

Facility Name & ID Number Brightview Care Center

0030551 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,470</u>	<u>1,181</u>	<u>4,241</u>	<u>20,892</u>	8
9	SNF/PED					9
10	ICF	<u>19,688</u>			<u>19,688</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,158</u>	<u>1,181</u>	<u>4,241</u>	<u>40,580</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.75%

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

None (Do not include bed-hold days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 02/01/1986

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

YES Date 02/01/1986 NO

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

YES NO If YES, enter number of beds certified 143 and days of care provided 4,005

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	262,235	50,605	11,985	324,825		324,825	17	324,842		1
2	Food Purchase		232,567		232,567	(25,291)	207,276	(1,449)	205,827		2
3	Housekeeping	234,911	41,715		276,626		276,626	989	277,615		3
4	Laundry	129,668	9,307	1,959	140,934		140,934		140,934		4
5	Heat and Other Utilities			125,163	125,163		125,163	(8,526)	116,637		5
6	Maintenance	83,285	21,453	66,166	170,904		170,904	7,475	178,379		6
7	Other (specify):*										7
8	TOTAL General Services	710,099	355,647	205,273	1,271,019	(25,291)	1,245,728	(1,494)	1,244,234		8
	B. Health Care and Programs										
9	Medical Director			55,000	55,000		55,000	11,186	66,186		9
10	Nursing and Medical Records	2,288,091	138,319	155,631	2,582,041		2,582,041	44,517	2,626,558		10
10a	Therapy	93,370			93,370		93,370		93,370		10a
11	Activities	110,824	13,683	916	125,423		125,423		125,423		11
12	Social Services	153,130			153,130		153,130	1,355	154,485		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,207	8,207		15
16	TOTAL Health Care and Programs	2,645,415	152,002	211,547	3,008,964		3,008,964	65,265	3,074,229		16
	C. General Administration										
17	Administrative	100,519		211,332	311,851		311,851	(125,290)	186,561		17
18	Directors Fees										18
19	Professional Services			307,571	307,571	(7,660)	299,911	(226,182)	73,729		19
20	Dues, Fees, Subscriptions & Promotions			125,253	125,253		125,253	(51,062)	74,191		20
21	Clerical & General Office Expenses	216,297	21,231	519,326	756,854		756,854	(351,967)	404,887		21
22	Employee Benefits & Payroll Taxes			636,394	636,394	25,291	661,685	(1,000)	660,685		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,589	2,589		2,589	478	3,067		24
25	Other Admin. Staff Transportation			4,328	4,328		4,328	2,089	6,417		25
26	Insurance-Prop.Liab.Malpractice			28,121	28,121		28,121	123,595	151,716		26
27	Other (specify):*							28,144	28,144		27
28	TOTAL General Administration	316,816	21,231	1,834,914	2,172,961	17,631	2,190,592	(601,195)	1,589,397		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,672,330	528,880	2,251,734	6,452,944	(7,660)	6,445,284	(537,424)	5,907,860		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:

01/01/13

Ending:

12/31/13

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			47,709	47,709		47,709	77,626	125,335			30
31	Amortization of Pre-Op. & Org.							(0)	(0)			31
32	Interest			48,287	48,287		48,287	113,348	161,635			32
33	Real Estate Taxes			21,973	21,973	7,660	29,633	169,385	199,018			33
34	Rent-Facility & Grounds			465,000	465,000		465,000	(465,000)	0			34
35	Rent-Equipment & Vehicles			12,284	12,284		12,284	(9,419)	2,865			35
36	Other (specify):*							21,586	21,586			36
37	TOTAL Ownership			595,253	595,253	7,660	602,913	(92,474)	510,439			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,617	830,844	1,064,461		1,064,461	(3,752)	1,060,709			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			300,041	300,041		300,041		300,041			42
43	Other (specify):*	48,401		5,221	53,622		53,622	(53,622)	(0)			43
44	TOTAL Special Cost Centers	48,401	233,617	1,136,106	1,418,124		1,418,124	(57,374)	1,360,750			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,720,731	762,497	3,983,093	8,466,321	0	8,466,321	(687,271)	7,779,050			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT

*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: 01/01/13

Ending: 12/31/13

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	(10,117)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,782)	30		9
10	Interest and Other Investment Income	(24,283)	32		10
11	Discounts, Allowances, Rebates & Refunds	(531)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	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	(72)	21		18
19	Entertainment				19
20	Contributions	(36,195)	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	(435,125)	21		24
25	Fund Raising, Advertising and Promotional	(20,331)	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	(145,014)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (686,517)		\$	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)	(754)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (754)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (687,271)		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
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Brightview Care CenterID# 0030551Report Period Beginning: 01/01/13Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (1,382)	02	1
2	Miscellaneous Income	(72)	21	2
3	Marketing Consultant	(5,190)	43	3
4	Bank Charges	(6,237)	21	4
5	Marketing Salaries	(35,173)	43	5
6	Theft and Loss	(745)	21	6
7	COPE Dues	(5,833)	20	7
8	Building Company - Legal & Professional Fees	(9,597)	19	8
9	Building Company - Amortization Expense	(2,198)	31	9
10	Additional R&M	4,585	06	10
11	Non-Allowable Auto Lease	(12,284)	35	11
12	Non-Allowable Legal	(500)	19	12
13	Prior Period - Maintenance	(909)	06	13
14	Prior Period - Medical Records Salary	(2,713)	10	14
15	Prior Period - A&G	(1,230)	21	15
16	Prior Period - Professional Services	(8,140)	19	16
17	Prior Period - Insurance	(17,294)	26	17
18	Prior Period - Employee Benefits	(1,000)	22	18
19	Marketing Expense	(32)	43	19
20	Sequestration	(22,708)	21	20
21	2012 Omnicare Settlement	(3,135)	39	21
22	Non-allowable Salary	(13,228)	43	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	(145,014)	49

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center# 0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

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			17									17	1
2	Food Purchase	(1,449)											(1,449)	2
3	Housekeeping			989									989	3
4	Laundry													4
5	Heat and Other Utilities	(10,117)		1,199		392							(8,526)	5
6	Maintenance	3,676		3,081		718							7,475	6
7	Other (specify):*													7
8	TOTAL General Services	(7,890)		5,286		1,110							(1,494)	8
	B. Health Care and Programs													
9	Medical Director			11,186									11,186	9
10	Nursing and Medical Records	(2,713)		47,230									44,517	10
10a	Therapy													10a
11	Activities													11
12	Social Services			1,355									1,355	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,207									8,207	15
16	TOTAL Health Care and Programs	(2,713)		67,978									65,265	16
	C. General Administration													
17	Administrative			29,463	51,181		(205,933)						(125,290)	17
18	Directors Fees													18
19	Professional Services	(18,237)	17,130	(167,001)	(58,578)	504							(226,182)	19
20	Fees, Subscriptions & Promotions	(62,359)		11,164		83	49						(51,062)	20
21	Clerical & General Office Expenses	(466,721)		114,708	21	25							(351,967)	21
22	Employee Benefits & Payroll Taxes	(1,000)											(1,000)	22
23	Inservice Training & Education													23
24	Travel and Seminar			478									478	24
25	Other Admin. Staff Transportation			1,262	2		826						2,089	25
26	Insurance-Prop.Liab.Malpractice	(17,294)	140,375	321		192							123,595	26
27	Other (specify):*			23,469	4,675								28,144	27
28	TOTAL General Administration	(565,611)	157,505	13,865	(2,700)	805	(205,058)						(601,195)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(576,214)	157,505	87,128	(2,700)	1,915	(205,058)						(537,424)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	(14,782)	81,998	8,067		2,343							77,626	30
31	Amortization of Pre-Op. & Org.	(2,198)	2,198										(0)	31
32	Interest	(24,283)	133,267	29		4,336							113,348	32
33	Real Estate Taxes		167,241			2,144							169,385	33
34	Rent-Facility & Grounds		(465,000)	12,675		(12,675)							(465,000)	34
35	Rent-Equipment & Vehicles	(12,284)		133	2,731								(9,419)	35
36	Other (specify):*		21,586										21,586	36
37	TOTAL Ownership	(53,546)	(58,710)	20,905	2,731	(3,853)							(92,474)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,135)						(617)					(3,752)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(53,622)											(53,622)	43
44	TOTAL Special Cost Centers	(56,757)						(617)					(57,374)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(686,517)	98,795	108,033	31	(1,938)	(205,058)	(617)					(687,271)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 465,000	Brightview Building Company	100.00%	\$	\$ (465,000)	1
2	V	32 Interest Income	2,231	Brightview Building Company	100.00%		(2,231)	2
3	V	30 Depreciation		Brightview Building Company	100.00%	81,998	81,998	3
4	V	26 Insurance Expense		Brightview Building Company	100.00%	140,375	140,375	4
5	V	32 Interest Expense		Brightview Building Company	100.00%	135,498	135,498	5
6	V	19 Legal & Professional Fees		Brightview Building Company	100.00%	9,597	9,597	6
7	V	36 Mortgage Insurance		Brightview Building Company	100.00%	21,586	21,586	7
8	V	31 Amortization Expense		Brightview Building Company	100.00%	2,198	2,198	8
9	V	33 Real Estate Taxes		Brightview Building Company	100.00%	167,241	167,241	9
10	V	19 Legal - R/E Tax Related		Brightview Building Company	100.00%	7,533	7,533	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 467,231			\$ 566,026	\$ * 98,795	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIETARY	\$	MANAGCARE, INC.	100.00%	\$ 17	\$	17	15
16	V	3 HOUSEKEEPING		MANAGCARE, INC.	100.00%	989		989	16
17	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,199		1,199	17
18	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,081		3,081	18
19	V	9 MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	11,186		11,186	19
20	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%	47,230		47,230	20
21	V	12 SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	1,355		1,355	21
22	V	15 NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	8,207		8,207	22
23	V	17 ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	29,463		29,463	23
24	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,066		1,066	24
25	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	11,164		11,164	25
26	V	21 CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	86,324		86,324	26
27	V	21 CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	28,384		28,384	27
28	V	24 SEMINARS		MANAGCARE, INC.	100.00%	478		478	28
29	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,262		1,262	29
30	V	26 INSURANCE		MANAGCARE, INC.	100.00%	321		321	30
31	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	23,469		23,469	31
32	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	8,067		8,067	32
33	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	29		29	33
34	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	12,675		12,675	34
35	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	133		133	35
36	V								36
37	V	19 BOOKKEEPING / CONSULTING	168,067	MANAGCARE, INC.	100.00%			(168,067)	37
38	V								38
39	Total		\$ 168,067			\$ 276,100	\$ *	108,033	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE SALARY - NATHAN	\$	TETRAD MANAGEMENT, LLC	100.00%	\$ 15,882	\$	15,882	15
16	V	17 ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	5,458		5,458	16
17	V	17 ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	15,882		15,882	17
18	V	17 ADMINISTRATIVE FEES - YOSEF DAVIS		TETRAD MANAGEMENT, LLC	100.00%	13,957		13,957	18
19	V								19
20	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	125		125	20
21	V	21 OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	21		21	21
22	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2		2	22
23	V	27 EMPLOYEE BEENFITS- PAYROLL TAXES		TETRAD MANAGEMENT, LLC	100.00%	4,675		4,675	23
24	V	35 AUTO LEASE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	2,731		2,731	24
25	V								25
26	V								26
27	V	19 ADMINISTRATIVE CONSULTING	58,703	TETRAD MANAGEMENT, LLC	100.00%			(58,703)	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		\$ 58,703			\$ 58,734	\$ *	31	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	5 UTILITIES	\$	4600 TOUHY, LLC	100.00%	\$ 392	\$	392	15
16	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	718		718	16
17	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	504		504	17
18	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	83		83	18
19	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	25		25	19
20	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	192		192	20
21	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	2,343		2,343	21
22	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	4,336		4,336	22
23	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,144		2,144	23
24	V								24
25	V								25
26	V	34 RENT	12,675	4600 TOUHY, LLC	100.00%			(12,675)	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		\$ 12,675			\$ 10,737	\$ *	(1,938)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 5,399	\$ 5,399
16	V						
17	V	20 FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	49	49
18	V						
19	V	25 ADMIN. STAFF TRAVEL		INTERCARE, LTD. C/O MANAGCARE	100.00%	826	826
20	V						
21	V						
22	V	17 MANAGEMENT FEES	211,332	INTERCARE, LTD. C/O MANAGCARE	100.00%		(211,332)
23	V						
24	V						
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		\$ 211,332			\$ 6,274	\$ * (205,058)

* 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	39 AMBULANCE	\$ 3,531	LIFELINE AMBULANCE	100.00%	\$ 2,914	\$ (617)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
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		\$ 3,531			\$ 2,914	\$ * (617)

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MOSHE WOLF	2.77%	MAYFIELD CARE CENTER	CHICAGO	BRIGHTVIEW BUILDING COM	LINCOLNWOOD	BUILDING CO.	1
2	EDIE DAVIS	0.71%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3	STANLEY KLEM	2.77%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO	3
4	YOSEF DAVIS DELTA TRUST	93.76%	CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD	INTERCARE, LTD.C/O MANAG	LINCOLNWOOD	MANAGEMENT CO	4
5			COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS	LIFELINE AMBULANCE	CHICAGO	AMBULANCE SERVICES	6
7			MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				7
8			MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				8
9			RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSELLES				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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Administrative	0.00%	See Attached	1.5	5.00%	Alloc Fee/Sal	\$ 19,357	17-7	1
2	Nesanel Davis	Relative	Administrative	0.00%	See Attached	4.0	8.33%	Alloc. Sal.	15,882	17-7	2
3	Moshe Wolf	Owner	Administrator	2.77%	See Attached	4.0	8.33%	Alloc. Sal.	7,008	17-7	3
4	Stanley Klem	Owner	Administrative	2.77%	See Attached	3.7	8.34%	Alloc. Sal.	10,560	17-7	4
5	Yisroel Davis	Relative	Administrator		None	40	100%	Salary	19,098	17-1	5
6	Moshe Davis	Relative	Administrative		See Attached	3.67	8%	Alloc. Sal.	15,882	17-7	6
7	Yehoshua Davis	Relative	Administrative		See Attached	4	8%	Alloc. Sal.	5,458	17-7	7
8	Eli Davis	Relative	Administrative		See Attached	3.34	8%	Alloc. Fees	584	17-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 93,829		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:

01/01/13

Ending: 12/31/13

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:

01/01/13

Ending: 12/31/13

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

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	DIETARY	PATIENT DAYS	486,626	10	\$ 198	\$ 40,580	\$ 17	1
2	3	HOUSEKEEPING	PATIENT DAYS	486,626	10	11,856	40,580	989	2
3	5	UTILITIES	PATIENT DAYS	486,626	10	14,381	40,580	1,199	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	486,626	10	36,948	40,580	3,081	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	486,626	10	134,142	40,580	11,186	5
6	10	NURSING SALARIES	PATIENT DAYS	486,626	10	566,366	566,366	47,230	6
7	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	486,626	10	16,247	16,247	1,355	7
8	15	NURSING EMP BENS & PR TA	PATIENT DAYS	486,626	10	98,421	40,580	8,207	8
9	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	486,626	10	353,309	353,309	29,463	9
10	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	12,785	40,580	1,066	10
11	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	486,626	10	133,874	40,580	11,164	11
12	21	CLERICAL AND GENERAL SA	PATIENT DAYS	486,626	10	1,035,183	1,035,183	86,324	12
13	21	CLERICAL AND GENERAL EX	PATIENT DAYS	486,626	10	340,374	40,580	28,384	13
14	24	SEMINARS	PATIENT DAYS	486,626	10	5,737	40,580	478	14
15	25	ADMIN. STAFF TRANS.	PATIENT DAYS	486,626	10	15,128	40,580	1,262	15
16	26	INSURANCE	PATIENT DAYS	486,626	10	3,851	40,580	321	16
17	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	486,626	10	281,440	40,580	23,469	17
18	30	DEPRECIATION	PATIENT DAYS	486,626	10	96,741	40,580	8,067	18
19	32	INTEREST EXPENSE	PATIENT DAYS	486,626	10	346	40,580	29	19
20	34	RENT - BUILDING (RELATED)	PATIENT DAYS	486,626	10	152,000	40,580	12,675	20
21	35	EQUIPMENT RENTAL	PATIENT DAYS	486,626	10	1,597	40,580	133	21
22									22
23									23
24									24
25	TOTALS				\$ 3,310,923	\$ 1,971,105		\$ 276,100	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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 SALARY - PATIENT DAYS	486,626	10	\$ 190,457	\$ 190,457	40,580	\$ 15,882	1
2	17	ADMINISTRATIVE SALARY - PATIENT DAYS	486,626	10	65,457	65,457	40,580	5,458	2
3	17	ADMINISTRATIVE SALARY - PATIENT DAYS	486,626	10	190,457	190,457	40,580	15,882	3
4	17	ADMINISTRATIVE FEES - YO PATIENT DAYS	486,626	10	167,375		40,580	13,957	4
5	17	TOTAL MANAGEMENT FEES PATIENT DAYS	486,626	10			40,580		5
6	19	PROFESSIONAL FEES PATIENT DAYS	486,626	10	1,500		40,580	125	6
7	21	OFFICE EXPENSE PATIENT DAYS	486,626	10	253		40,580	21	7
8	25	TRAVEL PATIENT DAYS	486,626	10	23		40,580	2	8
9	27	EMPLOYEE BEENFITS- PAY PATIENT DAYS	486,626	10	56,057		40,580	4,675	9
10	35	AUTO LEASE EXPENSE PATIENT DAYS	486,626	10	32,750		40,580	2,731	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				\$ 704,328	\$ 446,371		\$ 58,734	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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	5	UTILITIES	MNGCR. PATIENT DAYS 486,626	10	\$ 4,702	\$	40,580	\$ 392	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 486,626	10	8,610		40,580	718	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 486,626	10	6,043		40,580	504	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 486,626	10	1,001		40,580	83	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 486,626	10	300		40,580	25	5
6	26	INSURANCE	MNGCR. PATIENT DAYS 486,626	10	2,308		40,580	192	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS 486,626	10	28,092		40,580	2,343	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 486,626	10	51,990		40,580	4,336	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 486,626	10	25,708		40,580	2,144	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				\$ 128,752	\$		\$ 10,737	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	187,889	3	\$ 25,000	\$ 25,000	40,580	\$ 5,399	1
2										2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	187,889	3	228	40,580	49		3
4										4
5	25	ADMIN. STAFF TRAVEL	AVG. HOURS WORKED	187,889	3	3,826	40,580	826		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					\$ 29,054	\$ 25,000		\$ 6,274	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 LIFELINE AMBULANCE LLC
 Street Address 2424 S. WABASH AVENUE
 City / State / Zip Code CHICAGO, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

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	39	AMBULANCE	DIRECT COSTS		\$	\$		\$ 2,914	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				\$	\$		\$ 2,914	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending: 12/31/13

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:

01/01/13

Ending: 12/31/13

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:

01/01/13

Ending: 12/31/13

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:

01/01/13

Ending: 12/31/13

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:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		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	\$	\$ 4,269,567	7/1/2042	5.9000	\$	135,498						
2																		
3																		
4																		
5																		
Working Capital																		
6	MB Financial		X	Line of Credit				1,177,000				43,161						
7	Brightview Bldg. Co.	X		Working Capital								5,126						
8	See Supplemental Schedule											4,365						
9	TOTAL Facility Related				\$24,481.00		\$	\$ 5,446,567			\$	188,150						
B. Non-Facility Related*																		
10	Interest Income		X									(24,283)						
11	Interest Income - Bldg. Co.		X									(2,231)						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(26,514)						
15	TOTALS (line 9+line14)						\$	\$ 5,446,567			\$	161,636						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,586 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:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from Managcare Inc		X				\$	\$			\$ 29					
9	Allocated from 4600 Touhy LLC		X								4,336					
10																
11																
12																
13																
14	TOTAL Working Capital										4,365					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2012 report.		\$	163,300		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.)		\$	176,678		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	13,378		3														
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	178,000		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	7,660		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 21,973 For 2009 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	199,039		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	<u>153,577</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	<u>154,095</u>	9																
	2010	<u>160,803</u>	10																
	2011	<u>160,113</u>	11																
	2012	<u>174,535</u>	12																
2013 Accrual = \$174,535 x 1.02 = \$178,000																			
Allocated from 4600 Touhy LLC = \$2,144																			

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

2012 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-115-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>69,266.76</u>	\$ <u>69,266.76</u>
2. <u>14-17-115-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>66,221.75</u>	\$ <u>66,221.75</u>
3. <u>14-17-115-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>39,046.05</u>	\$ <u>39,046.05</u>
4. <u>See Attached</u>	<u>See Attached</u>	\$ <u>48,715.81</u>	\$ <u>2,031.22</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>223,250.37</u></u>	\$ <u><u>176,565.78</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Brightview Care Center

0030551 Report Period Beginning:

01/01/13 Ending:

12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
143		1968	\$ 1,899,326	\$ 81,998	35	\$	\$(81,998)	\$ 1,899,326	4
									5
									6
									7
									8
Improvement Type**									
Various		1986	10,306		20			10,284	9
Various		1987	4,719		20			4,712	10
Various		1988	2,895		20			2,891	11
Various		1989	67,265		20			67,250	12
Various		1991	22,384		20			20,454	13
Various		1992	17,019		20	143	143	15,609	14
Various		1993	44,200		20	1,223	1,223	43,379	15
Various		1994	63,594		20	3,174	3,174	62,087	16
Various		1995	7,105		20	355	355	6,605	17
Various		1996	37,640		20	1,882	1,882	33,505	18
Various		1997	17,411		20	871	871	14,004	19
Various		1998	49,850		20	2,493	2,493	38,279	20
Various		1999	215,484		20	10,774	10,774	156,903	21
Various		2000	47,834		20	2,392	2,392	32,246	22
Various		2001	35,034		20	1,337	1,337	25,057	23
Various		2002	33,534		20	651	651	28,936	24
Various		2003	21,000		20	1,356	1,356	14,291	25
Various		2004	67,457		20	5,352	5,352	56,565	26
Various		2005	20,650		20	1,669	1,669	14,688	27
Various		2006	19,318		20	1,454	1,454	10,792	28
Various		2007	2,500		20	125	125	854	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

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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		1,112,740			55,639	55,639	471,553	67
68		87,713		3,710	3,672	(38)	7,464	68
69				47,709		(47,709)		69
70		\$ 3,906,978	\$ 133,417		\$ 94,562	\$ (38,855)	\$ 3,037,735	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,906,978	\$ 133,417		\$ 94,562	\$ (38,855)	\$ 3,037,735	1
2	Wall-Mounted Sign	2011	9,417		20	942	942	2,197	2
3	Fire Alarm Devices	2012	4,474		20	639	639	692	3
4	Water Chiller	2013	37,500		20	1,249	1,249	1,249	4
5	Fence	2013	5,000		20	167	167	167	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)		\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	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)		\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	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)	\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	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)		\$ 3,963,369	\$ 133,417		\$ 97,558	\$ (35,859)	\$ 3,042,040	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	2004 Improvements	2004	534,642		20	26,732	26,732	267,321	9
10	2005 Improvements	2005	314,875		20	15,744	15,744	141,695	10
11	2007 Improvements	2007	19,048		20	952	952	6,666	11
12	2008 Improvements	2008	73,252		20	3,663	3,663	21,976	12
13	Brick & Cement Repair	2009	6,200		20	310	310	1,550	13
14	Custom Carpentry	2009	5,140		20	257	257	1,285	14
15	Window Repairs	2009	4,500		20	225	225	1,125	15
16	Copper Fittings & Valves	2009	5,693		20	285	285	1,424	16
17	Boiler Gas Valve Motor & Temp Control	2009	2,542		20	127	127	635	17
18	Sewer Access	2010	3,750		20	188	188	939	18
19	Basement Flooring	2010	12,700		20	635	635	3,175	19
20	Basement Door & Wall	2010	17,120		20	856	856	4,280	20
21	Wood Flooring	2010	12,000		20	600	600	3,000	21
22	Elevator	2010	59,711		20	2,986	2,986	11,944	22
23	Elevator Repair	2010	2,500		20	125	125	500	23
24	Fire Alarm	2011	13,957		20	698	698	2,094	24
25	Tile Flooring	2011	3,000		20	150	150	450	25
26	Generator Outlets	2012	7,750		20	388	388	776	26
27	Asphalt Resurface 9,246 sq. ft.	2013	14,360		20	718	718	718	27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	34
			1,112,740		55,639	55,639	471,553	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Allocated from 4600 Touhy LLC	2012	42,817	1,098	20	1,427	329	2,854	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare	2013	719	409	20	36	(373)	36	9
10	Allocated from Managcare	2012	8,940	958	20	447	(511)	894	10
11									11
12	Allocated from Inter Care LTD	2001	953		20	48	48	588	12
13									13
14	Allocated from 4600 Touhy LLC	2012	27,574	721	20	1,379	658	2,757	14
15	Allocated from 4600 Touhy LLC	2013	6,710	524	20	335	(189)	335	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 87,713	\$ 3,710		\$ 3,672	\$ (38)	\$ 7,464	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 408,521	\$ 1,944	\$ 24,283	\$ 22,339	10	\$ 238,378	71
72	Current Year Purchases	28,037	4,129	2,245	(1,884)	10	2,245	72
73	Fully Depreciated Assets	353,598		104	104	10	353,598	73
74								74
75	TOTALS	\$ 790,155	\$ 6,073	\$ 26,632	\$ 20,559		\$ 594,221	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Managcare	2013	\$ 10,078	\$ 626	\$ 1,144	\$ 518	5	\$ 8,072	76
77										77
78										78
79										79
80	TOTALS			\$ 10,078	\$ 626	\$ 1,144	\$ 518		\$ 8,072	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)	\$ 4,837,595	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,116	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,334	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,782)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,644,332	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	Architectural Services	\$ 7,038	92
93			93
94			94
95		\$ 7,038	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:

01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 133

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	Allocated from Tetrad Management LLC		\$	\$ 2,731	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,731	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	277,599	\$		\$	277,599	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				108,496				108,496	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				304,438				304,438	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					185,580			185,580	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>						140,311	48,037			188,348	13
14	TOTAL			\$		\$	830,844	233,617		\$	1,064,461	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

0030551

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 23,156	\$ 199,348	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,943,338	2,095,338	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,615	140,597	6
7	Other Prepaid Expenses	26,571	26,571	7
8	Accounts Receivable (owners or related parties)	663,977	1,078,010	8
9	Other(specify): <u>See Attached Schedule</u>	272,180	464,691	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,990,837	\$ 4,004,555	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	677,133	908,190	15
16	Equipment, at Historical Cost	638,600	851,458	16
17	Accumulated Depreciation (book methods)	(869,796)	(3,804,316)	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):		131,862	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 445,937	\$ 1,116,284	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,436,774	\$ 5,120,839	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,213,809	\$ 1,304,737	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,713	17,713	28
29	Short-Term Notes Payable	1,177,000	1,177,000	29
30	Accrued Salaries Payable	217,123	217,123	30
31	Accrued Taxes Payable (excluding real estate taxes)	86,858	86,858	31
32	Accrued Real Estate Taxes(Sch.IX-B)		178,000	32
33	Accrued Interest Payable	5,418	16,626	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	1,037,027	1,066,944	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,754,948	\$ 4,065,001	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,269,566	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,269,566	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,754,948	\$ 8,334,567	46
47	TOTAL EQUITY(page 18, line 24)	\$ (318,174)	\$ (3,213,728)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,436,774	\$ 5,120,839	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 115,047	1
2	Restatements (describe):		2
3	Prior Peroid	(31,564)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 83,483	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(401,657)	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)	\$ (401,657)	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)	\$ (318,174)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,867,756	1
2	Discounts and Allowances for all Levels	(1,448,411)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,419,345	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,398,895	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,398,895	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	157,022	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,743	19
20	Radiology and X-Ray	2,045	20
21	Other Medical Services	16,238	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 195,048	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	24,283	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,283	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	27,093	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,093	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,064,664	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,271,019	31
32	Health Care	3,008,964	32
33	General Administration	2,172,961	33
B. Capital Expense			
34	Ownership	595,253	34
C. Ancillary Expense			
35	Special Cost Centers	1,118,083	35
36	Provider Participation Fee	300,041	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,466,321	40
41	Income before Income Taxes (line 30 minus line 40)**	(401,657)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (401,657)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,942,574	44
45	Private Pay - Net Inpatient Revenue	211,066	45
46	Medicare - Net Inpatient Revenue	1,244,224	46
47	Other-(specify) <u>Hospice</u>	21,481	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,419,345	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center

0030551

Report Period Beginning:

01/01/13

Ending:

12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,016	2,151	\$ 82,853	\$ 38.52	1
2	Assistant Director of Nursing	1,864	1,920	64,430	33.56	2
3	Registered Nurses	22,027	23,992	671,011	27.97	3
4	Licensed Practical Nurses	26,798	29,109	696,680	23.93	4
5	CNAs & Orderlies	66,590	73,381	739,608	10.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,653	7,572	93,370	12.33	8
9	Activity Director	2,123	2,343	36,441	15.55	9
10	Activity Assistants	7,861	8,203	74,383	9.07	10
11	Social Service Workers	8,242	8,799	153,130	17.40	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,319	45,189	19.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,783	18,553	217,046	11.70	15
16	Dishwashers					16
17	Maintenance Workers	5,552	5,552	83,285	15.00	17
18	Housekeepers	17,944	20,252	234,911	11.60	18
19	Laundry	9,514	10,430	129,668	12.43	19
20	Administrator	1,752	1,888	100,519	53.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,933	13,847	216,297	15.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,604	1,636	33,509	20.48	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,200	1,249	35,173	28.16	33
34	TOTAL (lines 1 - 33)	213,384	233,196	\$ 3,707,503 *	\$ 15.90	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	236	\$ 11,985	01-03	35
36	Medical Director	Monthly	55,000	09-03	36
37	Medical Records Consultant	Monthly	4,608	10-03	37
38	Nurse Consultant	554	119,967	10-03	38
39	Pharmacist Consultant	Monthly	8,748	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	916	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>MDS Consultant</u>	Monthly	22,308	10-03	48
49	TOTAL (lines 35 - 48)	802	\$ 223,532		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: 01/01/13

Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mark Murphey (Term 2/22/13)	Administrator	0	\$ 25,130	Workers' Compensation Insurance	\$ 94,091	IDPH License Fee	\$ 783	
Yisroel Davis (Interim 2/25 - 7/1)	Administrator	0	19,098	Unemployment Compensation Insurance	55,887	Advertising: Employee Recruitment	34,613	
Gina McCarthy (Start 7/8/13)	Administrator	0	56,290	FICA Taxes	283,202	Health Care Worker Background Check		
				Employee Health Insurance	169,426	(Indicate # of checks performed)		
				Employee Meals	25,448	Patient Background Checks	304 3,040	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	19,553	
				Dental Insurance	356	License and Permits	4,906	
				Employee Benefits	14,303	Allocated from Managcare Inc.	11,164	
				Employee Pension	10,007	Allocated from Inter Care Ltd	49	
				Disability Insurance	2,620	See Supplemental Schedule	83	
				Holiday Expense	3,572	Less: Public Relations Expense	()	
				City Tax	1,771	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 100,518	TOTAL (agree to Schedule V, line 22, col.8)	\$ 660,683	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 74,190	
(List each licensed administrator separately.)								
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.			\$ 211,332				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 211,332	TOTAL		\$	Seminar Expense	2,589
(Attach a copy of any management service agreement)							Allocated from Managcare	478
C. Professional Services								
Vendor/Payee	Type		Amount					
Managcare, Inc.	Strategic Consulting		\$ 5,047					
Comprehensive Reimbursement	Reimbursement Consulting		5,400					
LTC Consulting Services	Medical Billing Consulting		235					
Prospect Resources	Natural Gas Procurement		1,375					
ProviNET Solutions	IT Consulting		1,100					
Templin Healthcare Accounting	Healthcare Consulting		835					
Tetrad Management	Administrative Consulting		58,703					
Ability Network, Inc.	Billing Software		682					
Adar, LLC	Cloud-based IT Solutions		9,563					
American Data	Electronic Charting System		6,500					
eHealth	MDS Software		4,722					
See Supplemental Schedule			213,409					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 307,571				Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,067

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

