

Facility Name & ID Number Brightview Care Center# 0030551 Report Period Beginning: 01/01/07 Ending: 12/31/07

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>25,891</u>	<u>120</u>	<u>3,009</u>	<u>29,020</u>	8
9	SNF/PED					9
10	ICF	<u>17,733</u>	<u>36</u>	<u>23</u>	<u>17,792</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,624</u>	<u>156</u>	<u>3,032</u>	<u>46,812</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.69%

D. How many bed-hold days during this year were paid by the Department?

602 (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 numberof beds certified 143 and days of care provided 2,930Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

* 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: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	207,058	42,561	5,085	254,704		254,704		254,704		1
2	Food Purchase		199,429		199,429	(17,421)	182,008	(7)	182,001		2
3	Housekeeping	246,167	55,214		301,381		301,381	1,376	302,757		3
4	Laundry	70,034	7,742		77,776		77,776		77,776		4
5	Heat and Other Utilities			157,246	157,246		157,246	3,585	160,831		5
6	Maintenance	27,349	20,289	22,864	70,502		70,502	2,248	72,750		6
7	Other (specify):*										7
8	TOTAL General Services	550,608	325,235	185,195	1,061,038	(17,421)	1,043,617	7,202	1,050,819		8
	B. Health Care and Programs										
9	Medical Director			30,300	30,300		30,300	(300)	30,000		9
10	Nursing and Medical Records	1,776,700	120,554	11,577	1,908,831		1,908,831	(34)	1,908,797		10
10a	Therapy	121,368	884	6,695	128,947		128,947		128,947		10a
11	Activities	67,027	4,202	567	71,796		71,796		71,796		11
12	Social Services	97,392		851	98,243		98,243		98,243		12
13	CNA Training										13
14	Program Transportation			510	510		510		510		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,062,487	125,640	50,500	2,238,627		2,238,627	(334)	2,238,293		16
	C. General Administration										
17	Administrative	192,364		114,000	306,364		306,364	(36,328)	270,036		17
18	Directors Fees										18
19	Professional Services			331,816	331,816	(6,175)	325,641	(250,541)	75,100		19
20	Dues, Fees, Subscriptions & Promotions			41,310	41,310		41,310	(23,525)	17,785		20
21	Clerical & General Office Expenses	130,472	29,205	301,250	460,927		460,927	(175,008)	285,919		21
22	Employee Benefits & Payroll Taxes			460,144	460,144	17,421	477,565		477,565		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,660	1,660		1,660	228	1,888		24
25	Other Admin. Staff Transportation			2,405	2,405		2,405	(378)	2,027		25
26	Insurance-Prop.Liab.Malpractice			89,980	89,980		89,980	52,427	142,407		26
27	Other (specify):*							51,338	51,338		27
28	TOTAL General Administration	322,836	29,205	1,342,565	1,694,606	11,246	1,705,852	(381,787)	1,324,065		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,935,931	480,080	1,578,260	4,994,271	(6,175)	4,988,096	(374,919)	4,613,177		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			23,115	23,115		23,115	151,935	175,050		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			59,750	59,750		59,750	287,793	347,543		32
33	Real Estate Taxes					6,175	6,175	140,816	146,991		33
34	Rent-Facility & Grounds			510,000	510,000		510,000	(510,000)			34
35	Rent-Equipment & Vehicles			7,331	7,331		7,331	254	7,585		35
36	Other (specify):*										36
37	TOTAL Ownership			600,196	600,196	6,175	606,371	70,798	677,169		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		225,684	193,444	419,128		419,128		419,128		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):*	115,394		1,937	117,331		117,331	(117,331)			43
44	TOTAL Special Cost Centers	115,394	225,684	273,674	614,752		614,752	(117,331)	497,421		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,051,325	705,764	2,452,130	6,209,219		6,209,219	(421,451)	5,787,768		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:

01/01/07

Ending:

12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,054)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	62,372	30		9
10	Interest and Other Investment Income	(17,477)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7)	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	(29,198)	21		18
19	Entertainment				19
20	Contributions	(6,000)	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	(235,432)	21		24
25	Fund Raising, Advertising and Promotional	(16,561)	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	(146,352)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (389,708)		\$	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)	(31,743)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,743)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (421,451)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Marketing Salaries	\$ (115,994)	43	1
2 Debt and Loss	(551)	21	2
3 C/PPI Dues	(1,828)	20	3
4 Building Co. - Professional Fees	(5,450)	19	4
5 Building Co. - Other Fees	625	21	5
6 Building Co. - Amortization	(2,511)	31	6
7 Non-Allowable and Out of Period Legal	(7,457)	19	7
8 Penalty - Prior Period	47	21	8
9 Marketing Contingent	(1,937)	43	9
10 Capitalized R&M	(2,500)	06	10
11 Non-Allowable Expense	(2,340)	21	11
12 Non-Allowable Accounting Fees	(5,000)	19	12
13 Duty Duty Income	(34)	10	13
14 Marketing Travel	(250)	28	14
15 Non-Allowable Auto & Travel Expense	(420)	28	15
16 Medical Director - Prior Period	(300)	09	16
17			17
18			18
19			19
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22			22
23			23
24			24
25			25
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95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(146,352)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(7)											(7)	2
3	Housekeeping			865		511							1,376	3
4	Laundry													4
5	Heat and Other Utilities			1,533		2,052							3,585	5
6	Maintenance	(3,554)		5,028		774							2,248	6
7	Other (specify):*													7
8	TOTAL General Services	(3,561)		7,426		3,337							7,202	8
	B. Health Care and Programs													
9	Medical Director	(300)											(300)	9
10	Nursing and Medical Records	(34)											(34)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(334)											(334)	16
	C. General Administration													
17	Administrative			69,786	(106,791)	677							(36,328)	17
18	Directors Fees													18
19	Professional Services	(17,907)	5,450	(238,830)	601	145							(250,541)	19
20	Fees, Subscriptions & Promotions	(24,389)		814	40	10							(23,525)	20
21	Clerical & General Office Expenses	(268,193)	625	92,186	258	116							(175,008)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			228									228	24
25	Other Admin. Staff Transportation	(378)											(378)	25
26	Insurance-Prop.Liab.Malpractice		51,821	413		193							52,427	26
27	Other (specify):*			50,716	622								51,338	27
28	TOTAL General Administration	(310,867)	57,896	(24,687)	(105,270)	1,141							(381,787)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(314,762)	57,896	(17,261)	(105,270)	4,478							(374,919)	29

STATE OF ILLINOIS

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	62,372	86,343	2,931		289							151,935	30
31	Amortization of Pre-Op. & Org.	(2,511)	2,511											31
32	Interest	(17,477)	302,465	37		2,768							287,793	32
33	Real Estate Taxes		135,955			4,861							140,816	33
34	Rent-Facility & Grounds		(510,000)	12,976		(12,976)							(510,000)	34
35	Rent-Equipment & Vehicles			254									254	35
36	Other (specify):*													36
37	TOTAL Ownership	42,384	17,274	16,198		(5,058)							70,798	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(117,331)											(117,331)	43
44	TOTAL Special Cost Centers	(117,331)											(117,331)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(389,708)	75,170	(1,063)	(105,270)	(580)							(421,451)	45

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	\$ 29,807	Brightview Building Company	100.00%	\$	\$ (29,807)	1
2	V	34 Rent	510,000	Brightview Building Company	100.00%		(510,000)	2
3	V	32 Interest Expense		Brightview Building Company	100.00%	332,272	332,272	3
4	V	30 Depreciation		Brightview Building Company	100.00%	86,343	86,343	4
5	V	31 Amortization		Brightview Building Company	100.00%	2,511	2,511	5
6	V	33 Real Estate Tax		Brightview Building Company	100.00%	135,955	135,955	6
7	V	26 Insurance		Brightview Building Company	100.00%	51,821	51,821	7
8	V	19 Professional Fees		Brightview Building Company	100.00%	5,450	5,450	8
9	V	21 Other Expense		Brightview Building Company	100.00%	625	625	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 539,807			\$ 614,977	\$ * 75,170	14

* 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: 01/01/07Ending: 12/31/07

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	\$	MANAGCARE, INC.	100.00%	\$ 865	\$ 865	15
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,533	1,533	16
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,028	5,028	17
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	69,786	69,786	19
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	894	894	20
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	814	814	21
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	92,186	92,186	22
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	228	228	23
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%			24
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	413	413	25
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	50,716	50,716	26
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	2,931	2,931	27
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	37	37	28
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	12,976	12,976	29
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	254	254	30
31	V	19 HOME OFFICE	239,724	MANAGCARE, INC.	100.00%		(239,724)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 239,724			\$ 238,661	\$ * (1,063)	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: 01/01/07Ending: 12/31/07

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%	\$ 7,209	\$ 7,209	15
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	601	601	16
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	40	40	17
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	258	258	18
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	622	622	19
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			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			\$ 8,730	\$ * (105,270)	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: 01/01/07Ending: 12/31/07

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%	\$ 511	\$ 511	15
16	V	5 UTILITIES		MAZEL MANAGEMENT		2,052	2,052	16
17	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		774	774	17
18	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		677	677	19
20	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		145	145	20
21	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		10	10	21
22	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		116	116	22
23	V	26 INSURANCE		MAZEL MANAGEMENT		193	193	23
24	V	30 DEPRECIATION		MAZEL MANAGEMENT		289	289	24
25	V	31 AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		2,768	2,768	26
27	V	33 REAL ESTATE TAXES				4,861	4,861	27
28	V							28
29	V	34 RENT	12,976				(12,976)	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		\$ 12,976			\$ 12,396	\$ * (580)	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: 01/01/07

Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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	4.81	13.74%	Sal, Allc Sal	\$ 22,209	17-1,17-7	1
2	Moshe Davis	Administrator	Administrative	0%	See Attached	14.50	25.89%	Salary	46,252	17-1	2
3	Yehoshua Davis	Operations	Administrative	0%	See Attached	-	0%	Salary	3,985	17-1	3
4	Nesanel Davis	Relative	Administrative	0%	See Attached	40.00	100%	Salary	127,127	17-1	4
5	Moshe Wolf	Relative	Administrative	0%	See Attached	14.17	25.30%	Sal, Allc Sal	17,612	17-7	5
6	Stanley Klem	Owner	Administrative	2.13%	See Attached	11.38	25.29%	Alloc Sal	31,800	17-7	6
7	Renee Wolf	Relative	Clerical	0%	See Attached	10.12	25.30%	Alloc Sal	4,726	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 253,711		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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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	185,062	3	\$ 3,420	\$ 46,812	\$ 865	1
2	5	UTILITIES	PATIENT DAYS	185,062	3	6,058	46,812	1,533	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	185,062	3	19,878	46,812	5,028	3
4	10	NURSING SALARIES	PATIENT DAYS	185,062	3		46,812		4
5	17	ADMINISTRATIVE	PATIENT DAYS	185,062	3	275,883	275,883	69,786	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	185,062	3	3,533	46,812	894	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	185,062	3	3,218	46,812	814	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	185,062	3	364,441	310,057	92,186	8
9	24	SEMINARS	PATIENT DAYS	185,062	3	900	46,812	228	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	185,062	3		46,812		10
11	26	INSURANCE	PATIENT DAYS	185,062	3	1,634	46,812	413	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	185,062	3	200,496	46,812	50,716	12
13	30	DEPRECIATION	PATIENT DAYS	185,062	3	11,587	46,812	2,931	13
14	32	INTEREST EXPENSE	PATIENT DAYS	185,062	3	145	46,812	37	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	185,062	3	51,300	46,812	12,976	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	185,062	3	1,006	46,812	254	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 943,499	\$ 585,940	\$ 238,661	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization INTERCARE, LTD. C/O MANAGCARE
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR
 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	17	ADMINISTRATIVE	AVG. HOURS WORKED	20	4	\$ 30,000	\$ 30,000	5	\$ 7,209	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	20	4	2,500		5	601	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	20	4	166		5	40	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	20	4	1,073		5	258	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	20	4	2,587		5	622	5
6	30	DEPRECIATION	AVG. HOURS WORKED	20	4			5		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					\$ 36,326	\$ 30,000		\$ 8,730	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 185,062	3	\$ 2,021	\$	46,812	\$ 511	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 185,062	3	8,112		46,812	2,052	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 185,062	3	3,058		46,812	774	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS 185,062	3			46,812		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS 185,062	3	2,676		46,812	677	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 185,062	3	573		46,812	145	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 185,062	3	40		46,812	10	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 185,062	3	460		46,812	116	8
9	26	INSURANCE	MNGCR. PATIENT DAYS 185,062	3	763		46,812	193	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS 185,062	3	1,141		46,812	289	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS 185,062	3			46,812		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 185,062	3	10,942		46,812	2,768	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 185,062	3	19,216		46,812	4,861	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				\$ 49,002	\$		\$ 12,396	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending:

12/31/07

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			\$	\$			\$ 153,772	1
2	Greystone Servicing Corp.		X	Mortgage	\$24,481.00	6/1/2007		4,328,844	7/1/2042	5.9000	178,500	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				375,000			30,887	6
7	Brightview Building	X		Working Capital							24,724	7
8	See Supplemental Schedule										6,944	8
9	TOTAL Facility Related				\$24,481.00		\$	\$ 4,703,844			\$ 394,827	9
	B. Non-Facility Related*											
10	Interest Income		X								(17,477)	10
11	Interest Income - Bldg Co		X								(29,807)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(47,284)	14
15	TOTALS (line 9+line14)						\$	\$ 4,703,844			\$ 347,543	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:

01/01/07

Ending:

12/31/07

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			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term											7						
Working Capital																		
8	Premium Financing		X	Premium Financing			\$	\$			\$	4,139	8					
9	Allocate Mazel Mgmt		X									2,768	9					
10	Allocate ManagCare		X									37	10					
11													11					
12													12					
13													13					
14	TOTAL Working Capital											14						
B. Non-Facility Related*																		
15							\$	\$			\$		15					
16													16					
17													17					
18													18					
19													19					
20	TOTAL Non-Facility Related											20						

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

** 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-115-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>60,879.63</u>	\$ <u>60,879.63</u>
2. <u>14-17-115-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>58,411.18</u>	\$ <u>58,411.18</u>
3. <u>14-17-115-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>34,064.59</u>	\$ <u>34,064.59</u>
4. <u>See Attached</u>	<u>Allocated Mazel Management</u>	\$ <u>14,286.74</u>	\$ <u>3,613.88</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>167,642.14</u>	\$ <u>156,969.28</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Brightview Care Center

0030551 Report Period Beginning:

01/01/07 Ending:

12/31/07

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: 6
3. Current Period Amortization: _____ 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	TOTALS			\$ <u>73,992</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

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
		Improvement Type**									
9	Various			1986	10,306		20			10,284	9
10	Various			1987	4,719		20	109	109	4,712	10
11	Various			1988	2,895		20	141	141	2,870	11
12	Various			1989	67,265		20	3,272	3,272	62,680	12
13	Various			1991	22,384		20	1,120	1,120	16,477	13
14	Various			1992	17,019		20	143	143	14,752	14
15	Various			1993	44,200		20	2,211	2,211	31,917	15
16	Various			1994	63,594		20	3,181	3,181	43,014	16
17	Various			1995	7,105		20	356	356	4,474	17
18	Various			1996	37,640		20	1,882	1,882	22,213	18
19	Various			1997	17,411		20	871	871	8,781	19
20	Various			1998	49,850		20	2,497	2,497	23,326	20
21	Various			1999	215,484		20	10,777	10,777	92,259	21
22	Various			2000	47,834		20	2,392	2,392	17,898	22
23	Various			2001	35,034		20	2,167	2,167	14,205	23
24	Various			2002	33,534		20	2,878	2,878	15,791	24
25	Various			2003	20,999		20	1,357	1,357	6,152	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:

01/01/07

Ending:

12/31/07

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		2,767,892	86,343		97,974	11,631	1,921,429	67
68		70,107	302		1,534	1,232	57,374	68
69			23,114			(23,114)		69
70		\$ 3,535,272	\$ 109,759		\$ 134,862	\$ 25,103	\$ 2,370,608	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:

01/01/07

Ending:

12/31/07

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 12A, Carried Forward		\$ 3,535,272	\$ 109,759		\$ 134,862	\$ 25,103	\$ 2,370,608	1
2	Faucets	2004	5,750		20	575	575	2,060	2
3	Door Hardware	2004	2,429		20	243	243	870	3
4	Door Hardware	2004	1,147		20	115	115	401	4
5	Waiting Room	2004	30,517		20	3,052	3,052	10,681	5
6	Water Heater	2004	3,785		20	315	315	999	6
7	Door Detector	2004	1,892		20	95	95	339	7
8	Pump Motor	2004	3,137		20	157	157	484	8
9	Valve Tamper Panel	2004	5,693		20	1,139	1,139	3,606	9
10	Elevator Repair	2004	2,500		20	250	250	938	10
11	Monitor System Repair	2004	852		20	43	43	163	11
12	Monitor System Repair	2004	706		20	35	35	135	12
13	Kitchen Air Handler	2004	804		20	40	40	151	13
14	Chiller Repair	2004	668		20	33	33	114	14
15	Electrical Work	2004	2,731		20	137	137	444	15
16	Fire Alarm Repair	2004	596		20	30	30	92	16
17	Kitchen Doors	2004	775		20	39	39	155	17
18	Paint	2004	634		20	32	32	119	18
19	Locks	2004	1,586		20	79	79	278	19
20	Door Locks	2004	837		20	42	42	167	20
21	Door Locks	2004	419		20	42	42	168	21
22	Boiler Tubs	2005	13,800		20	1,150	1,150	3,258	22
23	Retube	2005	5,300		20	442	442	1,215	23
24	Fence Repair	2005	1,550		20	78	78	200	24
25	Boiler	2006	4,695		20	391	391	717	25
26	Wainscot	2006	4,969		20	331	331	373	26
27	Econocare	2006	2,654		20	265	265	332	27
28	Laundry Room Remodeling	2006	7,000		20	467	467	642	28
29	Elevator Repair	2007	2,500		20	125	125	125	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

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	\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834		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:

01/01/07

Ending:

12/31/07

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	\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834		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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

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		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

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 12I, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

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 12L, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,198	\$ 109,759		\$ 144,604	\$ 34,845	\$ 2,399,834	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

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	143		1986	1968	\$ 1,899,326	\$	35	\$ 54,266	\$ 54,266	\$ 1,865,723	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Removal Of Cove Base, Ceilings, Closet Walls, Frames & Drywall		2004	169,742	86,343	20	8,487	(77,856)	2,122	9
10		Installation Of Carpet, Border, & Cove Base In 1st, 2nd & 3rd Floor		2004	89,574		20	4,479	4,479	1,120	10
11		Handrails, Bumper Guards & Corner Guards in 1st & 2nd Floors		2004	21,852		20	1,093	1,093	273	11
12		Light Fixtures, Floor Prep, Vinyl Tile In 1st Floor Dining Room		2004	23,145		20	1,157	1,157	289	12
13		Cubicle Tracks & Corner Guards		2004	8,419		20	421	421	105	13
14		Repainting, Ceiling Trimming, Crown Molding In Corridor		2004	42,081		20	2,104	2,104	526	14
15		Custom Installation of VCT & Cove Base		2004	51,661		20	2,583	2,583	646	15
16		Drapery Panels & Curtains In 2nd Floor Resident Rooms		2004	16,860		20	843	843	211	16
17		Repainting, Ceiling Trimming, Crown Molding On 2nd Floor		2004	38,520		20	1,926	1,926	482	17
18		Blinds & Mount Fixture		2004	3,706		20	185	185	46	18
19		Crown Molding In Resident Rooms & Nurses Station		2004	19,078		20	954	954	238	19
20		Replacing Drywall & Removal Of VCT In Therapy Room		2004	40,399		20	2,020	2,020	505	20
21		Furnish & Install Of Light Fixtures In Corridor		2004	9,605		20	480	480	120	21
22		Bathroom Remodeling		2005	1,925		20	96	96	289	22
23		Gluedown Carpet In Conf. Room		2005	980		20	49	49	147	23
24		Laminating Desk In Reception Area		2005	8,016		20	401	401	1,202	24
25		Crown Molding		2005	1,183		20	59	59	178	25
26		Wall Covering		2005	2,044		20	102	102	307	26
27		Light Fixtures		2005	643		20	32	32	96	27
28		Drapery Panels		2005	1,340		20	67	67	201	28
29		Removal & Installation Of Vinyl In Lobby		2005	12,547		20	627	627	1,882	29
30		Crown Molding & Wood Fronts In Nurses Station		2005	19,159		20	958	958	2,874	30
31		Installation Of New Carpet & Cove Base		2005	892		20	45	45	134	31
32		Faux Wood Blinds		2005	283		20	14	14	42	32
33		Installation Of New VCT And Cove Base		2005	258		20	13	13	39	33
34		Ceramic Tile Installation In Bathroom		2005	816		20	41	41	122	34
35		Pedimat & Ceramic Tile In Vestibule		2005	3,829		20	191	191	574	35
36		Wall Covering & Repainting In Med Room		2005	5,630		20	282	282	845	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:

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12/31/07

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	\$ 30,750	37
38	Bumpers, Corner Guards & Handrails	2005	3,998		20	200	200	600	38
39	Door Casings	2005	1,463		20	73	73	219	39
40	Elevator Wraps	2005	930		20	46	46	139	40
41	Resident Room Pvc Sheeting	2005	3,882		20	194	194	582	41
42	Bumpers, Corner Guards & Handrails	2005	2,442		20	122	122	366	42
43	Drywall & Framing For Sprinkler Piping	2005	1,872		20	94	94	281	43
44	Time & Materials For Invoice Period	2005	309		20	15	15	46	44
45	Demolition Of Medication & Linen Rooms	2005	3,453		20	173	173	518	45
46	Electrical For Receptacles & Lights	2005	2,129		20	106	106	319	46
47	Concrete Flatwork	2005	978		20	49	49	147	47
48	Sliding Doors	2005	7,654		20	383	383	1,148	48
49	Installation Of New Window Opening	2005	3,039		20	152	152	456	49
50	HVAC, Sprinkler, Fire Alarm	2005	17,141		20	857	857	2,571	50
51	Fireproofing Of Existing Steel Beams	2005	403		20	20	20	60	51
52	New Ceilings & Lighting	2005	2,129		20	106	106	319	52
53	Cabinets, Countertops, & Plumbing	2005	1,093		20	55	55	164	53
54	New Shelving For DON Office Closet	2005	460		20	23	23	69	54
55	Plumbing	2005	1,496		20	75	75	224	55
56	Faux Food Blinds	2005	1,055		20	53	53	159	56
57	A/C Compressor	2007	6,886		20	344	344	344	57
58	Wiring - 2 Rooms	2007	8,100		20	405	405	405	58
59	2 Smoke Detectors	2007	4,062		20	203	203	203	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,767,892	\$ 86,343		\$ 97,974	\$ 11,631	\$ 1,921,429	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:

01/01/07

Ending:

12/31/07

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	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Mazel Magement	1985	1985	\$ 26,097	\$	30	\$ 870	\$ 870	\$ 19,355	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Allocation - ManagCare		1997	3,042	-	20	177	177	2,865	9
10	Allocation - ManagCare		1993	239	-	20	12	12	162	10
11	Allocation - ManagCare		1988	372	12	20	18	6	338	11
12	Allocation - ManagCare		1986	28,223	-	20	-		28,221	12
13	Allocation - Mazel Management		2006	823	21	20	41	20	62	13
14	Allocation - Mazel Management		2005	616	108	20	62	(46)	152	14
15	Allocation - Mazel Management		2001	548	14	20	27	13	178	15
16	Allocation - Mazel Management		2000	277	7	20	14	7	101	16
17	Allocation - Mazel Management		1998	976	33	20	49	16	474	17
18	Allocation - Mazel Management		1997	910	23	20	46	23	470	18
19	Allocation - Mazel Management		1996	621	7	20	31	24	359	19
20	Allocation - Mazel Management		1995	140	4	20	7	3	88	20
21	Allocation - Mazel Management		1994	554	10	20	28	18	345	21
22	Allocation - Mazel Management		1993	327	10	20	16	6	236	22
23	Allocation - Mazel Management		1991	245	8	20	12	4	192	23
24	Allocation - Mazel Management		1990	381	8	20	19	11	331	24
25	Allocation - Mazel Management		1989	238	6	20	10	4	186	25
26	Allocation - Mazel Management		1987	542	11	20	-	(11)	542	26
27	Allocation - Mazel Management		1986	2,187	-	20	-		2,187	27
28	Allocation - Mazel Management		1985	152	-	20	-		152	28
29	Allocation - Mazel Management		2007	1,536	20	20	42	22	42	29
30	Allocation - Inter Care Ltd.		2001	1,061	-	20	53	53	336	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:

01/01/07

Ending:

12/31/07

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	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			70,107	302	1,534	1,232	57,374	

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: 01/01/07 Ending: 12/31/07

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	\$ 294,516	\$ 608	\$ 26,266	\$ 25,658	10	\$ 247,496	71
72	Current Year Purchases	13,264		296	296	10	296	72
73	Fully Depreciated Assets	174,145	57	227	170	10	170,001	73
74								74
75	TOTALS	\$ 481,925	\$ 665	\$ 26,789	\$ 26,124		\$ 417,793	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		Allocated ManagCare	2002	\$ 10,000	\$ 2,254	\$ 3,657	\$ 1,403	5	\$ 60,686	76
77										77
78										78
79										79
80	TOTALS			\$ 10,000	\$ 2,254	\$ 3,657	\$ 1,403		\$ 60,686	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,211,115	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,050	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 62,372	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,878,313	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning: 01/01/07

Ending: 12/31/07

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 254

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	<u>Nesanel Davis</u>		\$	\$ <u>7,331</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>7,331</u>	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

Facility Name & ID Number Brightview Care Center# 0030551 Report Period Beginning:01/01/07 Ending:12/31/07

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	\$		\$ 75,955	\$		\$ 75,955	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			40,427			40,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			74,801			74,801	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				146,427		146,427	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					2,032		2,032	12
13	Other (specify): <u>See Supplemental</u>					2,261	77,225		79,486	13
14	TOTAL			\$		\$ 193,444	\$ 225,684		\$ 419,128	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: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 52,400	\$ 83,898	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	836,469	1,410,628	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,567	176,126	6
7	Other Prepaid Expenses	8,691	8,691	7
8	Accounts Receivable (owners or related parties)	8,401	258,401	8
9	Other(specify): <u>See Attached Schedule</u>		295,348	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 983,528	\$ 2,236,092	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	617,979	630,141	15
16	Equipment, at Historical Cost	456,165	552,051	16
17	Accumulated Depreciation (book methods)	(646,223)	(3,307,909)	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>		119,045	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 427,921	\$ 1,022,418	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,411,449	\$ 3,258,510	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 483,925	\$ 483,924	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,260	20,260	28
29	Short-Term Notes Payable	375,000	375,000	29
30	Accrued Salaries Payable	168,391	168,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,257	16,257	31
32	Accrued Real Estate Taxes(Sch.IX-B)		156,400	32
33	Accrued Interest Payable	130,638	151,921	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	297,244	9,145	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,491,715	\$ 1,381,298	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,328,844	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,328,844	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,491,715	\$ 5,710,142	46
47	TOTAL EQUITY(page 18, line 24)	\$ (80,266)	\$ (2,451,632)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,411,449	\$ 3,258,510	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (87,832)	1
2	Restatements (describe):		2
3	Depreciation	3,189	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (84,643)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,377	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)	\$ 4,377	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (80,266)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Brightview Care Center**# **0030551**Report Period Beginning: **01/01/07**Ending: **12/31/07****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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,048,351	1
2	Discounts and Allowances for all Levels	(467,598)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,580,753	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	342,775	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 342,775	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	150,812	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,661	19
20	Radiology and X-Ray	1,290	20
21	Other Medical Services	22,834	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 187,597	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,477	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,477	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	84,994	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 84,994	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,213,596	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,061,038	31
32	Health Care	2,238,627	32
33	General Administration	1,694,606	33
B. Capital Expense			
34	Ownership	600,196	34
C. Ancillary Expense			
35	Special Cost Centers	536,459	35
36	Provider Participation Fee	78,293	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,209,219	40
41	Income before Income Taxes (line 30 minus line 40)**	4,377	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,377	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:

01/01/07

Ending:

12/31/07

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	2,008	2,095	\$ 82,908	\$ 39.57	1
2	Assistant Director of Nursing	1,486	1,667	51,685	31.00	2
3	Registered Nurses	13,057	14,416	405,997	28.16	3
4	Licensed Practical Nurses	24,648	27,835	634,192	22.78	4
5	CNAs & Orderlies	54,123	59,523	578,595	9.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	787	8,808	121,368	13.78	8
9	Activity Director	1,619	1,694	25,852	15.26	9
10	Activity Assistants	4,998	5,276	41,175	7.80	10
11	Social Service Workers	5,274	5,731	97,392	16.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,076	20,119	207,058	10.29	15
16	Dishwashers					16
17	Maintenance Workers	2,175	2,280	27,349	12.00	17
18	Housekeepers	22,707	24,952	246,167	9.87	18
19	Laundry	7,395	8,509	70,034	8.23	19
20	Administrator	754	754	39,043	51.78	20
21	Assistant Administrator	2,080	2,080	127,127	61.12	21
22	Other Administrative	2,873	2,873	26,194	9.12	22
23	Office Manager					23
24	Clerical	12,111	13,285	130,472	9.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,103	1,215	23,323	19.20	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,422	3,422	115,394	33.72	33
34	TOTAL (lines 1 - 33)	180,696	206,534	\$ 3,051,325 *	\$ 14.77	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	97	\$ 5,085	01-03	35
36	Medical Director	Monthly	30,300	09-03	36
37	Medical Records Consultant	40	1,760	10-03	37
38	Nurse Consultant	Monthly	2,239	10-03	38
39	Pharmacist Consultant	Monthly	2,145	10-03	39
40	Physical Therapy Consultant	70	4,065	10a-03	40
41	Occupational Therapy Consultant	38	2,201	10a-03	41
42	Respiratory Therapy Consultant	10	429	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	567	11-03	44
45	Social Service Consultant	16	851	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	\$ 49,642		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	170	5,433	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	170	\$ 5,433		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Moshe Davis	Administrator	0%	\$ 46,252	Workers' Compensation Insurance	\$ 42,186	IDPH License Fee	\$	
Nesanel Davis	Asst. Admin	0%	127,127	Unemployment Compensation Insurance	39,524	Advertising: Employee Recruitment	1,403	
Yosef Davis	Administrator	72.34%	15,000	FICA Taxes	223,536	Health Care Worker Background Check	640	
Yehoshua Davis	Operations	0%	3,985	Employee Health Insurance	129,843	(Indicate # of checks performed <u>64</u>)		
				Employee Meals	17,421	Patient Background Checks <u>188</u>	1,880	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,590	
				City Payroll Tax	4,808	License & Permits	3,765	
				Employee Benefits	2,763	Annual Fee	643	
				Holiday Expense	7,320	Allocate ManagCare	814	
				Employee Pension	6,850	See Supplemental Schedule	50	
				Disability Insurance	3,314	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 192,364					\$ 477,565	\$ 17,785		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - InterCare, Ltd.			\$ 114,000			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	1,660
\$ 114,000							Allocate ManagCare	228
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount					
Econocare, Inc.	Purchasing Consultant		\$ 2,538					
Kipp Computer Solutions	Computer Services		10,800					
Personnel Planner	Unemployment Tax Service		1,414					
E-Health Data Solutions	Computer Services		5,216					
American Data	Computer Services		5,644					
See Attached	Legal Services		29,385					
ManagCare	Bookkeeping		239,724					
FR&R	Accounting		37,095					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$			TOTAL	
\$ 331,816							\$ 1,888	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Brightview Care Center

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,852 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 17,421 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT