FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0031765

Facility Name: Briar Place Ltd.

Address: 6800 W Joliet Road (Number) | Indian Head Pk (City) | 60525 (Zip Code)

County: Cook

Telephone Number: (708) 246-8500 **Fax #** (708) 246-0086

HFS ID Number:

Date of Initial License for Current Owners: 11/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,560	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,699	610	2,456	29,765	8
9	SNF/PED					9
10	ICF	43,686	998	2,333	47,017	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,385	1,608	4,789	76,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.67%

D. How many bed-hold days during this year were paid by the Department?
2,488 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/1986 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 1,792

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	414,660	52,179	14,063	480,902		480,902	7,717	488,619			1
2	Food Purchase		413,579		413,579		413,579	(187)	413,392			2
3	Housekeeping	242,766	62,619		305,385		305,385	474	305,859			3
4	Laundry	140,836	31,167		172,003		172,003		172,003			4
5	Heat and Other Utilities			195,691	195,691		195,691	1,677	197,368			5
6	Maintenance	233,819		173,925	407,744		407,744	9,539	417,283			6
7	Other (specify):*							3,991	3,991			7
8	TOTAL General Services	1,032,081	559,544	383,679	1,975,304		1,975,304	23,211	1,998,515			8
	B. Health Care and Programs											
9	Medical Director			14,088	14,088		14,088		14,088			9
10	Nursing and Medical Records	2,666,501	186,417	29,646	2,882,564		2,882,564	(19,853)	2,862,711			10
10a	Therapy	160,825			160,825		160,825		160,825			10a
11	Activities	146,148	13,134		159,282		159,282		159,282			11
12	Social Services	398,569	2,091	18,567	419,227		419,227	9,249	428,476			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							15,181	15,181			15
16	TOTAL Health Care and Programs	3,372,043	201,642	62,301	3,635,986		3,635,986	4,577	3,640,563			16
	C. General Administration											
17	Administrative	153,111			153,111		153,111	73,157	226,268			17
18	Directors Fees											18
19	Professional Services			591,747	591,747	(41,872)	549,875	(424,031)	125,844			19
20	Dues, Fees, Subscriptions & Promotions			46,463	46,463		46,463	405	46,868			20
21	Clerical & General Office Expenses	93,512	33,325	80,535	207,372		207,372	154,475	361,847			21
22	Employee Benefits & Payroll Taxes			792,138	792,138		792,138	(17,997)	774,141			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,051	3,051		3,051	3,075	6,126			24
25	Other Admin. Staff Transportation			2,671	2,671		2,671	671	3,342			25
26	Insurance-Prop.Liab.Malpractice			257,309	257,309		257,309	1,490	258,799			26
27	Other (specify):*							44,226	44,226			27
28	TOTAL General Administration	246,623	33,325	1,773,914	2,053,862	(41,872)	2,011,990	(164,530)	1,847,460			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,650,747	794,511	2,219,894	7,665,152	(41,872)	7,623,280	(136,742)	7,486,538			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 Briar Place Ltd. #0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			93,837	93,837		93,837	220,552	314,389			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,953	26,953		26,953	670,920	697,873			32
33	Real Estate Taxes			121,193	121,193	41,872	163,065	2,483	165,548			33
34	Rent-Facility & Grounds			942,630	942,630		942,630	(942,530)	100			34
35	Rent-Equipment & Vehicles			10,447	10,447		10,447	(2,053)	8,394			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,195,060	1,195,060	41,872	1,236,932	(50,627)	1,186,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,615	90,918	307,533		307,533	(5,235)	302,298			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			469,022	469,022		469,022		469,022			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		216,615	559,940	776,555		776,555	(5,235)	771,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,650,747	1,011,126	3,974,894	9,636,767		9,636,767	(192,605)	9,444,162			45

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	40,253	30		9
10	Interest and Other Investment Income	(13,419)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(86)	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	(1,560)	21		18
19	Entertainment				19
20	Contributions	(1,250)	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	(13,543)	21		24
25	Fund Raising, Advertising and Promotional	(254)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,567)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,818)	20		28
29	Other-Attach Schedule	(100,649)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,893)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	(95,712)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (95,712)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (192,605)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (5,393)	06	1
2	Vending Income	(450)	02	2
3	Theft Loss	(1,751)	21	3
4	Collections Expense	(2,448)	21	4
5	Pharmacy - Veterans	(81,228)	10	5
6	Building Co. - State Taxes	(213)	21	6
7	Non-Allowable Legal	(6,767)	19	7
8	PPA - Professional Services	(2,125)	19	8
9	Annual Report	(100)	20	9
10	Trust Fee	(175)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(100,649)		49

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			400		11,183		(3,866)					7,717	1
2	Food Purchase	(536)		385				(36)					(187)	2
3	Housekeeping			810		145			(481)				474	3
4	Laundry													4
5	Heat and Other Utilities			1,422		255							1,677	5
6	Maintenance	(5,393)		4,082	10,803	52			(5)				9,539	6
7	Other (specify):*				2,108	1,883							3,991	7
8	**TOTAL General Services**	(5,929)		7,099	12,911	13,518		(3,902)	(486)				23,211	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(81,228)				62,403		(870)	(159)				(19,853)	10
10a	Therapy													10a
11	Activities													11
12	Social Services					9,249							9,249	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					12,061	3,120						15,181	15
16	**TOTAL Health Care and Programs**	(81,228)				83,713	3,120	(870)	(159)				4,577	16
	C. General Administration													
17	Administrative			4,264	14,519	54,374							73,157	17
18	Directors Fees													18
19	Professional Services	(8,891)		(330,405)		(84,735)							(424,031)	19
20	Fees, Subscriptions & Promotions	(4,597)		4,774		228							405	20
21	Clerical & General Office Expenses	(23,082)	213	17,682	148,413	11,249							154,475	21
22	Employee Benefits & Payroll Taxes				(14,877)		(3,120)						(17,997)	22
23	Inservice Training & Education													23
24	Travel and Seminar			264		2,811							3,075	24
25	Other Admin. Staff Transportation			671									671	25
26	Insurance-Prop.Liab.Malpractice			1,270		220							1,490	26
27	Other (specify):*				33,878	10,348							44,226	27
28	**TOTAL General Administration**	(36,571)	213	(301,480)	181,933	(5,505)	(3,120)						(164,530)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,727)	213	(294,381)	194,844	91,726		(4,772)	(645)				(136,742)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	40,253	164,470	13,726		2,103							220,552	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,419)	671,998	11,674		667							670,920	32
33	Real Estate Taxes			2,105		378							2,483	33
34	Rent-Facility & Grounds		(942,530)										(942,530)	34
35	Rent-Equipment & Vehicles			5,202						(7,255)			(2,053)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	26,834	(106,062)	32,707		3,148				(7,255)			(50,627)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,075)	(241)	(6,679)		3,760	(5,235)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(2,075)	(241)	(6,679)		3,760	(5,235)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,893)	(105,849)	(261,674)	194,844	94,874		(6,847)	(886)	(13,934)		3,760	(192,605)	45

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 942,530	G W H Limited Partnership	100.00%	$	$ (942,530)	1
2	V	30	Depreciation Expense		G W H Limited Partnership	100.00%	164,470	164,470	2
3	V	32	Interest		G W H Limited Partnership	100.00%	671,998	671,998	3
4	V	21	State Taxes		G W H Limited Partnership	100.00%	213	213	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,530			$ 836,681	$ * (105,849)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 400	$ 400	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	385	385	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	810	810	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,422	1,422	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,082	4,082	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,264	4,264	20
21	V	19	Professional Fees	343,389	Extended Care Consulting, LLC	100.00%	7,971	(330,405)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	4,774	4,774	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	17,682	17,682	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	264	264	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	671	671	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,270	1,270	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	13,726	13,726	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,674	11,674	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,105	2,105	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	5,202	5,202	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 343,389			$ 76,702	$ * (261,674)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	10,803	$ 10,803	15
16	V	06	Maintenance (Direct)	1,313	Extended Care Consulting, LLC	100.00%	1,313		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,937	1,937	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	171	171	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	14,519	14,519	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	148,413	148,413	22
23	V	21	Office and Clerical (Direct)	33,871	Extended Care Consulting, LLC	100.00%	33,871		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	28,035	28,035	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,843	5,843	25
26	V	22	Employee Benefits	14,877	Extended Care Consulting, LLC	100.00%		(14,877)	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			$ 50,061			$ 244,905	$ * 194,844	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 145	$ 145	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	255	255	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	52	52	17
18	V	19	Professional Fees	112,788	Extended Care Clinical, LLC	100.00%	28,053	(84,735)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	228	228	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	4,146	4,146	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,811	2,811	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	220	220	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	2,103	2,103	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	667	667	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	378	378	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	11,183	11,183	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,883	1,883	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	62,403	62,403	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	9,249	9,249	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	12,061	12,061	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	54,374	54,374	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	7,103	7,103	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,348	10,348	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 112,788			$ 207,662	$ * 94,874	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing / Medical Record Salary	15,236	Extended Care Clinical, LLC	100.00%	15,236		17
18	V	12	Social Service / Admission Salary	9,567	Extended Care Clinical, LLC	100.00%	9,567		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,120	3,120	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	3,120	Extended Care Clinical, LLC	100.00%		(3,120)	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			$ 27,923			$ 27,923	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	$ 8,067	Care Centers Health Systems, Inc.	100.00%	$ 4,201	$ (3,866)	15
16	V	2	Food	75	Care Centers Health Systems, Inc.	100.00%	39	(36)	16
17	V	10	Nursing Supplies	1,815	Care Centers Health Systems, Inc.	100.00%	945	(870)	17
18	V	39	Ancillary Expense	4,330	Care Centers Health Systems, Inc.	100.00%	2,255	(2,075)	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			$ 14,287			$ 7,440	$ * (6,847)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	7,935	Xcel Supply, LLC	100.00%	7,454	(481)	16
17	V	4	Laundry		Xcel Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance	87	Xcel Supply, LLC	100.00%	82	(5)	18
19	V	10	Nursing	2,620	Xcel Supply, LLC	100.00%	2,461	(159)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	3,970	Xcel Supply, LLC	100.00%	3,730	(241)	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			$ 14,613			$ 13,727	$ * (886)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ventilator Equipment	8,601	Vent Lease LLC	100.00%	2,931	(5,670)	15
16	V	39	Other Ancillary	1,530	Vent Lease LLC	100.00%	521	(1,009)	16
17	V	35	Matrix Leasing	7,255	Vent Lease LLC	100.00%		(7,255)	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			$ 17,386			$ 3,452	$ * (13,934)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 234,557	$ 234,557	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	234,557	CCS Employee Benefits Group	100.00%		(234,557)	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			$ 234,557			$ 234,557	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 78,849	TriCare Rehab	100.00%	$ 82,609	$ 3,760	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			$ 78,849			$ 82,609	$ * 3,760	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	ARI WOLFF	2.857%	WHEATON CARE CENTER	WHEATON	G W H LIMITED PARTNERSHIP	EVANSTON	BUILDING CO.	1
2	CELESTE GIANNINI TRUST DTD 3/13/00	1.020%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	CHERYL MAGENCE	3.469%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	ERIC ROTHNER	31.429%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5	LAURI WOLFF POLEN	2.857%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6	LORRAINE SUISSA	10.204%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7	MARILYN WOLFF REVOCABLE TR DTD 1/89	11.837%	DYER NURSING & REHAB	DYER, IN	VENTLEASE, LLC	EVANSTON	VENTILATOR RENTAL	7
8	MARK STEINBERG	2.041%	GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSIDE	THERAPY	8
9	MARK SUISSA	10.204%	HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	9
10	MEYER MAGENCE	3.469%	HOMESTEAD NURSING & REHAB	LINCOLN, NE	HARBOR LIGHT	GLEN ELLYN	HOSPICE	10
11	MICHAEL R. GIANNINI TRUST DTD	1.020%	GOLDEN PLAINES	HUTCHINSON, KS				11
12	NOAH WOLFF REVOCABLE TR DTD 1/89	11.837%	LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				12
13	RANAN WOLFF	2.857%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				13
14	SHIRLEY DRELICH	2.041%	LANCASTER MANOR	LINCOLN, NE				14
15	TZIONA ZEFFREN	2.857%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				15
16			MCKINLEY HEALTH CARE CENTER	CANTON, OH				16
17			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				17
18			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				18
19			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				19
20			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				20
21			RAINBOW BEACH QOC, L.L.C.	CHICAGO				21
22			SEBOS NURSING & REHAB	HOBART, IN				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				24
25			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				25
26			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28								28
29								29
30								30

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.05	0.13%	Alloc. Salary	$ 183	17-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	5.05	5.76%	Al Sal/Al Fees	16,552	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	1.73	4.33%	Alloc. Salary	3,060	22-7	3
4	Noah Wolf	Relative	Administrative	0.00%	See Attached	3.00	15.00%	None			4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,795		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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,332,501	31	$ 6,942	$	76,782	$ 400	1
2	02	Food	Patient Days	1,332,501	31	6,677		76,782	385	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		76,782	810	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		76,782	1,422	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		76,782	4,082	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		76,782	4,264	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		76,782	7,971	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		76,782	4,774	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		76,782	17,682	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		76,782	264	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		76,782	671	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		76,782	1,270	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		76,782	13,726	13
14	32	Interest	Patient Days	1,332,501	31	202,602		76,782	11,674	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		76,782	2,105	15
16	34	Rent - Building	Patient Days	1,332,501	31			76,782		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		76,782	5,202	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 76,702	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,332,501	31	187,474	187,474	76,782	10,803	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		1,313	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		76,782	1,937	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			171	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	76,782	14,519	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	76,782	148,413	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		33,871	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		76,782	28,035	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			5,843	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					$ 4,298,198	$ 3,682,723		$ 244,905	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	817,528	19	$ 1,549	$	76,782	$ 145	1
2	05	Utilities	Patient Days	817,528	19	2,718		76,782	255	2
3	06	Maintenance	Patient Days	817,528	19	557		76,782	52	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		76,782	28,053	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		76,782	228	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		76,782	4,146	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		76,782	2,811	7
8	26	Insurance	Patient Days	817,528	19	2,346		76,782	220	8
9	30	Depreciation	Patient Days	817,528	19	22,389		76,782	2,103	9
10	32	Interest	Patient Days	817,528	19	7,100		76,782	667	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		76,782	378	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	76,782	11,183	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		76,782	1,883	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	76,782	62,403	14
15	10a	Rehab Salary	Patient Days	817,528	19			76,782		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	76,782	9,249	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		76,782	12,061	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	76,782	54,374	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	76,782	7,103	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		76,782	10,348	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 207,662	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		15,236	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		9,567	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			3,120	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 27,923	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 4,201	1
2	2	Food	Direct Allocation						39	2
3	10	Nursing Supplies	Direct Allocation						945	3
4	39	Ancillary Expense	Direct Allocation						2,255	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					$	$		$ 7,440	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						7,454	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation						82	4
5	10	Nursing	Direct Allocation						2,461	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						3,730	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					$	$		$ 13,727	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ventilator Equipment	Direct Allocation						2,931	1
2	39	Other Ancillary	Direct Allocation						521	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					$	$		$ 3,452	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 234,557	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					$	$		$ 234,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation			$	$		$ 82,609	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					$	$		$ 82,609	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	White Oak Nursing Center		X	Mortgage	$78,544.00	03/01/97	$ 7,441,383	$ 5,450,773	11/01/21	12.0000	$ 671,998	1
2	Auto Loan		X									2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Daiwa		X	Line of Credit				2,563,850			26,953	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$78,544.00		$ 7,441,383	$ 8,014,623			$ 698,951	9
	B. Non-Facility Related*											
10	Interest Income										(13,419)	10
11	Alloc. From Extended Care Consltg.		X								11,674	11
12	Alloc. From Extended Care Clinical		X								667	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,078)	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 8,014,623			$ 697,873	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

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

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

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 Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 324,300	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.)		$ 219,796	2
3. Under or (over) accrual (line 2 minus line 1).		$ (104,504)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 228,179	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.**		$ 41,872	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** $ 51,144 **For** 2008 **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.		$ 165,547	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	287,284	8
2007	292,840	9
2008	342,236	10
2009	308,829	11
2010	217,313	12

2011 Accrual = $217,313 x 1.05 = $228,179

Allocated from Extended Care Consulting, LLC = $2,105

Allocated from Extended Care Clinical, LLC = $378

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-20-102-035-0000	Long Term Care Property	$ 217,313.36	$ 217,313.36
2.	See Attached	2201 Main Allocation	$ 126,481.18	$ 3,465.82
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 343,794.54	$ 220,779.18

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,200 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Facility		1997	$ 402,869	1
2	Allocated from EC Consulting / EC Clinical 2201 Main			22,469	2
3	TOTALS			$ 425,338	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	232			1976	$ 6,414,314	$ 164,470	39	$ 164,470	$ (0)	$ 2,545,560	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20			4,987	9
10	Various			1987	138,915		20			138,076	10
11	Various			1988	9,885		20			9,822	11
12	Various			1989	5,410		20			5,410	12
13	Various			1990	42,578		20			42,575	13
14	Various			1991	11,813		20	92	92	11,811	14
15	Various			1992	11,426		20	571	571	11,042	15
16	Various			1993	8,851		20	21	21	8,851	16
17	Various			1994	25,632		20	1,282	1,282	22,131	17
18	Various			1995	50,028		20	2,501	2,501	41,395	18
19	Various			1996	161,111		20	8,056	8,056	120,150	19
20	Various			1997	165,320		20	8,266	8,266	122,559	20
21	Various			1998	189,177		20	9,459	9,459	128,641	21
22	Various			1999	21,736		20	1,070	1,070	13,361	22
23	Various			2000	122,845		20	6,114	6,114	70,253	23
24	Various			2001	51,096		20	2,555	2,555	27,053	24
25	Various			2002	68,816		20	5,955	5,955	63,689	25
26	Various			2003	117,820		20	10,123	10,123	89,607	26
27	Various			2004	41,864		20	2,719	2,719	29,007	27
28	Various			2005	50,621		20	3,062	3,062	37,710	28
29	Various			2006	89,874		20	8,903	8,903	59,082	29
30	Various			2007	96,414		20	12,901	12,901	60,680	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
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
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		90,994	6,185		6,185		49,337	68
69	Financial Statement Depreciation			93,837			(93,837)		69
70	TOTAL (lines 4 thru 69)		$ 7,991,540	$ 264,492		$ 254,303	$ (10,189)	$ 3,712,789	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$ 7,991,540	$ 264,492		$ 254,303	$ (10,189)	$ 3,712,789	1
2	New Pumping Unit	2008	15,685		20	1,569	1,569	5,620	2
3	New Flooring	2008	13,167		20	878	878	3,145	3
4	New Alarm Coding	2008	4,435		20	444	444	1,515	4
5	Painting (Transfer From Home Office)	2008	11,345		20			11,345	5
6	Painting (Transfer From Home Office)	2008	4,467		20			4,467	6
7	Actuator	2009	3,189		20	319	319	664	7
8	Water Heater	2009	6,481		20	1,296	1,296	2,700	8
9	Painting	2009	8,135		20	814	814	1,628	9
10	Painting	2009	7,418		20	742	742	1,484	10
11	Painting	2009	12,538		20	1,254	1,254	2,508	11
12	Painting	2009	24,546		20	2,454	2,454	4,908	12
13	Communication System - New Ceiling Assembly, Cables And Spea	2010	3,823		20	382	382	765	13
14	Communication System - Wiring For Matrix	2010	4,630		20	463	463	849	14
15	Communication System - Nurse Call Station Installation	2010	8,305		20	1,661	1,661	3,045	15
16	Multistack 150 Ton Chiller	2010	174,658		20	17,466	17,466	23,288	16
17	Hvac Repairs	2010	2,519		20	252	252	420	17
18	Painting (Transfer From Home Office)	2010	2,667		20	267	267	467	18
19	Painting (Transfer From Home Office)	2010	3,506		20	351	351	584	19
20	Hvac Repairs	2010	8,765		20	877	877	1,534	20
21	Repair Chiller Compressor	2010	4,435		20	444	444	739	21
22	Installation Of Smoke Dampers	2010	2,800		20	280	280	420	22
23	Repair Circulating Pump	2010	3,350		20	335	335	391	23
24	Water Heater	2011	6,710		20	671	671	671	24
25	Rebuild Air Handler	2011	3,500		20	583	583	583	25
26	Install Filter Housing On Recirculating Pumps	2011	4,700		20	627	627	627	26
27	Elevator Repairs	2011	2,776		20	116	116	116	27
28	Valve & Pump Repair	2011	4,435		20	185	185	185	28
29	Walk In Freezer Door	2011	3,600		20	60	60	60	29
30	Boiler Valve Repair	2011	2,617		20	22	22	22	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12B, Carried Forward		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	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
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17									17
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12C, Carried Forward		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12D, Carried Forward		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,350,742	$ 264,492		$ 289,112	$ 24,620	$ 3,787,539	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Building Company 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
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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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main,LLC	2002	26,251	673	39	673		6,254	3
4	Allocated from Extended Care Clinical 2201 Main,LLC	2002	4,714	121	39	121		1,123	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	265	13	20	13		66	9
10	Allocated from Extended Care Consulting, LLC	2009	158	8	20	8		24	10
11	Allocated from Extended Care Consulting, LLC	2010	1,555	78	20	78		155	11
12	Allocated from Extended Care Consulting, LLC	2011	560	28	20	28		28	12
13									13
14	Allocated from Extended Care Consulting 2201 Main,LLC	2002	21,685	1,982	20	1,982		15,873	14
15	Allocated from Extended Care Consulting 2201 Main,LLC	2003	25,555	2,335	20	2,335		18,706	15
16	Allocated from Extended Care Consulting 2201 Main,LLC	2005	1,270	135	20	135		728	16
17	Allocated from Extended Care Consulting 2201 Main,LLC	2009	229	11	20	11		34	17
18									18
19	Allocated from Extended Care Clinical 2201 Main,LLC	2002	3,894	356	20	356		2,850	19
20	Allocated from Extended Care Clinical 2201 Main,LLC	2003	4,589	419	20	419		3,359	20
21	Allocated from Extended Care Clinical 2201 Main,LLC	2005	228	24	20	24		131	21
22	Allocated from Extended Care Clinical 2201 Main,LLC	2009	41	2	20	2		6	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 Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	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
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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)		$ 90,994	$ 6,185		$ 6,185	$	$ 49,337	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 375,232	$ 1,435	$ 12,161	$ 10,726	10	$ 349,267	71
72	Current Year Purchases	72,536	6,869	7,779	910	10	56,447	72
73	Fully Depreciated Assets	1,914,532				10	1,914,532	73
74								74
75	TOTALS	$ 2,362,299	$ 8,304	$ 19,940	$ 11,636		$ 2,320,246	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		Autos - See Attached	2088	$ 122,319	$	$ 3,997	$ 3,997	5	$ 121,067	76
77		Allocated from Extended Care Cc	2011	1,447	289	289		5	1,158	77
78		Allocated from Extended Care Cc	2011	17,082				5	17,082	78
79		Allocated from Extended Care Cl	2011	5,250	1,050	1,050		5	3,500	79
80	TOTALS			$ 146,098	$ 1,339	$ 5,336	$ 3,997		$ 142,807	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)	$ 11,284,477	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 274,135	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 314,388	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 40,253	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,250,592	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Storage Rental				100			5
6								6
7	TOTAL				$ 100 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 8,394 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. STATE OF ILLINOIS # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,058			9,058	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			69,791			69,791	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				147,556		147,556	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					12,069	69,059		81,128	13
14	TOTAL			$		$ 90,918	$ 216,615		$ 307,533	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

STATE OF ILLINOIS

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 335,145	$ 335,310	1
2	Cash-Patient Deposits	39,436	39,436	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,496,537	3,496,537	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	353,777	353,777	6
7	Other Prepaid Expenses	3,141	3,141	7
8	Accounts Receivable (owners or related parties)	742,929	742,929	8
9	Other(specify): See Attached Schedule	180,425	180,425	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,151,390	$ 5,151,555	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,543,232	2,768,232	15
16	Equipment, at Historical Cost	1,241,526	1,241,526	16
17	Accumulated Depreciation (book methods)	(2,410,193)	(6,067,978)	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): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 374,565	$ 4,758,163	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,525,955	$ 9,909,718	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,032,653	$ 2,032,653	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,738	28,738	28
29	Short-Term Notes Payable	2,563,850	2,563,850	29
30	Accrued Salaries Payable	342,429	342,429	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,750	13,750	31
32	Accrued Real Estate Taxes(Sch.IX-B)	228,179	228,179	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	108,424	108,424	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,318,023	$ 5,318,023	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,450,773	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		220,320	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,671,093	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,318,023	$ 10,989,116	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 207,932	$ (1,079,398)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,525,955	$ 9,909,718	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (574,450)	1
2	Restatements (describe):		2
3	Rounding	(7)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (574,457)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,027,389	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	(245,000)	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)**	$ 782,389	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)**	$ 207,932	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,570,960	1
2	Discounts and Allowances for all Levels	(551,721)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,019,239	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,939	6
7	Oxygen	110	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 296,049	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	237,016	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,241	19
20	Radiology and X-Ray	1,340	20
21	Other Medical Services	24,258	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 283,855	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,419	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,419	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	51,594	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,594	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,664,156	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,975,304	31
32	Health Care	3,635,986	32
33	General Administration	2,053,862	33
	B. Capital Expense		
34	Ownership	1,195,060	34
	C. Ancillary Expense		
35	Special Cost Centers	307,533	35
36	Provider Participation Fee	469,022	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,636,767	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,027,389	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,027,389	43

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,020	2,193	$ 98,277	$ 44.81	1
2	Assistant Director of Nursing	1,868	2,098	80,363	38.30	2
3	Registered Nurses	15,716	17,151	547,552	31.93	3
4	Licensed Practical Nurses	34,111	37,427	897,176	23.97	4
5	CNAs & Orderlies	78,437	86,501	989,995	11.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,123	11,256	160,825	14.29	8
9	Activity Director	3,325	3,712	52,189	14.06	9
10	Activity Assistants	8,992	9,923	93,959	9.47	10
11	Social Service Workers	21,274	23,384	398,569	17.04	11
12	Dietician	1,685	1,961	35,466	18.09	12
13	Food Service Supervisor	1,948	2,161	47,381	21.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,479	7,327	111,618	15.23	15
16	Dishwashers	20,668	22,837	220,195	9.64	16
17	Maintenance Workers	15,962	17,730	233,819	13.19	17
18	Housekeepers	23,207	25,324	242,766	9.59	18
19	Laundry	10,878	11,999	140,836	11.74	19
20	Administrator	2,024	2,147	109,993	51.23	20
21	Assistant Administrator	1,763	2,064	43,118	20.89	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,478	5,932	93,512	15.76	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	1,913	2,126	35,861	16.87	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,148	1,253	17,277	13.79	33
34	TOTAL (lines 1 - 33)	269,019	296,506	$ 4,650,747 *	$ 15.69	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 14,063	01-03	35
36	Medical Director	Monthly	14,088	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,410	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatrist Consultant	Monthly	9,000	12-03	47
48	See Attached - Extended Care Allocation		24,803	See Attached	48
49	TOTAL (lines 35 - 48)	288	$ 76,364		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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

** See instructions.

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda M. Pyfer (01/01/2011-11/15/2011)	Administrator	0.00%	$ 88,210
Delnaz Vazidfar (11/16/2011-Present)	Administrator	0.00%	21,783
Kirsten Larsen (01/01/2011-05/18/2011)	Assist. Admin.	0.00%	16,239
Margaret Pylko (06/29/2011-07/27/2011)	Assist. Admin.	0.00%	4,788
Stephanie Rucker (08/10/2011-Present)	Assist. Admin.	0.00%	22,092
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 153,111

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 9,597
Frost, Ruttenberg, & Rothblatt	Accounting	25,100
Personnel Planners	Unemployment Consulting	4,400
Daiwa	Line of Credit Audit	23,297
Moshe Calmaro & Associates	Structural Engineering	2,474
Extended Care Consulting	Other Professional Services	5,013
Extended Care Consulting	Home Office Expense	338,376
Extended Care Clinical	Home Office Expense	112,788
Allen A. Lefkovitz & Assoc.	Real Estate Appraisal	41,872
Paycor	Payroll Services	15,794
AIS Assesment	MDS Consulting	2,248
See Supplemetal Schedule		10,789
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 591,748

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 159,245
Unemployment Compensation Insurance	69,443
FICA Taxes	348,890
Employee Health Insurance	178,792
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,443
Other Employee Welfare	8,486
Holiday Expense	3,843
TOTAL (agree to Schedule V, line 22, col.8)	$ 774,142

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	619
Health Care Worker Background Check	
(Indicate # of checks performed 173)	5,320
Patient Background Checks	
Licenses & Fees	9,044
Dues & Subscriptions	24,893
Advertising & Promotions	3,072
Extended Care Consulting Allocation	4,774
See Supplemental Schedule	228
Less: Public Relations Expense	( )
Non-allowable advertising	(254)
Yellow page advertising	(2,818)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,867

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,051
Extended Care Consulting Allocation	264
Extended Care Clinical Allocation	2,811
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,126

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place Ltd. **#** 0031765 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC: $22,562**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,283** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **469,022**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.