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**To Stop Macro:**  
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Facility Name & ID Number Brightview Care Center

# 0030551 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>143</u>	Skilled (SNF)	<u>143</u>	<u>56,364</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>56,364</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,796</u>	<u>879</u>	<u>3,048</u>	<u>25,723</u>	8
9	SNF/PED					9
10	ICF	<u>18,872</u>		<u>2,971</u>	<u>21,843</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>40,668</u>	<u>879</u>	<u>6,019</u>	<u>47,566</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.39%

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

159 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 02/01/1986

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 02/01/1986 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 143 and days of care provided 3,033

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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
	<b>A. General Services</b>										
1	Dietary	213,497	38,631	5,250	257,378		257,378		257,378		1
2	Food Purchase		227,653		227,653	(83,701)	143,952	(42)	143,911		2
3	Housekeeping	253,891	54,804		308,695		308,695	1,368	310,063		3
4	Laundry	64,147	7,212		71,359		71,359		71,359		4
5	Heat and Other Utilities			193,449	193,449		193,449	3,319	196,768		5
6	Maintenance	79,076	16,302	30,051	125,429		125,429	3,345	128,774		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>610,611</b>	<b>344,602</b>	<b>228,750</b>	<b>1,183,963</b>	<b>(83,701)</b>	<b>1,100,262</b>	<b>7,990</b>	<b>1,108,253</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			29,016	29,016		29,016		29,016		9
10	Nursing and Medical Records	1,903,494	123,373	29,319	2,056,186		2,056,186		2,056,186		10
10a	Therapy	107,650	4,214	1,400	113,264		113,264		113,264		10a
11	Activities	73,319	3,738	27	77,084		77,084		77,084		11
12	Social Services	118,975		1,026	120,001		120,001		120,001		12
13	CNA Training										13
14	Program Transportation			1,367	1,367		1,367		1,367		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,203,438</b>	<b>131,325</b>	<b>62,155</b>	<b>2,396,918</b>		<b>2,396,918</b>		<b>2,396,918</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	213,355		198,664	412,019		412,019	(102,719)	309,300		17
18	Directors Fees										18
19	Professional Services			322,823	322,823	(234)	322,589	(243,614)	78,975		19
20	Dues, Fees, Subscriptions & Promotions			48,365	48,365		48,365	(32,015)	16,350		20
21	Clerical & General Office Expenses	120,067	29,335	284,690	434,092		434,092	(177,246)	256,846		21
22	Employee Benefits & Payroll Taxes			486,875	486,875	83,701	570,576		570,576		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,010	2,010		2,010	397	2,407		24
25	Other Admin. Staff Transportation							11	11		25
26	Insurance-Prop.Liab.Malpractice			5,741	5,741		5,741	149,343	155,084		26
27	Other (specify):*							55,121	55,121		27
28	<b>TOTAL General Administration</b>	<b>333,422</b>	<b>29,335</b>	<b>1,349,168</b>	<b>1,711,925</b>	<b>83,467</b>	<b>1,795,392</b>	<b>(350,722)</b>	<b>1,444,669</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,147,471</b>	<b>505,262</b>	<b>1,640,073</b>	<b>5,292,806</b>	<b>(234)</b>	<b>5,292,572</b>	<b>(342,732)</b>	<b>4,949,840</b>		<b>29</b>

\*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: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	<b>D. Ownership</b>										
30	Depreciation			25,569	25,569		25,569	141,347	166,916		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			30,035	30,035		30,035	239,487	269,522		32
33	Real Estate Taxes			69	69	234	303	152,907	153,210		33
34	Rent-Facility & Grounds			696,000	696,000		696,000	(696,000)			34
35	Rent-Equipment & Vehicles			6,360	6,360		6,360	260	6,620		35
36	Other (specify):*							21,421	21,421		36
37	<b>TOTAL Ownership</b>			758,033	758,033	234	758,267	(140,578)	617,689		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		227,826	343,101	570,927		570,927		570,927		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			84,546	84,546		84,546		84,546		42
43	Other (specify):*	97,465		52,962	150,427		150,427	(150,427)			43
44	<b>TOTAL Special Cost Centers</b>	97,465	227,826	480,609	805,900		805,900	(150,427)	655,473		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,244,936	733,088	2,878,715	6,856,739		6,856,739	(633,737)	6,223,002		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: 01/01/08

Ending: 12/31/08

**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	(2,919)	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	39,864	30		9
10	Interest and Other Investment Income	(1,673)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	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	(10)	21		18
19	Entertainment				19
20	Contributions	(10,629)	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	(265,665)	21		24
25	Fund Raising, Advertising and Promotional	(16,983)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(176,354)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (434,411)		\$	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)	(199,326)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (199,326)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (633,737)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

## Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salaries	\$ (97,465)	43	1
2	Marketing Consultant	(52,787)	43	2
3	Non-Allowable and Prior Period Legal Fees	(277)	19	3
4	Prior Period Insurance Expense	(2,382)	26	4
5	Marketing Travel Expense	(175)	43	5
6	Building Co. - Legal & Professional Fees	(9,590)	19	6
7	Building Co. - Amortization Expense	(3,459)	36	7
8	COPE Payments	(5,219)	20	8
9	Non-Allowable Accounting Fees	(5,000)	19	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(176,354)		49

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(42)											(42)	2
3	Housekeeping			883		485							1,368	3
4	Laundry													4
5	Heat and Other Utilities			1,559		1,760							3,319	5
6	Maintenance	(2,919)		5,529		735							3,345	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(2,961)</b>		<b>7,971</b>		<b>2,980</b>							<b>7,990</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			83,114	(186,438)	605							(102,719)	17
18	Directors Fees													18
19	Professional Services	(14,867)	9,590	(238,563)		226							(243,614)	19
20	Fees, Subscriptions & Promotions	(32,831)		721	63	32							(32,015)	20
21	Clerical & General Office Expenses	(265,675)		88,328	61	40							(177,246)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			397									397	24
25	Other Admin. Staff Transportation			11									11	25
26	Insurance-Prop.Liab.Malpractice	(2,382)	151,076	464		185							149,343	26
27	Other (specify):*			54,115	1,006								55,121	27
28	<b>TOTAL General Administration</b>	<b>(315,755)</b>	<b>160,666</b>	<b>(11,413)</b>	<b>(185,308)</b>	<b>1,088</b>							<b>(350,722)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(318,716)</b>	<b>160,666</b>	<b>(3,442)</b>	<b>(185,308)</b>	<b>4,068</b>							<b>(342,732)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

Summary B

12/31/08

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	39,864	95,359	5,795	48	281							141,347	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,673)	238,257	140		2,763							239,487	32
33	Real Estate Taxes		150,507			2,400							152,907	33
34	Rent-Facility & Grounds		(696,000)	13,241		(13,241)							(696,000)	34
35	Rent-Equipment & Vehicles			260									260	35
36	Other (specify):*	(3,459)	24,880										21,421	36
37	<b>TOTAL Ownership</b>	<b>34,732</b>	<b>(186,997)</b>	<b>19,436</b>	<b>48</b>	<b>(7,797)</b>							<b>(140,578)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(150,427)											(150,427)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(150,427)</b>											<b>(150,427)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(434,411)</b>	<b>(26,331)</b>	<b>15,994</b>	<b>(185,260)</b>	<b>(3,729)</b>							<b>(633,737)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 696,000	Brightview Building Company		\$	\$ (696,000)	1
2	V	32 Interest	15,896	Brightview Building Company		254,153	238,257	2
3	V	26 Insurance		Brightview Building Company		151,076	151,076	3
4	V	33 Real Estate Taxes		Brightview Building Company		150,507	150,507	4
5	V	30 Depreciation		Brightview Building Company		95,359	95,359	5
6	V	36 Amortization		Brightview Building Company		3,459	3,459	6
7	V	19 Legal & Professional Fees		Brightview Building Company		9,590	9,590	7
8	V	36 MIP Expense		Brightview Building Company		21,421	21,421	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 711,896			\$ 685,565	\$ * (26,331)	14

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

Facility Name & ID Number Brightview Care Center# 0030551Report Period Beginning: 01/01/08Ending: 12/31/08

## 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%	\$ 883	\$ 883	15
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,559	1,559	16
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,529	5,529	17
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	83,114	83,114	19
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,161	1,161	20
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	721	721	21
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	88,328	88,328	22
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	397	397	23
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	11	11	24
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	464	464	25
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	54,115	54,115	26
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	5,795	5,795	27
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	140	140	28
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	13,241	13,241	29
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	260	260	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			\$ 255,718	\$ * 15,994	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: 01/01/08Ending: 12/31/08

## 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%	\$ 12,226	\$ 12,226	15
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	63	63	17
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	61	61	18
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,006	1,006	19
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	48	48	20
21	V							21
22	V	17 MANAGEMENT FEES	198,664	INTERCARE, LTD. C/O MANAGCARE	100.00%		(198,664)	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		\$ 198,664			\$ 13,404	\$ * (185,260)	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: 01/01/08Ending: 12/31/08

## 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%	\$ 485	\$ 485	15
16	V	5 UTILITIES		MAZEL MANAGEMENT		1,760	1,760	16
17	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		735	735	17
18	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		605	605	19
20	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		226	226	20
21	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		32	32	21
22	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		40	40	22
23	V	26 INSURANCE		MAZEL MANAGEMENT		185	185	23
24	V	30 DEPRECIATION		MAZEL MANAGEMENT		281	281	24
25	V	31 AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		2,763	2,763	26
27	V	33 REAL ESTATE TAXES				2,400	2,400	27
28	V							28
29	V	34 RENT	13,241				(13,241)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 13,241			\$ 9,512	\$ * (3,729)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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: 01/01/08

Ending: 12/31/08

**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: 01/01/08

Ending: 12/31/08

**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: 01/01/08 Ending: 12/31/08

## 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	4.65	13.67%	Sal, Alloc Sal	\$ 27,226	17-1, 17-7	1
2	Moshe Davis	Relative	Administrative	0%	See Attached		0%	Salary	2,365	17-1	2
3	Yehoshua Davis	Relative	Administrative	0%	See Attached		0%	Salary	2,332	17-1	3
4	Nesanel Davis	Administrator	Administrative	0%	See Attached	48.00	100.00%	Salary	193,658	17-1	4
5	Moshe Wolf	Relative	Administrative	0%	See Attached	10.32	25.80%	Sal, Alloc Sal	22,520	17-7	5
6	Stanley Klem	Owner	Administrative	2.13%	See Attached	11.61	25.80%	Alloc Sal	34,084	17-7	6
7	Renee Wolf	Relative	Clerical	0%	See Attached	2.32	25.77%	Alloc Sal	1,033	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 283,218		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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	184,287	3	\$ 3,420	\$ 47,566	\$ 883	1
2	5	UTILITIES	PATIENT DAYS	184,287	3	6,039	47,566	1,559	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	184,287	3	21,421	47,566	5,529	3
4	10	NURSING SALARIES	PATIENT DAYS	184,287	3		47,566		4
5	17	ADMINISTRATIVE	PATIENT DAYS	184,287	3	322,013	322,013	83,114	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	184,287	3	4,498	47,566	1,161	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	184,287	3	2,792	47,566	721	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	184,287	3	342,215	291,331	88,328	8
9	24	SEMINARS	PATIENT DAYS	184,287	3	1,540	47,566	397	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	184,287	3	44	47,566	11	10
11	26	INSURANCE	PATIENT DAYS	184,287	3	1,796	47,566	464	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	184,287	3	209,662	47,566	54,115	12
13	30	DEPRECIATION	PATIENT DAYS	184,287	3	22,453	47,566	5,795	13
14	32	INTEREST EXPENSE	PATIENT DAYS	184,287	3	542	47,566	140	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	184,287	3	51,300	47,566	13,241	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	184,287	3	1,006	47,566	260	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 990,741	\$ 613,344		\$ 255,718	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	19	4	\$ 50,000	\$ 50,000	5	\$ 12,226	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	19	4			5		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	19	4	256		5	63	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	19	4	251		5	61	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	19	4	4,113		5	1,006	5
6	30	DEPRECIATION	AVG. HOURS WORKED	19	4	197		5	48	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					\$ 54,817	\$ 50,000		\$ 13,404	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	184,287	3	\$ 1,881	\$ 47,566	\$ 485	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	184,287	3	6,818	47,566	1,760	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	184,287	3	2,848	47,566	735	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	184,287	3		47,566		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	184,287	3	2,343	47,566	605	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	184,287	3	876	47,566	226	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	184,287	3	125	47,566	32	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	184,287	3	156	47,566	40	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	184,287	3	717	47,566	185	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	184,287	3	1,089	47,566	281	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	184,287	3		47,566		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	184,287	3	10,706	47,566	2,763	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	184,287	3	9,299	47,566	2,400	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					\$ 36,858	\$	\$ 9,512	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Midland		X	Mortgage						\$ 232,870	1									
2	Greystone Servicing Corp.		X	Mortgage	\$24,481.00	6/1/2007		4,289,414	7/1/2042	5.9000	21,283	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit				50,000			14,357	6								
7	Brightview Building	X		Working Capital							13,751	7								
8	See Supplemental Schedule											8								
9	<b>TOTAL Facility Related</b>				\$24,481.00			\$ 4,339,414			\$ 282,261	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(1,673)	10								
11	Interest Income - Bldg Co		X								(15,896)	11								
12	MB Financial/Mid America		X								1,928	12								
13	See Supplemental Schedule										2,903	13								
14	<b>TOTAL Non-Facility Related</b>										(12,738)	14								
15	<b>TOTALS (line 9+line14)</b>							\$ 4,339,414			\$ 269,523	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,421 Line # 36

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

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:

01/01/08

Ending:

12/31/08

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	<b>TOTAL Long-Term</b>											7							
	<b>Working Capital</b>																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>											14							
	<b>B. Non-Facility Related*</b>																		
15	Allocated from Managcare						\$	\$			\$	140							
16	Allocated from Mazel Mgmt.											2,763							
17												17							
18												18							
19												19							
20	<b>TOTAL Non-Facility Related</b>											2,903							

\* 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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>156,400</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>154,376</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,024)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>155,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>234</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>225</u> For <u>2000</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>153,210</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<u>171,974</u>	8	
	2004	<u>165,798</u>	9	
	2005	<u>168,711</u>	10	
	2006	<u>153,355</u>	11	
	2007	<u>151,976</u>	12	
<b>2008 Accrual = \$151,976 x 1.02 = \$155,000 (Rounded)</b>				
<b>Allocated from Mazel Management - \$2400</b>				

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-115-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>60,229.69</u>	\$ <u>60,229.69</u>
2. <u>14-17-115-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>57,787.57</u>	\$ <u>57,787.57</u>
3. <u>14-17-115-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>33,958.56</u>	\$ <u>33,958.56</u>
4. <u>See Attached</u>	<u>Allocated from Mazel Mgmt</u>	\$ <u>51,704.53</u>	\$ <u>3,059.60</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>203,680.35</u>	\$ <u>155,035.42</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Brightview Care Center

# 0030551 Report Period Beginning:

01/01/08 Ending:

12/31/08

**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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>73,992</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>73,992</b>	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
	<b>Improvement Type**</b>										
9	Various			1986	10,306		20			10,284	9
10	Various			1987	4,719		20			4,712	10
11	Various			1988	2,895		20	21	21	2,891	11
12	Various			1989	67,265		20	3,272	3,272	65,951	12
13	Various			1991	22,384		20	1,120	1,120	17,597	13
14	Various			1992	17,019		20	143	143	14,895	14
15	Various			1993	44,200		20	2,211	2,211	34,127	15
16	Various			1994	63,594		20	3,181	3,181	46,194	16
17	Various			1995	7,105		20	356	356	4,830	17
18	Various			1996	37,640		20	1,882	1,882	24,095	18
19	Various			1997	17,411		20	871	871	9,651	19
20	Various			1998	49,850		20	2,497	2,497	25,820	20
21	Various			1999	215,484		20	10,777	10,777	103,035	21
22	Various			2000	47,834		20	2,392	2,392	20,287	22
23	Various			2001	35,034		20	2,167	2,167	16,370	23
24	Various			2002	33,534		20	2,878	2,878	18,668	24
25	Various			2003	20,999		20	1,357	1,357	7,508	25
26	Various			2004	67,458		20	6,493	6,493	28,856	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:

01/01/08

Ending:

12/31/08

**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		2,841,144	95,359		101,637	6,278	2,115,695	67
68		75,141	1,243		1,747	504	60,521	68
69			25,569			(25,569)		69
70		\$ 3,681,016	\$ 122,171		\$ 145,002	\$ 22,831	\$ 2,631,987	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:

01/01/08

Ending:

12/31/08

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 12A, Carried Forward		\$ 3,681,016	\$ 122,171		\$ 145,002	\$ 22,831	\$ 2,631,987	1
2	Boiler Tubs	2005	13,800		20	1,150	1,150	4,408	2
3	Retube	2005	5,300		20	442	442	1,656	3
4	Fence Repair	2005	1,550		20	78	78	278	4
5	Boiler	2006	4,695		20	391	391	1,108	5
6	Wainscot	2006	4,969		20	331	331	704	6
7	Econocare	2006	2,654		20	265	265	597	7
8	Laundry Room Remodeling	2006	7,000		20	467	467	1,109	8
9	Elevator Repairs	2007	2,500		20	125	125	229	9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

01/01/08

Ending:

12/31/08

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 12B, Carried Forward		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

01/01/08

Ending:

12/31/08

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 12C, Carried Forward		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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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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)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12F, Carried Forward</b>		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

01/01/08

Ending:

12/31/08

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		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

01/01/08

Ending:

12/31/08

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		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

01/01/08

Ending:

12/31/08

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 12I, Carried Forward		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

**01/01/08**

Ending:

**12/31/08**

**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	<b>Totals from Page 12J, Carried Forward</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0030551**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	<b>Totals from Page 12K, Carried Forward</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0030551**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	<b>Totals from Page 12L, Carried Forward</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

**01/01/08**

Ending:

**12/31/08**

**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	<b>Totals from Page 12N, Carried Forward</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,723,484	\$ 122,171		\$ 148,251	\$ 26,080	\$ 2,642,076	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:

**01/01/08**

Ending:

**12/31/08**

**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	<b>Totals from Page 12P, Carried Forward</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>3,723,484</b>	\$ <b>122,171</b>		\$ <b>148,251</b>	\$ <b>26,080</b>	\$ <b>2,642,076</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	\$ 1,899,326	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Removal Of Cove Base, Ceilings, Closet Walls, Frames & Drywall		2004	169,742	95,359	20	8,487		42,436	9
10		Installation Of Carpet, Border, & Cove Base In 1st, 2nd & 3rd Floor		2004	89,574		20	4,479	4,479	22,394	10
11		Handrails, Bumper Guards & Corner Guards in 1st & 2nd Floors		2004	21,852		20	1,093	1,093	5,463	11
12		Light Fixtures, Floor Prep, Vinyl Tile In 1st Floor Dining Room		2004	23,145		20	1,157	1,157	5,786	12
13		Cubicle Tracks & Corner Guards		2004	8,419		20	421	421	2,105	13
14		Repainting, Ceiling Trimming, Crown Molding In Corridor		2004	42,081		20	2,104	2,104	10,520	14
15		Custom Installation of VCT & Cove Base		2004	51,661		20	2,583	2,583	12,915	15
16		Drapery Panels & Curtains In 2nd Floor Resident Rooms		2004	16,860		20	843	843	4,215	16
17		Repainting, Ceiling Trimming, Crown Molding On 2nd Floor		2004	38,520		20	1,926	1,926	9,630	17
18		Blinds & Mount Fixture		2004	3,706		20	185	185	927	18
19		Crown Molding In Resident Rooms & Nurses Station		2004	19,078		20	954	954	4,770	19
20		Replacing Drywall & Removal Of VCT In Therapy Room		2004	40,399		20	2,020	2,020	10,100	20
21		Furnish & Install Of Light Fixtures In Corridor		2004	9,605		20	480	480	2,401	21
22		Bathroom Remodeling		2005	1,925		20	96	96	385	22
23		Gluedown Carpet In Conf. Room		2005	980		20	49	49	196	23
24		Laminating Desk In Reception Area		2005	8,016		20	401	401	1,603	24
25		Crown Molding		2005	1,183		20	59	59	237	25
26		Wall Covering		2005	2,044		20	102	102	409	26
27		Light Fixtures		2005	643		20	32	32	129	27
28		Drapery Panels		2005	1,340		20	67	67	268	28
29		Removal & Installation Of Vinyl In Lobby		2005	12,547		20	627	627	2,509	29
30		Crown Molding & Wood Fronts In Nurses Station		2005	19,159		20	958	958	3,832	30
31		Installation Of New Carpet & Cove Base		2005	892		20	45	45	178	31
32		Faux Wood Blinds		2005	283		20	14	14	57	32
33		Installation Of New VCT And Cove Base		2005	258		20	13	13	52	33
34		Ceramic Tile Installation In Bathroom		2005	816		20	41	41	163	34
35		Pedimat & Ceramic Tile In Vestibule		2005	3,829		20	191	191	766	35
36		Wall Covering & Repainting In Med Room		2005	5,630		20	282	282	1,126	36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	\$ 51,249	37
38	Bumpers, Corner Guards & Handrails	2005	3,998		20	200	200	1,000	38
39	Door Casings	2005	1,463		20	73	73	366	39
40	Elevator Wraps	2005	930		20	46	46	232	40
41	Resident Room Pvc Sheeting	2005	3,882		20	194	194	970	41
42	Bumpers, Corner Guards & Handrails	2005	2,442		20	122	122	610	42
43	Drywall & Framing For Sprinkler Piping	2005	1,872		20	94	94	468	43
44	Time & Materials For Invoice Period	2005	309		20	15	15	77	44
45	Demolition Of Medication & Linen Rooms	2005	3,453		20	173	173	863	45
46	Electrical For Receptacles & Lights	2005	2,129		20	106	106	532	46
47	Concrete Flatwork	2005	978		20	49	49	245	47
48	Sliding Doors	2005	7,654		20	383	383	1,914	48
49	Installation Of New Window Opening	2005	3,039		20	152	152	760	49
50	HVAC, Sprinkler, Fire Alarm	2005	17,141		20	857	857	4,285	50
51	Fireproofing Of Existing Steel Beams	2005	403		20	20	20	101	51
52	New Ceilings & Lighting	2005	2,129		20	106	106	532	52
53	Cabinets, Countertops, & Plumbing	2005	1,093		20	55	55	273	53
54	New Shelving For DON Office Closet	2005	460		20	23	23	115	54
55	Plumbing	2005	1,496		20	75	75	374	55
56	Faux Food Blinds	2005	1,055		20	53	53	265	56
57	A/C Compressor	2007	6,886		20	344	344	689	57
58	Wiring - 2 Rooms	2007	8,100		20	405	405	810	58
59	2 Smoke Detectors	2007	4,062		20	203	203	406	59
60	150 AMP Volt Feeder	2008	2,000		20	100	100	100	60
61	Sprinkler System Repair	2008	2,520		20	126	126	126	61
62	Roofing and Tuckpointing	2008	5,000		20	250	250	250	62
63	Elevator	2008	17,000		20	850	850	850	63
64	Water Tube for Boiler	2008	2,800		20	140	140	140	64
65	Hot Water Storage Tank	2008	14,727		20	736	736	736	65
66	OEM Pump and Coil	2008	14,865		20	743	743	743	66
67	Cooling Tower	2008	5,250		20	263	263	263	67
68	Security Cameras	2008	9,090		20	455	455	455	68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,841,144	\$ 95,359		\$ 101,637	\$ 93,150	\$ 2,115,695	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Brightview Care Center

# 0030551

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	Mazel Management		1985	1985	\$ 26,629	\$	39	\$ 888	\$ 888	\$ 20,637	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocated from Managcare			2008	3,609	902	20	331	(571)	331	9
10	Allocated from Managcare			2008	3,104	-	20	-		3,104	10
11	Allocated from Managcare			2008	243	-	20	12	12	190	11
12	Allocated from Managcare			2008	380	12	20	16	4	380	12
13	Allocated from Managcare			2008	28,798	-	20	-		28,796	13
14	Allocated from Inter Care, Ltd.			2001	1,079	48	20	54	6	396	14
15	Allocated from Mazel Management			2007	1,567	40	20	78	38	121	15
16	Allocated from Mazel Management			2006	840	22	20	42	20	105	16
17	Allocated from Mazel Management			2005	628	78	20	63	(15)	218	17
18	Allocated from Mazel Management			2001	559	14	20	28	14	209	18
19	Allocated from Mazel Management			2000	283	7	20	14	7	117	19
20	Allocated from Mazel Management			1998	996	32	20	50	18	553	20
21	Allocated from Mazel Management			1997	929	24	20	46	22	526	21
22	Allocated from Mazel Management			1996	633	7	20	32	25	398	22
23	Allocated from Mazel Management			1995	143	4	20	7	3	97	23
24	Allocated from Mazel Management			1994	565	10	20	28	18	380	24
25	Allocated from Mazel Management			1993	334	10	20	17	7	258	25
26	Allocated from Mazel Management			1991	250	8	20	12	4	208	26
27	Allocated from Mazel Management			1990	389	8	20	19	11	357	27
28	Allocated from Mazel Management			1989	243	6	20	10	4	200	28
29	Allocated from Mazel Management			1987	553	11	20	-	(11)	553	29
30	Allocated from Mazel Management			1986	2,232	-	20	-		2,232	30
31	Allocated from Mazel Management			1985	155	-	20	-		155	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:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			75,141	1,243	1,747	504	60,521	

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: 01/01/08 Ending: 12/31/08

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	\$ 234,281	\$ 375	\$ 16,007	\$ 15,632	10	\$ 188,019	71
72	Current Year Purchases	28,754	872	684	(188)	10	684	72
73	Fully Depreciated Assets	249,128				10	249,072	73
74								74
75	TOTALS	\$ 512,163	\$ 1,247	\$ 16,691	\$ 15,444		\$ 437,775	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 from Managcare	2002	\$ 4,933	\$ 947	\$ 741	\$ (206)	5	\$ 2,214	76
77		Allocated from Managcare	2008	8,220	2,687	1,233	(1,454)	5	1,233	77
78										78
79										79
80	TOTALS			\$ 13,153	\$ 3,634	\$ 1,974	\$ (1,660)		\$ 3,447	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)		\$ 4,322,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 127,052	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 166,916	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 39,864	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,083,298	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: 01/01/08

Ending: 12/31/08

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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: \$ 260

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, Admin</u>		\$	\$ <u>6,360</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <u>6,360</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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 124,602	\$		\$ 124,602	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			106,768			106,768	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			111,461			111,461	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				132,677		132,677	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					270	95,149		95,419	13
14	TOTAL			\$		\$ 343,101	\$ 227,826		\$ 570,927	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: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 54,315	\$ 131,987	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,110,129	1,698,039	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,667	108,323	6
7	Other Prepaid Expenses	4,045	4,045	7
8	Accounts Receivable (owners or related parties)	9,974	259,974	8
9	Other(specify): <u>See Attached Schedule</u>	545	337,050	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,231,675	\$ 2,542,418	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	617,979	656,661	15
16	Equipment, at Historical Cost	466,748	626,084	16
17	Accumulated Depreciation (book methods)	(671,792)	(3,115,424)	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>		115,586	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 412,935	\$ 1,311,997	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,644,610	\$ 3,854,415	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 896,588	\$ 897,486	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,659	39,659	28
29	Short-Term Notes Payable	50,000	50,000	29
30	Accrued Salaries Payable	77,298	77,298	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,877	8,877	31
32	Accrued Real Estate Taxes(Sch.IX-B)		155,000	32
33	Accrued Interest Payable	143,421	164,511	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	349,231	124,257	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,565,074	\$ 1,517,088	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,289,414	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 4,289,414	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,565,074	\$ 5,806,502	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 79,536	\$ (1,952,087)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,644,610	\$ 3,854,415	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (80,266)	1
2	Restatements (describe):		2
3	<b>Rounding</b>	(2)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (80,268)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	239,804	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	(80,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 159,804	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 79,536	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Brightview Care Center**# **0030551**Report Period Beginning: **01/01/08**Ending: **12/31/08****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,718,985	1
2	Discounts and Allowances for all Levels	(563,024)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,155,961</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	570,680	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 570,680</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133,736	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,800	19
20	Radiology and X-Ray	2,055	20
21	Other Medical Services	23,259	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 171,850</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,673	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,673</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>	196,379	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 196,379</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,096,543</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,183,963	31
32	Health Care	2,396,918	32
33	General Administration	1,711,925	33
<b>B. Capital Expense</b>			
34	Ownership	758,033	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	721,354	35
36	Provider Participation Fee	84,546	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,856,739</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>239,804</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 239,804</b>	<b>43</b>

\* 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: 01/01/08

Ending:

12/31/08

**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	1,640	1,917	\$ 81,779	\$ 42.66	1
2	Assistant Director of Nursing	1,744	1,944	63,866	32.85	2
3	Registered Nurses	13,970	15,832	453,394	28.64	3
4	Licensed Practical Nurses	25,837	28,498	666,326	23.38	4
5	CNAs & Orderlies	57,364	62,552	612,789	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,532	8,535	107,650	12.61	8
9	Activity Director	1,774	1,966	27,834	14.16	9
10	Activity Assistants	5,252	5,659	45,485	8.04	10
11	Social Service Workers	6,619	7,131	118,975	16.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,994	20,110	213,497	10.62	15
16	Dishwashers					16
17	Maintenance Workers	5,224	5,470	79,076	14.46	17
18	Housekeepers	22,470	24,906	253,891	10.19	18
19	Laundry	6,879	7,578	64,147	8.46	19
20	Administrator	2,080	2,496	193,658	77.59	20
21	Assistant Administrator					21
22	Other Administrative	312	312	19,697	63.13	22
23	Office Manager					23
24	Clerical	9,031	9,831	120,067	12.21	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	978	1,139	25,340	22.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,638	2,638	97,465	36.95	33
34	TOTAL (lines 1 - 33)	189,338	208,514	\$ 3,244,936 *	\$ 15.56	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	98	\$ 5,250	01-03	35
36	Medical Director	Monthly	29,016	09-03	36
37	Medical Records Consultant	56	2,520	10-03	37
38	Nurse Consultant	4	225	10-03	38
39	Pharmacist Consultant	Monthly	2,574	10-03	39
40	Physical Therapy Consultant	8	455	10a-03	40
41	Occupational Therapy Consultant	3	180	10a-03	41
42	Respiratory Therapy Consultant	17	765	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	27	11-03	44
45	Social Service Consultant	19	1,026	12-03	45
46	Other(specify)				46
47	<u>Rehab Medical Director</u>	Monthly	18,000	10-03	47
48	<u>Psychiatric Medical Director</u>	Monthly	6,000	10-03	48
49	TOTAL (lines 35 - 48)	206	\$ 66,038		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

# **0030551**

Report Period Beginning: **01/01/08**

Ending: **12/31/08**

**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		
Nesanel Davis	Administrator	0	\$ 193,658	Workers' Compensation Insurance	\$ 52,314	IDPH License Fee	\$ 2,316		
Yosef Davis	Administrative	72.34	15,000	Unemployment Compensation Insurance	25,385	Advertising: Employee Recruitment	2,316		
Yehoshua Davis	Operations	0	2,332	FICA Taxes	240,479	Health Care Worker Background Check			
Moshe Davis	Operations	0	2,365	Employee Health Insurance	142,184	(Indicate # of checks performed <u>47</u> )	595		
				Employee Meals	83,701	Patient Background Checks <u>88</u>	880		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,191		
				Holiday Expense	8,578	ILCLTC	5,084		
				City Payroll Tax	4,920	Dues & Subscriptions	2,825		
				Dental Insurance	63	Annual Fee	643		
				Employee Benefits	2,620	See Supplemental Schedule	816		
				Employee Pension	6,650	Less: Public Relations Expense	( )		
				Disability Insurance	3,682	Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 213,355	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,350	
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.			\$ 198,664				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			\$	Seminar Expense	2,010
								Allocated from Managcare	397
								Entertainment Expense	( )
								(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 322,823	TOTAL	\$ 2,407

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Brightview Care Center

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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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 - \$10,303
- (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. \$ 20,139 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. \$ 84,546  
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. \$ 83,701 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT