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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,704	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,912	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	27,462	363	3,938	31,763	8
9	SNF/PED					9
10	ICF	44,935	594	2,957	48,486	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,397	957	6,895	80,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.51%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 3,096

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: 12/31/2012 Fiscal Year: 12/31/2012

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

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	414,649	50,613	14,531	479,793		479,793	13,878	493,671			1
2	Food Purchase		470,108		470,108		470,108	744	470,852			2
3	Housekeeping	251,579	80,454		332,033		332,033	1,001	333,034			3
4	Laundry	108,748	27,342		136,090		136,090		136,090			4
5	Heat and Other Utilities			163,760	163,760		163,760	1,449	165,209			5
6	Maintenance	252,482		173,388	425,870		425,870	11,392	437,262			6
7	Other (specify):*							5,074	5,074			7
8	**TOTAL General Services**	1,027,458	628,517	351,679	2,007,654		2,007,654	33,538	2,041,192			8
	B. Health Care and Programs											
9	Medical Director			20,544	20,544		20,544		20,544			9
10	Nursing and Medical Records	2,761,911	199,942	14,525	2,976,378		2,976,378	(12,862)	2,963,516			10
10a	Therapy	185,752		377	186,129		186,129		186,129			10a
11	Activities	154,685	8,032		162,717		162,717		162,717			11
12	Social Services	405,980	8,453	750	415,183		415,183	37,653	452,836			12
13	CNA Training											13
14	Program Transportation			625	625		625		625			14
15	Other (specify):*							21,803	21,803			15
16	**TOTAL Health Care and Programs**	3,508,328	216,427	36,821	3,761,576		3,761,576	46,594	3,808,170			16
	C. General Administration											
17	Administrative	151,232			151,232		151,232	145,018	296,250			17
18	Directors Fees											18
19	Professional Services			623,334	623,334	(20,417)	602,917	(492,656)	110,261			19
20	Dues, Fees, Subscriptions & Promotions			46,631	46,631		46,631	(1,759)	44,872			20
21	Clerical & General Office Expenses	112,473	32,946	212,608	358,027		358,027	76,961	434,988			21
22	Employee Benefits & Payroll Taxes			771,490	771,490		771,490	(6,778)	764,712			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,722	6,722		6,722	2,898	9,620			24
25	Other Admin. Staff Transportation			7,542	7,542		7,542	1,383	8,925			25
26	Insurance-Prop.Liab.Malpractice			273,365	273,365		273,365	2,579	275,944			26
27	Other (specify):*							59,419	59,419			27
28	**TOTAL General Administration**	263,705	32,946	1,941,692	2,238,343	(20,417)	2,217,926	(212,935)	2,004,992			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,799,491	877,890	2,330,192	8,007,573	(20,417)	7,987,156	(132,803)	7,854,353			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: 01/01/12 Ending: 12/31/12

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			84,037	84,037		84,037	220,408	304,445			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,371	53,371		53,371	664,310	717,681			32
33	Real Estate Taxes			466,162	466,162	20,417	486,579	4,596	491,175			33
34	Rent-Facility & Grounds			956,309	956,309		956,309	(954,000)	2,309			34
35	Rent-Equipment & Vehicles			3,666	3,666		3,666	1,323	4,989			35
36	Other (specify):*											36
37	TOTAL Ownership			1,563,545	1,563,545	20,417	1,583,962	(63,362)	1,520,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		315,395	166,850	482,245		482,245	(7,141)	475,104			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			581,430	581,430		581,430		581,430			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		315,395	748,280	1,063,675		1,063,675	(7,141)	1,056,534			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,799,491	1,193,285	4,642,017	10,634,793		10,634,793	(203,306)	10,431,487			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	41,779	30		9
10	Interest and Other Investment Income	(28,344)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	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				18
19	Entertainment				19
20	Contributions	(275)	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	(108,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,202)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(129,290)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (227,387)		$	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)	24,081		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,081		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (203,306)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (4,500)	06	1
2	Other Income	(2,497)	21	2
3	Jury Duty Income	(17)	21	3
4	Patient Clothing	(34)	10	4
5	Theft Loss	(2,000)	21	5
6	Collection Expense	(4,475)	21	6
7	Pharmacy - Veterans	(106,759)	10	7
8	Bldg Co. - Miscellaneous Expense	(275)	21	8
9	Non Allowable Legal	(4,219)	19	9
10	PPA - R&M	(11)	06	10
11	COPE Dues	(4,504)	20	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**	(129,290)		49

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			418		16,391	(2,931)						13,878	1
2	Food Purchase	(55)		799									744	2
3	Housekeeping			798		203							1,001	3
4	Laundry													4
5	Heat and Other Utilities			1,155		294							1,449	5
6	Maintenance	(4,511)		4,574	11,238	91							11,392	6
7	Other (specify):*				2,359	2,715							5,074	7
8	**TOTAL General Services**	(4,566)		7,744	13,597	19,694	(2,931)						33,538	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(106,793)				93,967	(36)						(12,862)	10
10a	Therapy													10a
11	Activities													11
12	Social Services					37,653							37,653	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					21,803							21,803	15
16	**TOTAL Health Care and Programs**	(106,793)				153,423	(36)						46,594	16
	C. General Administration													
17	Administrative			4,941	23,140	116,937							145,018	17
18	Directors Fees													18
19	Professional Services	(4,219)		(327,874)		(160,563)							(492,656)	19
20	Fees, Subscriptions & Promotions	(7,981)		6,058		164							(1,759)	20
21	Clerical & General Office Expenses	(117,264)	275	20,679	162,424	10,847							76,961	21
22	Employee Benefits & Payroll Taxes				(6,778)								(6,778)	22
23	Inservice Training & Education													23
24	Travel and Seminar			371		2,527							2,898	24
25	Other Admin. Staff Transportation			1,383									1,383	25
26	Insurance-Prop.Liab.Malpractice			1,632		947							2,579	26
27	Other (specify):*				38,853	20,566							59,419	27
28	**TOTAL General Administration**	(129,464)	275	(292,810)	217,639	(8,575)							(212,935)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(240,822)	275	(285,066)	231,236	164,542	(2,968)						(132,803)	29

STATE OF ILLINOIS **Summary B**

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

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	41,779	164,470	11,614		2,545							220,408	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(28,344)	637,688	7,222		47,744							664,310	32
33	Real Estate Taxes			3,663		933							4,596	33
34	Rent-Facility & Grounds		(954,000)										(954,000)	34
35	Rent-Equipment & Vehicles			1,786				(463)					1,323	35
36	Other (specify):*													36
37	**TOTAL Ownership**	13,435	(151,842)	24,285		51,222		(463)					(63,362)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,465)	(5,356)	(310)		(11)		(7,141)	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**						(1,465)	(5,356)	(310)		(11)		(7,141)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(227,387)	(151,567)	(260,781)	231,236	215,764	(4,432)	(5,819)	(310)		(11)		(203,306)	45

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

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	$ 954,000	G W H Limited Partnership	100.00%	$	$ (954,000)	1
2	V	21	Miscellaneous Admin Expense		G W H Limited Partnership	100.00%	275	275	2
3	V	30	Depreciation		G W H Limited Partnership	100.00%	164,470	164,470	3
4	V	32	Interest		G W H Limited Partnership	100.00%	637,688	637,688	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			$ 954,000			$ 802,433	$ * (151,567)	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: 01/01/12 Ending: 12/31/12

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%	$ 418	$ 418	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	799	799	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	798	798	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,155	1,155	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,574	4,574	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,941	4,941	20
21	V	19	Professional Fees	334,860	Extended Care Consulting, LLC	100.00%	6,986	(327,874)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	6,058	6,058	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	20,679	20,679	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	371	371	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,383	1,383	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,632	1,632	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	11,614	11,614	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,222	7,222	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,663	3,663	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%	1,786	1,786	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 334,860			$ 74,079	$ * (260,781)	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: 01/01/12 Ending: 12/31/12

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%	10,689	$ 10,689	15
16	V	06	Maintenance (Direct)	1,183	Extended Care Consulting, LLC	100.00%	1,732	549	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,964	1,964	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	395	395	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	23,140	23,140	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	162,424	162,424	22
23	V	21	Office and Clerical (Direct)	20,862	Extended Care Consulting, LLC	100.00%	20,862		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	34,094	34,094	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,759	4,759	25
26	V	22	Employee Benefits	6,778	Extended Care Consulting, LLC	100.00%		(6,778)	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			$ 28,823			$ 260,059	$ * 231,236	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: 01/01/12 Ending: 12/31/12

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%	$ 203	$ 203	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	294	294	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	91	91	17
18	V	19	Professional Fees	164,928	Extended Care Clinical, LLC	100.00%	4,365	(160,563)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	164	164	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	3,628	3,628	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,527	2,527	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	947	947	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	2,545	2,545	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	47,744	47,744	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	933	933	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	16,391	16,391	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	2,715	2,715	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	93,967	93,967	28
29	V								29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	37,653	37,653	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	21,803	21,803	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	116,937	116,937	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	7,219	7,219	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	20,566	20,566	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 164,928			$ 380,692	$ * 215,764	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: 01/01/12 Ending: 12/31/12

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	$ 10,469	Care Centers Health Systems, Inc.	100.00%	$ 7,538	$ (2,931)	15
16	V	10	Nursing Supplies	130	Care Centers Health Systems, Inc.	100.00%	94	(36)	16
17	V	39	Ancillary Expense	5,231	Care Centers Health Systems, Inc.	100.00%	3,766	(1,465)	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			$ 15,830			$ 11,398	$ * (4,432)	39

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

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

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	2,850	Vent Lease LLC	100.00%	1,227	$ (1,623)	15
16	V	39	Other Ancillary	6,555	Vent Lease LLC	100.00%	2,822	(3,733)	16
17	V	35	Matrix Leasing	463	Vent Lease LLC	100.00%		(463)	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			$ 9,868			$ 4,049	$ * (5,819)	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: 01/01/12 Ending: 12/31/12

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	$ 177,482	Tri Care Rehab	100.00%	$ 177,172	$ (310)	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			$ 177,482			$ 177,172	$ * (310)	39

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

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

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%	$ 198,958	$ 198,958	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	198,958	CCS Employee Benefits Group	100.00%		(198,958)	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			$ 198,958			$ 198,958	$ *	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: 01/01/12 Ending: 12/31/12

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	Ancillary Expense	1,201	Reliable Medical of the Midwest, LLC	100.00%	1,190	$ (11)	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			$ 1,201			$ 1,190	$ * (11)	39

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

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

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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	Adam Vales	Relative	Clerical	0.00%	See Attached	1.71	4.28%	Alloc. Salary	$ 3,121	22-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	5.31	9.65%	Al Sal/Al Fees	18,458	17-7	2
3	Noah Wolff	Relative	Administrative	0.00%	See Attached	2.00	8.00%	None			3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 21,579		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: 01/01/12 Ending: 12/31/12

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

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	1,364,178	31	$ 7,101	$	80,249	$ 418	1
2	02	Food	Patient Days	1,364,178	31	13,586		80,249	799	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		80,249	798	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		80,249	1,155	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		80,249	4,574	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		80,249	4,941	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		80,249	6,986	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		80,249	6,058	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		80,249	20,679	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		80,249	371	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		80,249	1,383	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		80,249	1,632	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		80,249	11,614	13
14	32	Interest	Patient Days	1,364,178	31	122,765		80,249	7,222	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		80,249	3,663	15
16	34	Rent - Building	Patient Days	1,364,178	31			80,249		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		80,249	1,786	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 74,079	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,364,178	31	181,713	181,713	80,249	10,689	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754		1,732	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		80,249	1,964	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137			395	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	80,249	23,140	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	80,249	162,424	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		20,862	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		80,249	34,094	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			4,759	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					$ 4,679,511	$ 3,961,379		$ 260,059	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	611,520	14	$ 1,549	$	80,249	$ 203	1
2	05	Utilities	Patient Days	611,520	14	2,241		80,249	294	2
3	06	Maintenance	Patient Days	611,520	14	691		80,249	91	3
4	19	Professional Fees	Patient Days	611,520	14	33,266		80,249	4,365	4
5	20	Dues and Subscriptions	Patient Days	611,520	14	1,249		80,249	164	5
6	21	Office & Clerical	Patient Days	611,520	14	27,644		80,249	3,628	6
7	24	Travel and Seminar	Patient Days	611,520	14	19,257		80,249	2,527	7
8	26	Insurance	Patient Days	611,520	14	7,216		80,249	947	8
9	30	Depreciation	Patient Days	611,520	14	19,393		80,249	2,545	9
10	32	Interest	Patient Days	611,520	14	363,826		80,249	47,744	10
11	33	Real Estate Taxes	Patient Days	611,520	14	7,106		80,249	933	11
12	01	Dietary Salary	Patient Days	611,520	14	124,907	124,907	80,249	16,391	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	611,520	14	20,691		80,249	2,715	13
14	10	Nursing Salary	Patient Days	611,520	14	716,058	716,058	80,249	93,967	14
15										15
16	12	Social Service Salary	Patient Days	611,520		286,925	286,925	80,249	37,653	16
17	15	Emp. Ben. - Healthcare	Patient Days	611,520		166,142		80,249	21,803	17
18	17	Administration Salary	Patient Days	611,520		891,091	891,091	80,249	116,937	18
19	21	Office Salary	Patient Days	611,520		55,009	55,009	80,249	7,219	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	611,520		156,720		80,249	20,566	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,900,982	$ 2,073,990		$ 380,692	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 7,538	1
2	10	Nursing Supplies	Direct Allocation						94	2
3	39	Ancillary Expense	Direct Allocation						3,766	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					$	$		$ 11,398	25

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

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						1,227	1
2	39	Other Ancillary	Direct Allocation						2,822	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					$	$		$ 4,049	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 177,172	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					$	$		$ 177,172	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 198,958	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					$	$		$ 198,958	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
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	39	Ancillary Expense	Direct Allocation						1,190	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					$	$		$ 1,190	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

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	$ 5,145,930	11/01/21	12.0000	$ 637,688	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Daiwa		X	Line of Credit							53,371	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$78,544.00		$ 7,441,383	$ 5,145,930			$ 691,059	9
	B. Non-Facility Related*											
10	Interest Income		X								(28,344)	10
11	Alloc. From Extended Care Consltg.		X								7,222	11
12	Alloc. From Extended Care Clinical		X								47,744	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 26,622	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 5,145,930			$ 717,681	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: 01/01/12 Ending: 12/31/12

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 228,179	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.)		$ 343,299	2
3. Under or (over) accrual (line 2 minus line 1).		$ 115,120	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 355,638	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.**		$ 20,417	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 $ For 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.		$ 491,175	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	292,840	8
	2008	342,236	9
	2009	308,829	10
	2010	217,313	11
	2011	338,703	12

2012 Accrual = $338,703 x 1.05

Allocated from Extended Care Consulting, LLC = $3,663

Allocated from Extended Care Clinical, LLC = $933

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 338,702.77	$ 338,702.77
2.	See Attached	2201 Main Allocation	$ 127,119.67	$ 3,651.49
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 465,822.44	$ 342,354.26

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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: 01/01/12 Ending: 12/31/12

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			23,554	2
3	TOTALS			$ 426,423	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

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)	$ 2,710,030	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			11,811	14
15	Various			1992	11,426		20	381	381	11,423	15
16	Various			1993	8,851		20			8,851	16
17	Various			1994	25,632		20	1,282	1,282	23,413	17
18	Various			1995	50,028		20	2,501	2,501	43,896	18
19	Various			1996	161,111		20	8,056	8,056	128,205	19
20	Various			1997	165,320		20	8,266	8,266	130,825	20
21	Various			1998	189,177		20	9,459	9,459	138,100	21
22	Various			1999	21,736		20	1,070	1,070	14,431	22
23	Various			2000	122,845		20	6,114	6,114	76,367	23
24	Various			2001	51,096		20	2,555	2,555	29,608	24
25	Various			2002	68,816		20	3,476	3,476	67,165	25
26	Various			2003	117,820		20	10,123	10,123	99,730	26
27	Various			2004	41,864		20	2,642	2,642	31,649	27
28	Various			2005	50,621		20	3,062	3,062	40,772	28
29	Various			2006	89,874		20	6,688	6,688	65,770	29
30	Various			2007	96,414		20	8,133	8,133	68,813	30
31	Various			2008	49,099		20	2,890	2,890	28,983	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: 01/01/12 Ending: 12/31/12

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
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		95,501	6,490		6,490		58,202	68
69	Financial Statement Depreciation			84,037			(84,037)		69
70	TOTAL (lines 4 thru 69)		$ 8,045,146	$ 254,997		$ 247,657	$ (7,340)	$ 3,988,914	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: 01/01/12 Ending: 12/31/12

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		$ 8,045,146	$ 254,997		$ 247,657	$ (7,340)	$ 3,988,914	1
2	Actuator	2009	3,189		20	319	319	983	2
3	Water Heater	2009	6,481		20	1,296	1,296	3,997	3
4	Painting	2009	8,135		20	814	814	3,254	4
5	Painting	2009	7,418		20	742	742	2,905	5
6	Painting	2009	12,538		20	1,254	1,254	4,806	6
7	Painting	2009	24,546		20	2,455	2,455	7,568	7
8	Communication System - New Ceiling Assembly, Cables And Spea	2010	3,823		20	382	382	1,147	8
9	Communication System - Wiring For Matrix	2010	4,630		20	463	463	1,312	9
10	Communication System - Nurse Call Station Installation	2010	8,305		20	1,661	1,661	4,706	10
11	Multistack 150 Ton Chiller	2010	174,658		20	17,466	17,466	40,754	11
12	Hvac Repairs	2010	2,519		20	252	252	672	12
13	Painting (Transfer From Home Office)	2010	2,667		20	267	267	733	13
14	Painting (Transfer From Home Office)	2010	3,506		20	351	351	935	14
15	Hvac Repairs	2010	8,765		20	877	877	2,410	15
16	Repair Chiller Compressor	2010	4,435		20	444	444	1,183	16
17	Installation Of Smoke Dampers	2010	2,800		20	280	280	700	17
18	Repair Circulating Pump	2010	3,350		20	335	335	726	18
19	Water Heater	2011	6,710		20	671	671	1,342	19
20	Rebuild Air Handler	2011	3,500		20	700	700	1,283	20
21	Install Filter Housing On Recirculating Pumps	2011	4,700		20	940	940	1,567	21
22	Elevator Repairs	2011	2,776		20	278	278	393	22
23	Valve & Pump Repair	2011	4,435		20	444	444	628	23
24	Walk In Freezer Door	2011	3,600		20	360	360	420	24
25	Boiler Valve Repair	2011	2,617		20	131	131	153	25
26	Piping & Valves	2012	16,928		20	1,693	1,693	1,693	26
27	Boiler Repair	2012	4,500		20	150	150	150	27
28	Install Surplus Ats	2012	5,635		20	376	376	376	28
29	Concrete Patio-Walkway & Drainage Pipe	2012	12,500		20	416	416	416	29
30	Addt'L Concrete Work & Soding	2012	5,600		20	186	186	186	30
31	Replacement Of 2 Boilers	2012	126,500		20	4,217	4,217	4,217	31
32	Piping Insulation	2012	4,015		20	33	33	33	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	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: 01/01/12 Ending: 12/31/12

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		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	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: 01/01/12 Ending: 12/31/12

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		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	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: 01/01/12 Ending: 12/31/12

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		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,530,926	$ 254,997		$ 287,907	$ 32,910	$ 4,080,563	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: 01/01/12 Ending: 12/31/12

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

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
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

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

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	25,873	663	39	663		6,828	3
4	Allocated from Extended Care Clinical 2201 Main,LLC	2002	6,586	169	39	169		1,738	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	271	14	20	14		81	9
10	Allocated from Extended Care Consulting, LLC	2009	162	8	20	8		32	10
11	Allocated from Extended Care Consulting, LLC	2010	1,587	79	20	79		238	11
12	Allocated from Extended Care Consulting, LLC	2011	571	29	20	29		57	12
13	Allocated from Extended Care Consulting, LLC	2012	188	9	20	9		9	13
14									14
15	Allocated from Extended Care Consulting 2201 Main,LLC	2002	21,373	1,953	20	1,953		17,598	15
16	Allocated from Extended Care Consulting 2201 Main,LLC	2003	25,187	2,302	20	2,302		20,739	16
17	Allocated from Extended Care Consulting 2201 Main,LLC	2005	1,251	133	20	133		850	17
18	Allocated from Extended Care Consulting 2201 Main,LLC	2009	226	11	20	11		45	18
19									19
20	Allocated from Extended Care Clinical 2201 Main,LLC	2002	5,440	497	20	497		4,480	20
21	Allocated from Extended Care Clinical 2201 Main,LLC	2003	6,411	586	20	586		5,279	21
22	Allocated from Extended Care Clinical 2201 Main,LLC	2005	318	34	20	34		216	22
23	Allocated from Extended Care Clinical 2201 Main,LLC	2009	57	3	20	3		12	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: 01/01/12 Ending: 12/31/12

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
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 95,501	$ 6,490		$ 6,490	$	$ 58,202	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: 01/01/12 Ending: 12/31/12

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	$ 366,319	$ 1,506	$ 9,739	$ 8,233	10	$ 340,076	71
72	Current Year Purchases	63,015	3,264	3,264		10	59,942	72
73	Fully Depreciated Assets	1,938,205				10	1,938,205	73
74								74
75	TOTALS	$ 2,367,539	$ 4,770	$ 13,003	$ 8,233		$ 2,338,223	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	various	$ 122,319	$	$ 637	$ 637	5	$ 121,704	76
77		Allocated from Extended Care Cc	2012	9,117	1,823	1,823		5	9,117	77
78		Allocated from Extended Care Cl	2012	6,742	1,074	1,074		5	644	78
79										79
80	TOTALS			$ 138,178	$ 2,897	$ 3,534	$ 637		$ 131,465	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)	$ 11,463,067	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 262,664	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 304,443	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,779	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,550,251	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: 01/01/12 Ending: 12/31/12

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				2,309			5
6								6
7	TOTAL				$ 2,309 **			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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 4,989 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: 01/01/12 Ending: 12/31/12

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

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	39 - 03	hrs	$		$ 31,070	$		$ 31,070	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			26,974			26,974	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			119,436			119,436	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				202,986		202,986	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					(10,563)	115,005		104,442	13
14	TOTAL			$		$ 166,917	$ 317,991		$ 484,908	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: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 4,018	$ 14,922	1
2	Cash-Patient Deposits	43,644	43,644	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,307,228	1,307,228	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	309,076	309,076	6
7	Other Prepaid Expenses	1,992	1,992	7
8	Accounts Receivable (owners or related parties)	794,308	794,308	8
9	Other(specify): See Attached Schedule	726,313	726,313	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,186,579	$ 3,197,483	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	1,714,417	1,714,417	15
16	Equipment, at Historical Cost	1,241,527	2,466,527	16
17	Accumulated Depreciation (book methods)	(2,494,230)	(6,316,485)	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)**	$ 461,714	$ 4,680,842	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,648,293	$ 7,878,325	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,233,292	$ 2,233,292	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,919	43,919	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	359,669	359,669	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,250	16,250	31
32	Accrued Real Estate Taxes(Sch.IX-B)	355,638	355,638	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			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,008,768	$ 3,008,768	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,145,930	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)**	$	$ 5,366,250	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,008,768	$ 8,375,018	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 639,525	$ (496,693)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,648,293	$ 7,878,325	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 207,932	1
2	Restatements (describe):		2
3	Rounding	10	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 207,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	481,583	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	(50,000)	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)**	$ 431,583	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)**	$ 639,525	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,046,827	1
2	Discounts and Allowances for all Levels	(990,863)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,055,964	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	688,493	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 688,493	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	296,748	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,253	19
20	Radiology and X-Ray	2,180	20
21	Other Medical Services	21,880	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 341,061	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,344	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,514	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,514	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,116,376	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,007,654	31
32	Health Care	3,761,576	32
33	General Administration	2,238,343	33
	B. Capital Expense		
34	Ownership	1,563,545	34
	C. Ancillary Expense		
35	Special Cost Centers	482,245	35
36	Provider Participation Fee	581,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,634,793	40
41	**Income before Income Taxes (line 30 minus line 40)****	481,583	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 481,583	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,039,617	44
45	Private Pay - Net Inpatient Revenue	156,583	45
46	Medicare - Net Inpatient Revenue	299,104	46
47	Other-(specify) Hospice	108,570	47
48	Other-(specify) Veterans, Insurance	452,090	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,055,964	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,014	2,193	$ 104,612	$ 47.70	1
2	Assistant Director of Nursing	1,842	2,047	81,095	39.62	2
3	Registered Nurses	17,063	18,510	605,469	32.71	3
4	Licensed Practical Nurses	33,167	36,311	895,203	24.65	4
5	CNAs & Orderlies	75,821	83,359	1,013,138	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,175	11,442	185,752	16.23	8
9	Activity Director	3,912	4,255	64,888	15.25	9
10	Activity Assistants	9,274	9,979	89,797	9.00	10
11	Social Service Workers	21,127	23,165	405,980	17.53	11
12	Dietician	1,518	1,716	32,195	18.76	12
13	Food Service Supervisor	1,773	2,031	45,877	22.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,229	7,066	109,993	15.57	15
16	Dishwashers	21,358	23,267	226,584	9.74	16
17	Maintenance Workers	17,302	18,968	252,482	13.31	17
18	Housekeepers	23,175	25,392	251,579	9.91	18
19	Laundry	8,587	9,423	108,748	11.54	19
20	Administrator	2,031	2,100	108,996	51.90	20
21	Assistant Administrator	1,812	1,927	42,236	21.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,273	6,978	112,473	16.12	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	1,832	2,069	35,632	17.22	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,809	1,964	26,762	13.63	33
34	TOTAL (lines 1 - 33)	268,094	294,162	$ 4,799,491 *	$ 16.32	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	312	$ 14,531	01-03	35
36	Medical Director	Monthly	20,544	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,525	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	377	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatrist Consultant	Monthly	750	12-03	47
48					48
49	TOTAL (lines 35 - 48)	320	$ 50,727		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Delnaz Vazidfar	Administrator	0.00%	$ 108,996
Stephanie Rucker	Asst. Admin	0.00%	42,236
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 151,232

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
Frost, Ruttenberg & Rothblatt	Accounting	$ 29,117
Extended Care Consulting	Home Office Expense	164,928
Extended Care Clinical	Home Office Expense	334,860
Personnel Planners	Unemployment Consult.	5,150
Paycor	Payroll Services	14,782
Pro Payroll Solutions	Payroll Services	8,845
AIS Assesment	MDS Consulting	1,343
E-Health Data Solutions	MDS Software	3,180
Ability Network	Medicare Billing	1,624
National Datacare Corporation	Resident Fund Processing	3,949
See Attached	Legal	22,543
See Supplemetal Schedule		33,014
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 623,335

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 150,558
Unemployment Compensation Insurance	91,401
FICA Taxes	362,899
Employee Health Insurance	145,181
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,221
Other Employee Welfare	5,720
Holdiay Expense	3,732
TOTAL (agree to Schedule V, line 22, col.8)	$ 764,712

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 148)	3,467
Patient Background Checks	
Dues & Subscriptions	17,160
Licenses & Fees	18,023
Allocated from EC Consulting	6,058
Allocated from EC Clinical	164
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,872

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,723
Allocated from EC Consulting	371
Allocated from EC Clinical	2,527
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,621

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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: $20,068**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,515** 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. $ **581,430**
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.