prop.Liab.Malpractice			123,468	123,468		123,468	7,214	130,682		26
27	Other (specify):*							46,742	46,742		27
28	<b>TOTAL General Administration</b>	376,152	36,471	1,250,892	1,663,515	14,130	1,677,645	(330,565)	1,347,080		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,838,026	443,605	1,697,698	4,979,329	(2,500)	4,976,829	(320,771)	4,656,058		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center #0030551 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			28,763	28,763		28,763	151,754	180,517			30
31	Amortization of Pre-Op. & Org.							5,920	5,920			31
32	Interest			71,733	71,733		71,733	243,633	315,366			32
33	Real Estate Taxes					2,500	2,500	173,843	176,343			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles							205	205			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			556,496	556,496	2,500	558,996	119,355	678,351			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,857	137,300	310,157		310,157		310,157			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*	118,469			118,469		118,469	(118,469)				43
44	<b>TOTAL Special Cost Centers</b>	118,469	172,857	215,593	506,919		506,919	(118,469)	388,450			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,956,495	616,462	2,469,787	6,042,744		6,042,744	(319,886)	5,722,858			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,205)	30		9
10	Interest and Other Investment Income	(1,504)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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	(38)	21		18
19	Entertainment				19
20	Contributions	(7,615)	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	(143,755)	21		24
25	Fund Raising, Advertising and Promotional	(21,722)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(176,907)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (361,768)		\$	30

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

		1	2	
		Amount	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)	41,882		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 41,882		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (319,886)		37

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

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

		1	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Bank Charges	\$ (980)	21	1
2 Debt and Loss	(162)	21	2
3 C/OP/I Fees	(2,032)	20	3
4 Marketing Salaries	(118,469)	43	4
5 Jury Duty Income	(13)	40	5
6 Rehab Refunds	(64)	10a	6
7 Jury Duty Income	(34)	01	7
8 Building Co. - Professional Fees	(2,790)	19	8
9 Building Co. - Other Expense	(1,077)	21	9
10 Non-Allowable and Out of Period Legal	(9,041)	19	10
11 Non-Allowable Expense	(41,561)	21	11
12 Marketing Travel	(714)	25	12
13			13
14			14
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97			97
98			98
99			99
100			100
101 Total	(176,907)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(34)											(34)	1
2	Food Purchase	(21)											(21)	2
3	Housekeeping			761	450								1,211	3
4	Laundry													4
5	Heat and Other Utilities			1,277	1,519								2,796	5
6	Maintenance			4,914	1,009								5,923	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(55)</b>		<b>6,952</b>	<b>2,978</b>								<b>9,875</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(17)											(17)	10
10a	Therapy	(64)											(64)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(81)</b>											<b>(81)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			61,660	589	(93,223)							(30,974)	17
18	Directors Fees													18
19	Professional Services	(11,791)	2,750	(202,185)	217	519							(210,490)	19
20	Fees, Subscriptions & Promotions	(31,369)		665	53	38							(30,613)	20
21	Clerical & General Office Expenses	(187,579)	1,077	74,024	68	343							(112,067)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			321									321	24
25	Other Admin. Staff Transportation	(714)		16									(698)	25
26	Insurance-Prop.Liab.Malpractice		6,600	452	162								7,214	26
27	Other (specify):*			45,216		1,526							46,742	27
28	<b>TOTAL General Administration</b>	<b>(231,453)</b>	<b>10,427</b>	<b>(19,831)</b>	<b>1,089</b>	<b>(90,797)</b>							<b>(330,565)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(231,589)</b>	<b>10,427</b>	<b>(12,879)</b>	<b>4,067</b>	<b>(90,797)</b>							<b>(320,771)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(10,205)	158,046	3,567	264	82							151,754	30
31	Amortization of Pre-Op. & Org.		5,920										5,920	31
32	Interest	(1,504)	242,315	327	2,495								243,633	32
33	Real Estate Taxes		171,711		2,132								173,843	33
34	Rent-Facility & Grounds		(456,000)	11,420	(11,420)								(456,000)	34
35	Rent-Equipment & Vehicles			205									205	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(11,709)</b>	<b>121,992</b>	<b>15,519</b>	<b>(6,529)</b>	<b>82</b>							<b>119,355</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(118,469)											(118,469)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(118,469)</b>											<b>(118,469)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(361,768)</b>	<b>132,419</b>	<b>2,640</b>	<b>(2,462)</b>	<b>(90,715)</b>							<b>(319,886)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Brightview Building Company		Building Co.

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	32 Interest Income	\$ 81,493	Brightview Building Company	100.00%	\$	\$ (81,493)	1
2	V	34 Rent	456,000	Brightview Building Company	100.00%		(456,000)	2
3	V	32 Interest Expense		Brightview Building Company	100.00%	323,808	323,808	3
4	V	30 Depreciation		Brightview Building Company	100.00%	158,046	158,046	4
5	V	31 Amortization		Brightview Building Company	100.00%	5,920	5,920	5
6	V	33 Real Estate Tax		Brightview Building Company	100.00%	171,711	171,711	6
7	V	26 Insurance		Brightview Building Company	100.00%	6,600	6,600	7
8	V	19 Professional Fees		Brightview Building Company	100.00%	2,750	2,750	8
9	V	21 Other Expense		Brightview Building Company	100.00%	1,077	1,077	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 537,493			\$ 669,912	\$ * 132,419	14

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/06 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	3	HOUSEKEEPING	\$	MANAGCARE, INC.	100.00%	\$ 761	761	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,277	1,277	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	4,914	4,914	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	61,660	61,660	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	303	303	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	665	665	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	74,024	74,024	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	321	321	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	16	16	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	452	452	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	45,216	45,216	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	3,567	3,567	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	327	327	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	11,420	11,420	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	205	205	30
31	V	19	HOME OFFICE	202,488	MANAGCARE, INC.	100.00%		(202,488)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 202,488			\$ 205,128	\$ * 2,640	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center# 0030551Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	\$	MAZEL MANAGEMENT	100.00%	\$ 450	450	15
16	V	5 UTILITIES		MAZEL MANAGEMENT		1,519	1,519	16
17	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		1,009	1,009	17
18	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		589	589	19
20	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		217	217	20
21	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		53	53	21
22	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		68	68	22
23	V	26 INSURANCE		MAZEL MANAGEMENT		162	162	23
24	V	30 DEPRECIATION		MAZEL MANAGEMENT		264	264	24
25	V	31 AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		2,495	2,495	26
27	V	33 REAL ESTATE TAXES				2,132	2,132	27
28	V							28
29	V	34 RENT	11,420				(11,420)	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		\$ 11,420			\$ 8,958	\$ * (2,462)	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	17 ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 20,777	20,777	15
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	519	519	16
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	38	38	17
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	343	343	18
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,526	1,526	19
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	82	82	20
21	V							21
22	V	17 MANAGEMENT FEES	114,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(114,000)	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		\$ 114,000			\$ 23,285	\$ * (90,715)	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.

**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.

**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.

**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

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Owner	Administrative	72.34%	See Attached	6.23	10.38%	Sal, Allc Sal	\$ 35,777	17-1, 17-7	1
2	Moshe Davis	Administrator	Administrative		See Attached	52.40	93.57%	Salary	141,527	17-1	2
3	Yehoshua Davis	Operations	Administrative		See Attached	1.00	1.64%	Salary	3,949	17-1	3
4	Nesanel Davis	Relative	Administrative		See Attached	40.00	100.00%	Salary	95,073	17-1	4
5	Moshe Wolf	Relative	Administrative		See Attached	12.47	22.27%	Alloc Sal,Fee	15,934	17-3, 17-7	5
6	Stanley Klem	Owner	Administrative	2.13%	See Attached	10.02	22.27%	Alloc Sal	27,856	17-7	6
7	Renee Wolf	Relative	Clerical		See Attached	8.90	22.25%	Alloc Sal	3,279	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 323,395		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: 01/01/06

Ending: 12/31/06

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 3553 W. PETERSON AVE -3RD FLR  
 City / State / Zip Code CHICAGO, IL. 60659  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	207,261	4	\$ 3,420	\$ 46,138	\$ 761	1
2	5	UTILITIES	PATIENT DAYS	207,261	4	5,735	46,138	1,277	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	207,261	4	22,076	46,138	4,914	3
4	10	NURSING SALARIES	PATIENT DAYS	207,261	4		46,138		4
5	17	ADMINISTRATIVE	PATIENT DAYS	207,261	4	276,989	276,989	61,660	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	207,261	4	1,360	46,138	303	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	207,261	4	2,989	46,138	665	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	207,261	4	332,530	297,835	74,024	8
9	24	SEMINARS	PATIENT DAYS	207,261	4	1,440	46,138	321	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	207,261	4	70	46,138	16	10
11	26	INSURANCE	PATIENT DAYS	207,261	4	2,029	46,138	452	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	207,261	4	203,119	46,138	45,216	12
13	30	DEPRECIATION	PATIENT DAYS	207,261	4	16,022	46,138	3,567	13
14	32	INTEREST EXPENSE	PATIENT DAYS	207,261	4	1,471	46,138	327	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	207,261	4	51,300	46,138	11,420	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	207,261	4	922	46,138	205	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 921,472	\$ 574,824	\$ 205,128	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 MAZEL MANAGEMENT  
 Street Address 3553 W.PETERSON AVE.  
 City / State / Zip Code CHICAGO, IL. 60659  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS 207,261	4	\$ 2,021	\$	46,138	\$ 450	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 207,261	4	6,826		46,138	1,519	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 207,261	4	4,531		46,138	1,009	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS 207,261	4			46,138		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS 207,261	4	2,644		46,138	589	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 207,261	4	973		46,138	217	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 207,261	4	237		46,138	53	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 207,261	4	307		46,138	68	8
9	26	INSURANCE	MNGCR. PATIENT DAYS 207,261	4	728		46,138	162	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS 207,261	4	1,187		46,138	264	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS 207,261	4			46,138		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 207,261	4	11,207		46,138	2,495	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 207,261	4	9,579		46,138	2,132	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				\$ 40,240	\$		\$ 8,958	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

Name of Related Organization INTERCARE, LTD. C/O MANAGCARE  
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR  
 City / State / Zip Code CHICAGO, IL. 60659  
 Phone Number ( 773) 463-1313  
 Fax Number ( 773) 463- 5311

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	30	6	\$ 100,000	\$ 100,000	6	\$ 20,777	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	30	6	2,500		6	519	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	30	6	182		6	38	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	30	6	1,652		6	343	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	30	6	7,344		6	1,526	5
6	30	DEPRECIATION	AVG. HOURS WORKED	30	6	394		6	82	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					\$ 112,072	\$ 100,000		\$ 23,285	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MB Financial		X	Mortgage			\$ 4,000,000	\$ 3,996,588	11/23/10	8.2500	\$ 323,808	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit				325,000			25,216	6								
7	Brightview Building	X		Working Capital							42,378	7								
8	See Supplemental Schedule										6,961	8								
9	TOTAL Facility Related						\$ 4,000,000	\$ 4,321,588			\$ 398,363	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(1,504)	10								
11	Interest Income - Bldg Co.		X								(81,493)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(82,997)	14								
15	TOTALS (line 9+line14)						\$ 4,000,000	\$ 4,321,588			\$ 315,366	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	<b>TOTAL Long-Term</b>											7						
<b>Working Capital</b>																		
8	Premium Financing		X	Premium Financing			\$	\$			\$	4,139	8					
9	Allocate Mazel Mgmt		X									2,495	9					
10	Allocate ManagCare		X									327	10					
11													11					
12													12					
13													13					
14	<b>TOTAL Working Capital</b>											14						
<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$		15					
16													16					
17													17					
18													18					
19													19					
20	<b>TOTAL Non-Facility Related</b>											20						

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-115-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>66,996.17</u>	\$ <u>66,996.17</u>
2. <u>14-17-115-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>65,263.77</u>	\$ <u>65,263.77</u>
3. <u>14-17-115-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>36,450.86</u>	\$ <u>36,450.86</u>
4. <u>See Attached</u>	<u>Allocate Mazel Management</u>	\$ <u>42,181.71</u>	\$ <u>2,152.78</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>210,892.51</u>	\$ <u>170,863.58</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Brightview Care Center

# 0030551 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 29,600 2. Number of Years Over Which it is Being Amortized: 5  
3. Current Period Amortization: 5,920 4. Dates Incurred: 01/27/2002

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

# **0030551**

Report Period Beginning:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various		1986		10,306		20			10,284	9
10	Various		1987		4,719		20	236	236	4,604	10
11	Various		1988		2,895		20	145	145	2,729	11
12	Various		1989		67,265		20	3,272	3,272	59,409	12
13	Various		1991		22,384		20	1,120	1,120	15,358	13
14	Various		1992		17,019		20	143	143	14,609	14
15	Various		1993		44,200		20	2,211	2,211	29,708	15
16	Various		1994		63,594		20	3,181	3,181	39,836	16
17	Various		1995		7,105		20	356	356	4,119	17
18	Various		1996		37,640		20	1,882	1,882	20,331	18
19	Various		1997		17,411		20	871	871	7,910	19
20	Various		1998		49,850		20	2,497	2,497	20,836	20
21	Various		1999		215,484		20	10,777	10,777	81,487	21
22	Various		2000		47,834		20	2,392	2,392	15,507	22
23	Various		2001		35,034		20	2,167	2,167	12,039	23
24	Various		2002		33,534		20	2,878	2,878	12,914	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

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

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

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,748,844	158,046		97,022	(61,024)	1,923,701	67
68		60,331	356		1,441	1,085	33,233	68
69			15,669			(15,669)		69
70		\$ 3,485,449	\$ 174,071		\$ 132,591	\$ (41,480)	\$ 2,308,614	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,485,449	\$ 174,071		\$ 132,591	\$ (41,480)	\$ 2,308,614	1
2	Delivery Security Camera	2003	1,858		20	93	93	325	2
3	Front Door Security Camera	2003	1,858		20	93	93	333	3
4	Condensing Unit	2003	7,825		20	652	652	2,228	4
5	A/C Compressor Circuit	2003	1,370		20	114	114	390	5
6	Piston Packing & Installation	2003	600		20	30	30	98	6
7	Thermostat & Actuator Control	2003	1,037		20	52	52	207	7
8	Connect Air Handler To Fire Alarm	2003	781		20	39	39	140	8
9	Service On Pa System & Monitor System	2003	738		20	37	37	129	9
10	Repair Cooling Coil & Air Handler	2003	3,992		20	200	200	765	10
11	Freezer Stat Controls	2003	940		20	47	47	180	11
12	Faucets	2004	5,750		20	575	575	1,485	12
13	Door Hardware	2004	2,429		20	243	243	627	13
14	Door Hardware	2004	1,147		20	115	115	287	14
15	Waiting Room	2004	30,517		20	3,052	3,052	7,629	15
16	Water Heater	2004	3,785		20	315	315	683	16
17	Door Detector	2004	1,892		20	95	95	244	17
18	Pump Motor	2004	3,137		20	157	157	327	18
19	Valve Tamper Panel	2004	5,693		20	1,139	1,139	2,467	19
20	Elevator Repair	2004	2,500		20	250	250	688	20
21	Monitor System Repair	2004	852		20	43	43	121	21
22	Monitor System Repair	2004	706		20	35	35	100	22
23	Kitchen Air Handler	2004	804		20	40	40	111	23
24	Chiller Repair	2004	668		20	33	33	81	24
25	Electrical Work	2004	2,731		20	137	137	307	25
26	Fire Alarm Repair	2004	596		20	30	30	62	26
27	Kitchen Doors	2004	775		20	39	39	116	27
28	Paint	2004	634		20	32	32	87	28
29	Locks	2004	1,586		20	79	79	198	29
30	Door Locks	2004	837		20	42	42	126	30
31	Door Locks	2004	419		20	42	42	126	31
32	Boiler Tubes	2005	13,800		20	1,150	1,150	2,108	32
33	Retube	2005	5,300		20	442	442	773	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,593,006	\$ 174,071		\$ 142,033	\$ (32,038)	\$ 2,332,162	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,593,006	\$ 174,071		\$ 142,033	\$ (32,038)	\$ 2,332,162	1
2	Fence Repair	2005	1,550		20	78	78	123	2
3	Boiler	2006	4,695		20	326	326	326	3
4	Wainscot*	2006	4,969		20	41	41	41	4
5	Window Treatments And Wall Covering*	2006	2,654		20	66	66	66	5
6	Laundry Room Remodeling*	2006	7,000		20	175	175	175	6
7									7
8									8
9									9
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1	
2									2
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1
2								2
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1
2								2
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893		1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893		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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	1
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30									30
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12I, Carried Forward</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12J, Carried Forward</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	1
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1
2									2
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4									4
5									5
6									6
7									7
8									8
9									9
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12M, Carried Forward</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12N, Carried Forward</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	1
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12O, Carried Forward</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	1
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,613,874</b>	\$ <b>174,071</b>		\$ <b>142,719</b>	\$ <b>(31,352)</b>	\$ <b>2,332,893</b>	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	1
2								2
3								3
4								4
5								5
6								6
7								7
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9								9
10								10
11								11
12								12
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15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,613,874	\$ 174,071		\$ 142,719	\$ (31,352)	\$ 2,332,893	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		1986	1968	\$ 1,899,326	\$	35	\$ 54,266	\$ 54,266	\$ 1,811,457	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Removal Of Cove Base, Ceilings, Closet Walls, Frames & Drywall		2004	169,742		20	8,487	8,487	25,461	9
10		Installation Of Carpet, Border, & Cove Base In 1st, 2nd & 3rd Floor		2004	89,574		20	4,479	4,479	13,436	10
11		Handrails, Bumper Guards & Corner Guards in 1st & 2nd Floors		2004	21,852		20	1,093	1,093	3,278	11
12		Light Fixtures, Floor Prep, Vinyl Tile In 1st Floor Dining Room		2004	23,145		20	1,157	1,157	3,472	12
13		Cubicle Tracks & Corner Guards		2004	8,419		20	421	421	1,263	13
14		Repainting, Ceiling Trimming, Crown Molding In Corridor		2004	42,081		20	2,104	2,104	6,312	14
15		Custom Installation of VCT & Cove Base		2004	51,661		20	2,583	2,583	7,749	15
16		Drapery Panels & Curtains In 2nd Floor Resident Rooms		2004	16,860		20	843	843	2,529	16
17		Repainting, Ceiling Trimming, Crown Molding On 2nd Floor		2004	38,520		20	1,926	1,926	5,778	17
18		Blinds & Mount Fixture		2004	3,706		20	185	185	556	18
19		Crown Molding In Resident Rooms & Nurses Station		2004	19,078		20	954	954	2,862	19
20		Replacing Drywall & Removal Of VCT In Therapy Room		2004	40,399		20	2,020	2,020	6,060	20
21		Furnish & Install Of Light Fixtures In Corridor		2004	9,605		20	480	480	1,441	21
22		Bathroom Remodeling		2005	1,925		20	96	96	192	22
23		Gluedown Carpet In Conf. Room		2005	980		20	49	49	98	23
24		Laminating Desk In Reception Area		2005	8,016		20	401	401	802	24
25		Crown Molding		2005	1,183		20	59	59	118	25
26		Wall Covering		2005	2,044		20	102	102	204	26
27		Light Fixtures		2005	643		20	32	32	64	27
28		Drapery Panels		2005	1,340		20	67	67	134	28
29		Removal & Installation Of Vinyl In Lobby		2005	12,547		20	627	627	1,255	29
30		Crown Molding & Wood Fronts In Nurses Station		2005	19,159		20	958	958	1,916	30
31		Installation Of New Carpet & Cove Base		2005	892		20	45	45	89	31
32		Faux Wood Blinds		2005	283		20	14	14	28	32
33		Installation Of New VCT And Cove Base		2005	258		20	13	13	26	33
34		Ceramic Tile Installation In Bathroom		2005	816		20	41	41	82	34
35		Pedimat & Ceramic Tile In Vestibule		2005	3,829		20	191	191	383	35
36		Wall Covering & Repainting In Med Room		2005	5,630		20	282	282	563	36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Vestibule	2005	\$ 199,403	\$	20	\$ 10,250	\$ 10,250	\$ 20,500	37
38	Bumpers, Corner Guards & Handrails	2005	3,998		20	200	200	400	38
39	Door Casings	2005	1,463		20	73	73	146	39
40	Elevator Wraps	2005	930		20	46	46	93	40
41	Resident Room Pvc Sheeting	2005	3,882		20	194	194	388	41
42	Bumpers, Corner Guards & Handrails	2005	2,442		20	122	122	244	42
43	Drywall & Framing For Sprinkler Piping	2005	1,872		20	94	94	187	43
44	Time & Materials For Invoice Period	2005	309		20	15	15	31	44
45	Demolition Of Medication & Linen Rooms	2005	3,453		20	173	173	345	45
46	Electrical For Receptacles & Lights	2005	2,129		20	106	106	213	46
47	Concrete Flatwork	2005	978		20	49	49	98	47
48	Sliding Doors	2005	7,654		20	383	383	765	48
49	Installation Of New Window Opening	2005	3,039		20	152	152	304	49
50	HVAC, Sprinkler, Fire Alarm	2005	17,141		20	857	857	1,714	50
51	Fireproofing Of Existing Steel Beams	2005	403		20	20	20	40	51
52	New Ceilings & Lighting	2005	2,129		20	106	106	213	52
53	Cabinets, Countertops, & Plumbing	2005	1,093		20	55	55	109	53
54	New Shelving For DON Office Closet	2005	460		20	23	23	46	54
55	Plumbing	2005	1,496		20	75	75	150	55
56	Faux Food Blinds	2005	1,055		20	53	53	106	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Book Depreciation			158,046			(158,046)		69
70	TOTAL (lines 4 thru 69)		\$ 2,748,844	\$ 158,046		\$ 97,022	\$ (61,024)	\$ 1,923,701	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:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Mazel Mgmt		1985	1985	\$ 22,966	\$	30	\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocation - ManagCare			1997	2,677	-	20	268	268	2,521	9
10	Allocation - ManagCare			1993	210	-	20	11	11	142	10
11	Allocation - ManagCare			1988	328	10	20	16	6	298	11
12	Allocation - ManagCare			1986	24,837	-	20	754	754	24,836	12
13	Allocation - Mazel Management			2006	725	9	20	18	9	18	13
14	Allocation - Mazel Management			2005	542	133	20	54	(79)	80	14
15	Allocation - Mazel Management			2001	482	12	20	24	12	132	15
16	Allocation - Mazel Management			2000	244	6	20	12	6	76	16
17	Allocation - Mazel Management			1998	859	29	20	43	14	374	17
18	Allocation - Mazel Management			1997	801	21	20	40	19	374	18
19	Allocation - Mazel Management			1996	546	6	20	27	21	289	19
20	Allocation - Mazel Management			1995	124	3	20	6	3	72	20
21	Allocation - Mazel Management			1994	488	9	20	24	15	279	21
22	Allocation - Mazel Management			1993	288	8	20	14	6	194	22
23	Allocation - Mazel Management			1991	216	7	20	11	4	158	23
24	Allocation - Mazel Management			1990	335	7	20	17	10	274	24
25	Allocation - Mazel Management			1989	210	5	20	9	4	155	25
26	Allocation - Mazel Management			1987	477	9	20	-	(9)	477	26
27	Allocation - Mazel Management			1986	1,925	-	20	47	47	1,925	27
28	Allocation - Mazel Management			1985	134	-	20	-		314	28
29											29
30	Allocation - Inter Care Ltd.			2001	917	82	20	46	(36)	245	30
31											31
32											32
33											33
34											34
35											35
36											36

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:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		60,331	356		1,441	1,085	33,233	

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: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 298,688	\$ 9,779	\$ 32,135	\$ 22,356	10	\$ 229,413	71
72	Current Year Purchases	5,283	3,990	287	(3,703)	10	287	72
73	Fully Depreciated Assets	155,832		710	710	10	155,783	73
74								74
75	TOTALS	\$ 459,803	\$ 13,769	\$ 33,132	\$ 19,363		\$ 385,483	75

D. Vehicle Depreciation (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		Allocate ManagCare	2002	\$ 26,212	\$ 2,880	\$ 4,664	\$ 1,784	5	\$ 13,509	76
77										77
78										78
79										79
80	TOTALS			\$ 26,212	\$ 2,880	\$ 4,664	\$ 1,784		\$ 13,509	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)	\$ 4,173,881	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,720	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,515	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,205)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,731,885	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Satellite TV	\$ 16,000	92
93			93
94			94
95		\$ 16,000	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 205

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	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 63,364	\$		\$ 63,364	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,783			7,783	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			59,900			59,900	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 prescripts				90,542		90,542	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					12,820		12,820	12
13	Other (specify): <b>See Supplemental</b>					6,253	69,495		75,748	13
14	<b>TOTAL</b>			\$		\$ 137,300	\$ 172,857		\$ 310,157	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center# 0030551Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 73,223	\$ 180,939	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	851,732	1,197,029	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,118	156,118	6
7	Other Prepaid Expenses	4,904	48,892	7
8	Accounts Receivable (owners or related parties)	14,599	464,599	8
9	Other(specify): <u>See Attached Schedule</u>			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,103,576	\$ 2,050,577	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	617,979	617,979	15
16	Equipment, at Historical Cost	451,901	531,901	16
17	Accumulated Depreciation (book methods)	(626,299)	(3,201,632)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	16,000	16,493	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 459,581	\$ 993,831	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,563,157	\$ 3,044,408	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 675,494	\$ 675,495	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,462	33,462	28
29	Short-Term Notes Payable	325,000	325,000	29
30	Accrued Salaries Payable	54,391	54,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,966	31,966	31
32	Accrued Real Estate Taxes(Sch.IX-B)		173,800	32
33	Accrued Interest Payable	100,811	129,203	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	429,865	8,521	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,650,989	\$ 1,431,838	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,996,588	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 3,996,588	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,650,989	\$ 5,428,426	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (87,832)	\$ (2,384,018)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,563,157	\$ 3,044,408	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 110,025	1
2	Restatements (describe):		2
3	State Replacement Tax	3,855	3
4	Rounding	6	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 113,886	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(201,718)	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)	\$ (201,718)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (87,832)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Brightview Care Center**# **0030551**Report Period Beginning: **01/01/06**Ending: **12/31/06****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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,653,044	1
2	Discounts and Allowances for all Levels	(342,126)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,310,918	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	269,774	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 269,774	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,925	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,231	19
20	Radiology and X-Ray	1,480	20
21	Other Medical Services	22,275	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 127,911	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,504	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,504	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	130,919	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 130,919	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,841,026	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,033,995	31
32	Health Care	2,281,819	32
33	General Administration	1,663,515	33
<b>B. Capital Expense</b>			
34	Ownership	556,496	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	428,626	35
36	Provider Participation Fee	78,293	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,042,744	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(201,718)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (201,718)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	2,056	2,192	\$ 78,660	\$ 35.89	1
2	Assistant Director of Nursing	1,936	1,992	65,717	32.99	2
3	Registered Nurses	11,014	11,713	331,246	28.28	3
4	Licensed Practical Nurses	23,080	24,443	565,271	23.13	4
5	CNAs & Orderlies	57,339	62,621	592,588	9.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,874	8,711	108,936	12.51	8
9	Activity Director	1,604	1,754	22,261	12.69	9
10	Activity Assistants	4,251	4,749	35,768	7.53	10
11	Social Service Workers	6,099	6,592	110,649	16.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,112	19,928	199,247	10.00	15
16	Dishwashers					16
17	Maintenance Workers	2,099	2,315	25,926	11.20	17
18	Housekeepers	22,179	24,146	232,321	9.62	18
19	Laundry	8,999	9,934	83,677	8.42	19
20	Administrator	2,725	2,725	141,527	51.94	20
21	Assistant Administrator	2,080	2,080	95,073	45.71	21
22	Other Administrative	376	376	18,949	50.40	22
23	Office Manager					23
24	Clerical	11,619	12,335	120,603	9.78	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	697	774	9,607	12.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,213	3,213	118,469	36.87	33
34	TOTAL (lines 1 - 33)	187,352	202,593	\$ 2,956,495 *	\$ 14.59	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	104	\$ 5,400	01-03	35
36	Medical Director	Monthly	27,800	09-03	36
37	Medical Records Consultant	40	1,760	10-03	37
38	Nurse Consultant	29	2,500	10-03	38
39	Pharmacist Consultant	Monthly	3,080	10-03	39
40	Physical Therapy Consultant	54	2,872	10a-03	40
41	Occupational Therapy Consultant	39	2,036	10a-03	41
42	Respiratory Therapy Consultant	3	144	10a-03	42
43	Speech Therapy Consultant	1	29	10a-03	43
44	Activity Consultant	80	4,214	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Religious Supervision</u>	8	150	12-03	47
48					48
49	TOTAL (lines 35 - 48)	358	\$ 49,985		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	6,129	202,709	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,129	\$ 202,709		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Brightview Care Center

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
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. ILCLTC - \$7,743
- (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? \_\_\_\_\_
- (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. \$ 19,327 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 78,293  
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. \$ 16,630 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT