

Facility Name & ID Number Brightview Care Center

0030551 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	<u>21,766</u>	<u>629</u>	<u>4,240</u>	<u>26,635</u>	8	
9	SNF/PED					9	
10	ICF	<u>20,195</u>			<u>20,195</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>41,961</u>	<u>629</u>	<u>4,240</u>	<u>46,830</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.72%

D. How many bed-hold days during this year were paid by the Department? 122 (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 2,747

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 Fiscal Year: 12/31

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

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	219,003	41,611	5,520	266,134		266,134		266,134		1
2	Food Purchase		241,148		241,148	(90,217)	150,931	(32)	150,899		2
3	Housekeeping	275,411	66,991		342,402		342,402	852	343,254		3
4	Laundry	53,070	8,875		61,945		61,945		61,945		4
5	Heat and Other Utilities			161,897	161,897		161,897	3,045	164,942		5
6	Maintenance	81,055	16,147	35,029	132,231		132,231	12,611	144,842		6
7	Other (specify):*										7
8	TOTAL General Services	628,539	374,772	202,446	1,205,757	(90,217)	1,115,540	16,476	1,132,016		8
	B. Health Care and Programs										
9	Medical Director			27,600	27,600		27,600		27,600		9
10	Nursing and Medical Records	1,971,629	155,022	45,352	2,172,003		2,172,003	(17)	2,171,986		10
10a	Therapy	135,112	5,615	675	141,402		141,402		141,402		10a
11	Activities	58,958	8,139	1,334	68,431		68,431		68,431		11
12	Social Services	122,119		1,485	123,604		123,604		123,604		12
13	CNA Training										13
14	Program Transportation			360	360		360		360		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,287,818	168,776	76,806	2,533,400		2,533,400	(17)	2,533,383		16
	C. General Administration										
17	Administrative	208,791		382,171	590,962		590,962	(286,725)	304,237		17
18	Directors Fees										18
19	Professional Services			321,415	321,415	(7,815)	313,600	(238,280)	75,320		19
20	Dues, Fees, Subscriptions & Promotions			97,236	97,236		97,236	(56,422)	40,814		20
21	Clerical & General Office Expenses	122,193	30,175	285,557	437,925		437,925	(174,782)	263,143		21
22	Employee Benefits & Payroll Taxes			505,659	505,659	90,217	595,876		595,876		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,714	3,714		3,714	346	4,060		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			2,204	2,204		2,204	156,672	158,876		26
27	Other (specify):*							47,191	47,191		27
28	TOTAL General Administration	330,984	30,175	1,597,956	1,959,115	82,402	2,041,517	(552,000)	1,489,517		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,247,341	573,723	1,877,208	5,698,272	(7,815)	5,690,457	(535,541)	5,154,916		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Brightview Care Center

#0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
	D. Ownership											
30	Depreciation			21,991	21,991		21,991	91,792	113,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,392	12,392		12,392	245,110	257,502			32
33	Real Estate Taxes			15,510	15,510	7,815	23,325	142,661	165,986			33
34	Rent-Facility & Grounds			618,800	618,800		618,800	(618,800)	(0)			34
35	Rent-Equipment & Vehicles			6,360	6,360		6,360	249	6,609			35
36	Other (specify):*							21,210	21,210			36
37	TOTAL Ownership			675,053	675,053	7,815	682,868	(117,778)	565,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		247,776	396,715	644,491		644,491		644,491			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*	97,321		39,239	136,560		136,560	(136,560)				43
44	TOTAL Special Cost Centers	97,321	247,776	514,247	859,344		859,344	(136,560)	722,784			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,344,662	821,499	3,066,508	7,232,669		7,232,669	(789,880)	6,442,789			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:

01/01/09

Ending:

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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	(2,232)	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	(16,421)	30		9
10	Interest and Other Investment Income	(79)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	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	(290)	21		18
19	Entertainment				19
20	Contributions	(33,350)	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	(257,738)	21		24
25	Fund Raising, Advertising and Promotional	(19,216)	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	(152,997)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (482,356)		\$	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)	(307,524)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (307,524)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (789,880)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty	\$ (17)	10	1
2	Marketing Salaries	(97,321)	43	2
3	Theft and Loss	(21)	21	3
4	Marketing Consultant	(38,011)	43	4
5	COPE Payments	(4,467)	20	5
6	Marketing Travel Expense	(1,228)	43	6
7	Building Co. - Legal & Professional Fees	(10,091)	19	7
8	Building Co. - Amortization Expense	(3,459)	36	8
9	Building Co. - Other Expense	(100)	21	9
10	Non-Allowable Accounting Fees	(5,000)	19	10
11	Reclass Capital Additions to Repairs and Maintenance	6,718	06	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	Total	(152,997)		49

Brightview Care CenterID# 0030551Report Period Beginning: 01/01/09Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(32)											(32)	2
3	Housekeeping			847		5							852	3
4	Laundry													4
5	Heat and Other Utilities			1,467		1,578							3,045	5
6	Maintenance	4,486		7,233		892							12,611	6
7	Other (specify):*													7
8	TOTAL General Services	4,454		9,547		2,475							16,476	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)											(17)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(17)											(17)	16
	C. General Administration													
17	Administrative			82,508	(369,782)	549							(286,725)	17
18	Directors Fees													18
19	Professional Services	(15,091)	15,406	(238,752)		157							(238,280)	19
20	Fees, Subscriptions & Promotions	(57,033)		583	19	9							(56,422)	20
21	Clerical & General Office Expenses	(258,149)	100	83,221	43	3							(174,782)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			346									346	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		156,131	349		192							156,672	26
27	Other (specify):*			46,211	980								47,191	27
28	TOTAL General Administration	(330,273)	171,637	(25,534)	(368,740)	910							(552,000)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(325,837)	171,637	(15,987)	(368,740)	3,385							(535,541)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(16,421)	105,470	2,495		248							91,792	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(79)	241,475	525	446	2,743							245,110	32
33	Real Estate Taxes		139,667			2,994							142,661	33
34	Rent-Facility & Grounds		(618,800)	12,711		(12,711)							(618,800)	34
35	Rent-Equipment & Vehicles			249									249	35
36	Other (specify):*	(3,459)	24,669										21,210	36
37	TOTAL Ownership	(19,959)	(107,519)	15,980	446	(6,726)							(117,778)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(136,560)											(136,560)	43
44	TOTAL Special Cost Centers	(136,560)											(136,560)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(482,356)	64,118	(7)	(368,294)	(3,341)							(789,880)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Rent	\$ 618,800	Brightview Building Company		\$	(618,800)	1	
2	V	32 Interest	10,276			251,751	241,475	2	
3	V	26 Insurance				156,131	156,131	3	
4	V	19 Legal & Professional Fees				15,406	15,406	4	
5	V	36 Mortgage Insurance				21,210	21,210	5	
6	V	36 Amortization				3,459	3,459	6	
7	V	33 Real Estate Taxes				139,667	139,667	7	
8	V	30 Depreciation				105,470	105,470	8	
9	V	21 Other Expense				100	100	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 629,076			\$ 693,194	\$ *	64,118	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	MANAGCARE, INC.	100.00%	\$ 847	\$ 847
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,467	1,467
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	7,233	7,233
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%		
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	82,508	82,508
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	972	972
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	583	583
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	83,221	83,221
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	346	346
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%		
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	349	349
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	46,211	46,211
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	2,495	2,495
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	525	525
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	12,711	12,711
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	249	249
31	V	19 HOME OFFICE	239,724	MANAGCARE, INC.	100.00%		(239,724)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 239,724			\$ 239,717	\$ * (7)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 12,389	\$ 12,389
16	V	19 PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%		
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	19	19
18	V	21 CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	43	43
19	V	27 EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	980	980
20	V	30 DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%		
21	V	32 INVESTMENT		INTERCARE, LTD. C/O MANAGCARE	100.00%	446	446
22	V	35 EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%		
23	V						
24	V	17 MANAGEMENT FEES	382,171	INTERCARE, LTD. C/O MANAGCARE	100.00%		(382,171)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 382,171			\$ 13,877	\$ * (368,294)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSEKEEPING	\$	MAZEL MANAGEMENT	100.00%	\$ 5	\$	5	15
16	V	5 UTILITIES		MAZEL MANAGEMENT		1,578		1,578	16
17	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		892		892	17
18	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT					18
19	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		549		549	19
20	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		157		157	20
21	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		9		9	21
22	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		3		3	22
23	V	26 INSURANCE		MAZEL MANAGEMENT		192		192	23
24	V	30 DEPRECIATION		MAZEL MANAGEMENT		248		248	24
25	V	31 AMORTIZATION		MAZEL MANAGEMENT					25
26	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		2,743		2,743	26
27	V	33 REAL ESTATE TAXES				2,994		2,994	27
28	V								28
29	V	34 RENT	12,711					(12,711)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 12,711			\$ 9,370	\$ *	(3,341)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Brightview Care Center

0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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:

01/01/09

Ending:

12/31/09

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	95.04%	See Attached	4.46	14.87%	Sal, Alloc Sal	\$ 27,389	17-1, 17-7	1
2	Nesanel Davis	Relative	Administrator	0%	None	48.00	100.00%	Salary	189,835	17-1	2
3	Moshe Wolf	Relative	Administrative	0%	See Attached	9.91	20.65%	Alloc. Salary	22,942	17-7	3
4	Stanley Klem	Owner	Administrative	2.13%	See Attached	11.15	24.78%	Alloc. Salary	33,300	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 273,466		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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	188,999	3	\$ 3,420	\$ 46,830	\$ 847	1
2	5	UTILITIES	PATIENT DAYS	188,999	3	5,922	46,830	1,467	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	188,999	3	29,193	46,830	7,233	3
4	10	NURSING SALARIES	PATIENT DAYS	188,999	3		46,830		4
5	17	ADMINISTRATIVE	PATIENT DAYS	188,999	3	332,989	332,989	46,830	82,508
6	19	PROFESSIONAL FEES	PATIENT DAYS	188,999	3	3,921	46,830	972	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	188,999	3	2,354	46,830	583	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	188,999	3	335,868	287,322	46,830	83,221
9	24	SEMINARS	PATIENT DAYS	188,999	3	1,395	46,830	346	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	188,999	3		46,830		10
11	26	INSURANCE	PATIENT DAYS	188,999	3	1,409	46,830	349	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	188,999	3	186,499	46,830	46,211	12
13	30	DEPRECIATION	PATIENT DAYS	188,999	3	10,070	46,830	2,495	13
14	32	INTEREST EXPENSE	PATIENT DAYS	188,999	3	2,119	46,830	525	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	188,999	3	51,300	46,830	12,711	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	188,999	3	1,005	46,830	249	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 967,464	\$ 620,311	\$ 239,717	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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 18	4	\$ 50,000	\$ 50,000	4	\$ 12,389	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 18	4			4		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED 18	4	75		4	19	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED 18	4	2,191		4	43	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 18	4	3,955		4	980	5
6	30	DEPRECIATION	AVG. HOURS WORKED 18	4			4		6
7	32	INVEESTMENT	AVG. HOURS WORKED 18	4	1,800		4	446	7
8	35	EQUIPMENT RENTAL	AVG. HOURS WORKED 18	4			4		8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 58,021	\$ 50,000		\$ 13,877	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V	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	
Line Reference									
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	188,999	3	\$ 20	\$ 46,830	\$ 5	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	188,999	3	6,369	46,830	1,578	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	188,999	3	3,599	46,830	892	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	188,999	3		46,830		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	188,999	3	2,215	46,830	549	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	188,999	3	632	46,830	157	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	188,999	3	35	46,830	9	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	188,999	3	10	46,830	3	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	188,999	3	777	46,830	192	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	188,999	3	1,002	46,830	248	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	188,999	3		46,830		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	188,999	3	11,072	46,830	2,743	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	188,999	3	12,083	46,830	2,994	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					\$ 37,814	\$ 46,830	\$ 9,370	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

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Report Period Beginning:

01/01/09

Ending: 12/31/09

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

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Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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: 01/01/09 Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Midland		X	Mortgage	\$24,481.00	6/1/2007	\$	\$ 4,247,594	7/1/2042	5.9000	\$ 251,751	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
Working Capital																			
6	MB Financial		X	Line of Credit				775,000			3,288	6							
7	Brightview Building Co.	X		Working Capital							9,104	7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related				\$24,481.00		\$	\$ 5,022,594			\$ 264,143	9							
B. Non-Facility Related*																			
10	Interest Income		X								(79)	10							
11	Interest Income - Bldg. Co.		X								(10,276)	11							
12	Allocated from Managcare										525	12							
13	See Supplemental Schedule										3,189	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (6,641)	14							
15	TOTALS (line 9+line14)						\$	\$ 5,022,594			\$ 257,502	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,210 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:

01/01/09

Ending:

12/31/09

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

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

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

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

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

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1986	10,306		20			10,284
10	Various		1987	4,719		20			4,712
11	Various		1988	2,895		20			2,891
12	Various		1989	67,265		20	1,300	1,300	67,251
13	Various		1991	22,384		20	1,120	1,120	18,715
14	Various		1992	17,019		20	143	143	15,038
15	Various		1993	44,200		20	2,211	2,211	36,337
16	Various		1994	63,594		20	3,181	3,181	49,373
17	Various		1995	7,105		20	356	356	5,184
18	Various		1996	37,640		20	1,882	1,882	25,977
19	Various		1997	17,411		20	871	871	10,521
20	Various		1998	49,850		20	2,497	2,497	28,309
21	Various		1999	215,484		20	10,777	10,777	113,806
22	Various		2000	47,834		20	2,392	2,392	22,680
23	Various		2001	35,034		20	2,167	2,167	18,537
24	Various		2002	33,534		20	2,856	2,856	21,522
25	Various		2003	20,999		20	1,357	1,357	8,866
26	Various		2004	67,458		20	6,303	6,303	35,156
27	Various		2005	20,650		20	1,670	1,670	8,011
28									
29									
30									
31									
32									
33									
34									
35									
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

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	Related Building Company (Pages 12F & 12G)	2,865,219	105,470		48,940	(56,530)	2,151,588	67
68	Related Party Allocations (Pages 12H & 12I)	72,194	633		1,694	1,061	59,795	68
69	Financial Statement Depreciation		21,991			(21,991)		69
70	TOTAL (lines 4 thru 69)	\$ 3,722,794	\$ 128,094		\$ 91,717	\$ (36,377)	\$ 2,714,553	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 3,722,794	\$ 128,094		\$ 91,717	\$ (36,377)	\$ 2,714,553	1
2	Boiler	2006	4,695		20	391	391	1,500	2
3	Wainscot	2006	4,969		20	331	331	1,036	3
4	Econocare	2006	2,654		20	265	265	863	4
5	Laundry Room Remodeling	2006	7,000		20	467	467	1,576	5
6	Elevator Repairs	2007	2,500		20	125	125	354	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,744,612	\$ 128,094		\$ 93,296	\$ (34,798)	\$ 2,719,882	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:

01/01/09

Ending:

12/31/09**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	Building Company Information								1
2	Buildings:								2
3	Brightview Building Company	1968	1,899,326		35			1,899,326	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	2004 Improvements	2004	534,642	105,470	20	26,732	(78,738)	160,392	9
10	Bathroom Remodeling	2005	1,925		20	96	96	481	10
11	Gluedown Carpet In Conf. Room	2005	980		20	49	49	245	11
12	Laminating Desk In Reception Area	2005	8,016		20	401	401	2,004	12
13	Crown Molding	2005	1,183		20	59	59	296	13
14	Wall Covering	2005	2,044		20	102	102	511	14
15	Light Fixtures	2005	643		20	32	32	161	15
16	Drapery Panels	2005	1,340		20	67	67	335	16
17	Removal & Installation Of Vinyl In Lobby	2005	12,547		20	627	627	3,137	17
18	Crown Molding & Wood Fronts In Nurses Station	2005	19,159		20	958	958	4,790	18
19	Installation Of New Carpet & Cove Base	2005	892		20	45	45	223	19
20	Faux Wood Blinds	2005	283		20	14	14	71	20
21	Installation Of New VCT And Cove Base	2005	258		20	13	13	64	21
22	Ceramic Tile Installation In Bathroom	2005	816		20	41	41	204	22
23	Pedimat & Ceramic Tile In Vestibule	2005	3,829		20	191	191	957	23
24	Wall Covering & Repainting In Med Room	2005	5,630		20	282	282	1,408	24
25	Vestibule	2005	199,403		20	10,250	10,250	51,249	25
26	Bumpers, Corner Guards & Handrails	2005	3,998		20	200	200	1,000	26
27	Door Casings	2005	1,463		20	73	73	366	27
28	Elevator Wraps	2005	930		20	46	46	232	28
29	Resident Room Pvc Sheeting	2005	3,882		20	194	194	970	29
30	Bumpers, Corner Guards & Handrails	2005	2,442		20	122	122	610	30
31	Drywall & Framing For Sprinkler Piping	2005	1,872		20	94	94	468	31
32	Time & Materials For Invoice Period	2005	309		20	15	15	77	32
33	Demolition Of Medication & Linen Rooms	2005	3,453		20	173	173	863	33
34									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:

01/01/09

Ending:

12/31/09**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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Electrical For Receptacles & Lights	2005	2,129		20	106	106	532	2
3	Concrete Flatwork	2005	978		20	49	49	245	3
4	Sliding Doors	2005	7,654		20	383	383	1,914	4
5	Installation Of New Window Opening	2005	3,039		20	152	152	760	5
6	HVAC, Sprinkler, Fire Alarm	2005	17,141		20	857	857	4,285	6
7	Fireproofing Of Existing Steel Beams	2005	403		20	20	20	101	7
8	New Ceilings & Lighting	2005	2,129		20	106	106	532	8
9	Cabinets, Countertops, & Plumbing	2005	1,093		20	55	55	273	9
10	New Shelving For DON Office Closet	2005	460		20	23	23	115	10
11	Plumbing	2005	1,496		20	75	75	374	11
12	Faux Food Blinds	2005	1,055		20	53	53	265	12
13	A/C Compressor	2007	6,886		20	344	344	1,033	13
14	Wiring - 2 Rooms	2007	8,100		20	405	405	1,215	14
15	2 Smoke Detectors	2007	4,062		20	203	203	609	15
16	150 AMP Volt Feeder	2008	2,000		20	100	100	200	16
17	Sprinkler System Repair	2008	2,520		20	126	126	252	17
18	Roofing and Tuckpointing	2008	5,000		20	250	250	500	18
19	Elevator	2008	17,000		20	850	850	1,700	19
20	Water Tube for Boiler	2008	2,800		20	140	140	280	20
21	Hot Water Storage Tank	2008	14,727		20	736	736	1,473	21
22	OEM Pump and Coil	2008	14,865		20	743	743	1,487	22
23	Cooling Tower	2008	5,250		20	263	263	525	23
24	Security Cameras	2008	9,090		20	455	455	909	24
25	Brick & Cement Repair	2009	6,200		20	352	352	352	25
26	Custom Carpentry	2009	5,140		20	428	428	428	26
27	Window Repairs	2009	4,500		20	225	225	225	27
28	Copper Fittings & Valves	2009	5,693		20	522	522	522	28
29	Boiler Gas Valve Motor & Temp Control	2009	2,542		20	42	42	42	29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 2,865,219	\$ 105,470		\$ 48,940	\$ (56,530)	\$ 2,151,588	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:

01/01/09

Ending:

12/31/09**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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Mazel Management</u>	1985	25,563		39	852	852	20,663	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from Managcare</u>	2008	3,465	371	20	346	(25)	664	9
10	<u>Allocated from Managcare</u>	1997	2,980		20			2,980	10
11	<u>Allocated from Managcare</u>	1993	234		20	12	12	193	11
12	<u>Allocated from Managcare</u>	1988	365	12	20		(12)	365	12
13	<u>Allocated from Managcare</u>	1986	27,645		20			27,644	13
14	<u>Allocated from Inter Care, Ltd.</u>	2001	1,094		20	55	55	456	14
15	<u>Allocated from Mazel Management</u>	2007	1,504	39	20	75	36	191	15
16	<u>Allocated from Mazel Management</u>	2006	807	21	20	40	19	141	16
17	<u>Allocated from Mazel Management</u>	2005	603	54	20	60	6	270	17
18	<u>Allocated from Mazel Management</u>	2001	537	14	20	27	13	228	18
19	<u>Allocated from Mazel Management</u>	2000	271	7	20	14	7	126	19
20	<u>Allocated from Mazel Management</u>	1998	956	31	20	48	17	560	20
21	<u>Allocated from Mazel Management</u>	1997	892	23	20	45	22	550	21
22	<u>Allocated from Mazel Management</u>	1996	608	7	20	30	23	412	22
23	<u>Allocated from Mazel Management</u>	1995	137	4	20	7	3	100	23
24	<u>Allocated from Mazel Management</u>	1994	543	10	20	27	17	392	24
25	<u>Allocated from Mazel Management</u>	1993	321	9	20	16	7	264	25
26	<u>Allocated from Mazel Management</u>	1991	240	8	20	12	4	211	26
27	<u>Allocated from Mazel Management</u>	1990	373	8	20	19	11	361	27
28	<u>Allocated from Mazel Management</u>	1989	233	5	20	9	4	201	28
29	<u>Allocated from Mazel Management</u>	1987	531	10	20		(10)	531	29
30	<u>Allocated from Mazel Management</u>	1986	2,143		20			2,143	30
31	<u>Allocated from Mazel Management</u>	1985	149		20			149	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 72,194	\$ 633		\$ 1,694	\$ 1,061	\$ 59,795	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 226,089	\$ 437	\$ 13,764	\$ 13,327	10	\$ 165,655	71
72	Current Year Purchases	46,715		4,754	4,754	10	4,754	72
73	Fully Depreciated Assets	283,238				10	283,183	73
74								74
75	TOTALS	\$ 556,042	\$ 437	\$ 18,518	\$ 18,081		\$ 453,592	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	2009	\$ 17,687	\$ 1,675	\$ 1,971	\$ 296	5	\$ 10,340	76
77										77
78										78
79										79
80	TOTALS			\$ 17,687	\$ 1,675	\$ 1,971	\$ 296		\$ 10,340	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)	\$ 4,392,333	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,206	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,785	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,421)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,183,814	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 249 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, Administrator</u>		\$ <u>530.00</u>	\$ <u>6,360</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>530.00</u>	\$ <u>6,360</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 140,142	\$		\$ 140,142	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			105,371			105,371	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			149,522			149,522	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				102,770		102,770	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,680	145,006		146,686	13
14	TOTAL			\$		\$ 396,715	\$ 247,776		\$ 644,491	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: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 60,275	\$ 95,256	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,164,297	1,761,311	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,480	113,343	6
7	Other Prepaid Expenses	7,185	7,185	7
8	Accounts Receivable (owners or related parties)	679,861	929,861	8
9	Other(specify): <u>See Attached Schedule</u>	545	335,901	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,966,643	\$ 3,245,857	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,879,090	14
15	Leasehold Improvements, at Historical Cost	617,979	680,688	15
16	Equipment, at Historical Cost	470,971	679,563	16
17	Accumulated Depreciation (book methods)	(693,783)	(3,242,885)	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>		112,127	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 395,167	\$ 1,258,583	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,361,810	\$ 4,504,440	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 648,465	\$ 649,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,984	48,984	28
29	Short-Term Notes Payable	775,000	775,000	29
30	Accrued Salaries Payable	92,067	92,067	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,595	11,595	31
32	Accrued Real Estate Taxes(Sch.IX-B)		156,600	32
33	Accrued Interest Payable	151,292	172,176	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	302,820	115,465	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,030,223	\$ 2,021,001	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,247,593	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,247,593	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,030,223	\$ 6,268,594	46
47	TOTAL EQUITY(page 18, line 24)	\$ 331,587	\$ (1,764,154)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,361,810	\$ 4,504,440	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 79,536	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 79,539	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	252,048	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 252,048	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 331,587	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center# 0030551Report Period Beginning: 01/01/09Ending: 12/31/09**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,044,096	1
2	Discounts and Allowances for all Levels	(552,027)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,492,069	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	642,543	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 642,543	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,981	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,829	19
20	Radiology and X-Ray	725	20
21	Other Medical Services	20,704	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 141,239	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	78	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 78	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	208,788	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 208,788	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,484,717	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,205,757	31
32	Health Care	2,533,400	32
33	General Administration	1,959,115	33
B. Capital Expense			
34	Ownership	675,053	34
C. Ancillary Expense			
35	Special Cost Centers	781,051	35
36	Provider Participation Fee	78,293	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,232,669	40
41	Income before Income Taxes (line 30 minus line 40)**	252,048	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 252,048	43

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

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

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

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

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

0030551

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,912	2,032	\$ 83,357	\$ 41.02	1
2	Assistant Director of Nursing	1,904	2,088	66,324	31.76	2
3	Registered Nurses	9,877	11,485	346,179	30.14	3
4	Licensed Practical Nurses	30,504	32,925	766,163	23.27	4
5	CNAs & Orderlies	62,017	67,947	683,892	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,166	10,050	135,112	13.44	8
9	Activity Director	1,156	1,296	20,575	15.88	9
10	Activity Assistants	4,339	4,709	38,383	8.15	10
11	Social Service Workers	7,039	7,629	122,119	16.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,615	19,865	219,003	11.02	15
16	Dishwashers					16
17	Maintenance Workers	4,922	5,442	81,055	14.89	17
18	Housekeepers	23,153	25,652	275,411	10.74	18
19	Laundry	5,305	6,068	53,070	8.75	19
20	Administrator	2,496	2,496	189,835	76.06	20
21	Assistant Administrator	80	80	3,956	49.45	21
22	Other Administrative	232	232	15,000	64.66	22
23	Office Manager					23
24	Clerical	9,002	10,077	122,193	12.13	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	951	1,057	25,714	24.33	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,375	2,375	97,321	40.98	33
34	TOTAL (lines 1 - 33)	194,045	213,505	\$ 3,344,662 *	\$ 15.67	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	104	\$ 5,520	01-03	35
36	Medical Director	Monthly	27,600	09-03	36
37	Medical Records Consultant	96	4,328	10-03	37
38	Nurse Consultant	Monthly	6,450	10-03	38
39	Pharmacist Consultant	Monthly	2,574	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	15	675	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,334	11-03	44
45	Social Service Consultant	27	1,485	12-03	45
46	Other(specify) <u>Rehab Medical Dir.</u>	Monthly	18,000	10-03	46
47	<u>Geriatric Program Director</u>	Monthly	8,000	10-03	47
48	<u>Psychiatric Medical Director</u>	Monthly	6,000	09-03	48
49	TOTAL (lines 35 - 48)	266	\$ 81,966		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

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - \$11,004
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,723 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 78,293
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 90,217 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.