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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0031765

Facility Name: Briar Place

Address: 6800 West Joliet (Number) | Indian Head Park (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: 11/1/1986

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,356	610	3,657	31,623	8
9	SNF/PED					9
10	ICF	44,763	999	2,788	48,550	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,119	1,609	6,445	80,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.68%

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 2,863

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	429,932	57,318	15,552	502,802		502,802	8,266	511,068			1
2	Food Purchase		491,425		491,425		491,425	1,065	492,490			2
3	Housekeeping	280,978	74,090		355,068		355,068	1,034	356,102			3
4	Laundry	56,834	31,312		88,146		88,146		88,146			4
5	Heat and Other Utilities			215,219	215,219		215,219	2,263	217,482			5
6	Maintenance	254,023		241,109	495,132		495,132	15,507	510,639			6
7	Other (specify):*							2,278	2,278			7
8	TOTAL General Services	1,021,767	654,145	471,880	2,147,792		2,147,792	30,413	2,178,205			8
	B. Health Care and Programs											
9	Medical Director			17,489	17,489		17,489		17,489			9
10	Nursing and Medical Records	2,687,285	229,246	105,259	3,021,790		3,021,790	(16,761)	3,005,029			10
10a	Therapy	222,846		93	222,939		222,939		222,939			10a
11	Activities	168,265	11,642		179,907		179,907		179,907			11
12	Social Services	378,069	7,989		386,058		386,058	33,413	419,471			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,234	12,234			15
16	TOTAL Health Care and Programs	3,456,465	248,877	122,841	3,828,183		3,828,183	28,886	3,857,069			16
	C. General Administration											
17	Administrative	175,759			175,759		175,759	151,191	326,950			17
18	Directors Fees											18
19	Professional Services			697,294	697,294	(43,967)	653,327	(515,488)	137,839			19
20	Dues, Fees, Subscriptions & Promotions			53,164	53,164		53,164	(15,173)	37,991			20
21	Clerical & General Office Expenses	106,429	34,139	317,106	457,674		457,674	11,066	468,740			21
22	Employee Benefits & Payroll Taxes			812,632	812,632		812,632	(6,517)	806,115			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,053	5,053		5,053	2,685	7,738			24
25	Other Admin. Staff Transportation			5,940	5,940		5,940	2,198	8,138			25
26	Insurance-Prop.Liab.Malpractice			311,085	311,085		311,085	3,253	314,338			26
27	Other (specify):*							60,039	60,039			27
28	TOTAL General Administration	282,188	34,139	2,202,274	2,518,601	(43,967)	2,474,634	(306,747)	2,167,888			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,760,420	937,161	2,796,995	8,494,576	(43,967)	8,450,609	(247,448)	8,203,162			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 #0031765 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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			87,568	87,568		87,568	220,617	308,185			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							586,896	586,896			32
33	Real Estate Taxes			292,080	292,080	43,967	336,047	5,042	341,089			33
34	Rent-Facility & Grounds			955,200	955,200		955,200	(954,000)	1,200			34
35	Rent-Equipment & Vehicles			14,781	14,781		14,781	1,292	16,073			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,349,629	1,349,629	43,967	1,393,596	(140,153)	1,253,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		224,311	438,244	662,555		662,555	(31,175)	631,380			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			594,622	594,622		594,622		594,622			42
43	Other (specify):*	14,153			14,153		14,153	(14,153)				43
44	**TOTAL Special Cost Centers**	14,153	224,311	1,032,866	1,271,330		1,271,330	(45,328)	1,226,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,774,573	1,161,472	5,179,490	11,115,535		11,115,535	(432,929)	10,682,606			45

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	46,764	30		9
10	Interest and Other Investment Income	(73,972)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	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	(60)	21		18
19	Entertainment				19
20	Contributions	(1,774)	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	(207,441)	21		24
25	Fund Raising, Advertising and Promotional	(2,825)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,338)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(148,680)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (399,424)		$	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)	(33,505)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,505)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (432,929)		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

STATE OF ILLINOIS **Page 5A**

Briar Place

ID# 0031765

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (52)	10	1
2	Patient Clothing	(243)	10	2
3	Theft Loss	(27)	21	3
4	Collection Expense	(6,081)	21	4
5	Veterans Expense	(90,226)	10	5
6	Bldg Co. - Management Fees	(3,063)	17	6
7	Bldg Co. - Misc Admin Expense	(305)	21	7
8	Bldg Co. - Bank Service Charge	(35)	21	8
9	Marketing Salary	(14,153)	43	9
10	PAC Dues	(13,860)	20	10
11	Out of Period Fees	(1,879)	21	11
12	Non Allowable Legal Fees	(11,965)	19	12
13	Capitalized R&M	(6,791)	06	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**	(148,680)		49

Briar Place

ID# 0031765

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			260		8,006							8,266	1
2	Food Purchase	(98)		1,163									1,065	2
3	Housekeeping			870		164							1,034	3
4	Laundry													4
5	Heat and Other Utilities			1,962		301							2,263	5
6	Maintenance	(6,791)		8,097	13,953	248							15,507	6
7	Other (specify):*				1,364	914							2,278	7
8	**TOTAL General Services**	(6,889)		12,352	15,317	9,633							30,413	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(90,521)				73,760							(16,761)	10
10a	Therapy													10a
11	Activities													11
12	Social Services					33,413							33,413	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					12,234							12,234	15
16	**TOTAL Health Care and Programs**	(90,521)				119,407							28,886	16
	C. General Administration													
17	Administrative	(3,063)	3,063	5,381	29,094	116,716							151,191	17
18	Directors Fees													18
19	Professional Services	(11,965)		(375,002)		(128,521)							(515,488)	19
20	Fees, Subscriptions & Promotions	(18,459)		2,859		427							(15,173)	20
21	Clerical & General Office Expenses	(227,165)	340	19,575	170,711	47,605							11,066	21
22	Employee Benefits & Payroll Taxes				(6,517)				(0)				(6,517)	22
23	Inservice Training & Education													23
24	Travel and Seminar			448		2,237							2,685	24
25	Other Admin. Staff Transportation			2,198									2,198	25
26	Insurance-Prop.Liab.Malpractice			2,362		891							3,253	26
27	Other (specify):*				41,562	18,477							60,039	27
28	**TOTAL General Administration**	(260,653)	3,403	(342,179)	234,850	57,832			(0)				(306,747)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(358,063)	3,403	(329,827)	250,167	186,872			(0)				(247,448)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	46,764	164,470	7,280		2,103							220,617	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(73,972)	599,615	1,666		59,587							586,896	32
33	Real Estate Taxes			4,243		799							5,042	33
34	Rent-Facility & Grounds		(954,000)										(954,000)	34
35	Rent-Equipment & Vehicles			1,292									1,292	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(27,208)	(189,915)	14,481		62,489							(140,153)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(841)	(30,334)					(31,175)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(14,153)											(14,153)	43
44	**TOTAL Special Cost Centers**	(14,153)					(841)	(30,334)					(45,328)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(399,424)	(186,512)	(315,346)	250,167	249,361	(841)	(30,334)	(0)				(432,929)	45

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	17	Management Fees		G. W. H. Limited Partnership	100.00%	3,063	3,063	2
3	V	21	Misc Admin Expense		G. W. H. Limited Partnership	100.00%	305	305	3
4	V	21	Bank Service Charge		G. W. H. Limited Partnership	100.00%	35	35	4
5	V	30	Depreciation		G. W. H. Limited Partnership	100.00%	164,470	164,470	5
6	V	32	Interest		G. W. H. Limited Partnership	100.00%	599,615	599,615	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			$ 767,488	$ * (186,512)	14

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 260	$ 260	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	1,163	1,163	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	870	870	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,962	1,962	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	8,097	8,097	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	5,381	5,381	20
21	V	19	Professional Fees	390,348	Extended Care Consulting, LLC	100.00%	15,346	(375,002)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,859	2,859	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	19,575	19,575	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	448	448	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	2,198	2,198	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,362	2,362	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	7,280	7,280	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,666	1,666	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,243	4,243	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,292	1,292	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			$ 390,348			$ 75,002	$ * (315,346)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	13,953	$ 13,953	15
16	V	06	Maintenance (Direct)	384	Extended Care Consulting, LLC	100.00%	384		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,324	1,324	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	40	40	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	29,094	29,094	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	170,711	170,711	22
23	V	21	Office and Clerical (Direct)	21,339	Extended Care Consulting, LLC	100.00%	21,339		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	36,802	36,802	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,760	4,760	25
26	V	22	Employee Benefits	6,517	Extended Care Consulting, LLC	100.00%		(6,517)	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			$ 28,240			$ 278,407	$ * 250,167	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 164	$ 164	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	301	301	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	248	248	17
18	V	19	Professional Fees	130,116	Extended Care Clinical, LLC	100.00%	1,595	(128,521)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	427	427	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,461	2,461	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,237	2,237	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	891	891	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	2,103	2,103	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	59,587	59,587	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	799	799	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,006	8,006	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	914	914	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	73,760	73,760	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	33,413	33,413	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	12,234	12,234	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	116,716	116,716	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	45,144	45,144	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	18,477	18,477	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,116			$ 379,477	$ * 249,361	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Various Equipment	9,445	Vent Lease LLC	100.00%	8,604	$ (841)	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			$ 9,445			$ 8,604	$ * (841)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 425,708	Tri Care Rehab	100.00%	$ 395,373	$ (30,334)	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			$ 425,708			$ 395,373	$ * (30,334)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 259,472	$ 259,472	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	259,472	CCS Employee Benefits Group	100.00%		(259,472)	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			$ 259,472			$ 259,472	$ * (0)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 4,696	Care Centers Health Systems, Inc.	100.00%	$ 4,696	$	15
16	V	39	Ancillary Expense	900	Care Centers Health Systems, Inc.	100.00%	900		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			$ 5,596			$ 5,596	$ *	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.**

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.**

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	G. W. H. LIMITED PARTNERSHIP		BUILDING CO.	1
2	CELESTE GIANNINI TRUST DTD 3/13/00	1.020%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKK	2
3	CHERYL MAGENCE	3.469%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	ERIC ROTHNER	31.429%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPP	4
5	LAURI WOLFF POLEN	2.857%	GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	LORRAINE SUISSA	10.204%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7	MARILYN WOLFF REVOCABLE TR DTD 1/89	11.837%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	TRICARE REHAB	HILLSIDE	THERAPY	7
8	MARK STEINBERG	2.041%	MAJOR HOSPITAL DYER	DYER, IN	HARBOR LIGHT	GLEN ELLYN	HOSPICE	8
9	MARK SUISSA	10.204%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	9
10	MEYER MAGENCE	3.469%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN	RELIABLE MEDICAL	DES PLAINES	MEDICAL SUPPLIES	10
11	MICHAEL R. GIANNINI TRUST DTD	1.020%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12	NOAH WOLFF REVOCABLE TR DTD 1/89	11.837%	MAJOR HOSPITAL SEBOS	HOBART, IN				12
13	RANAN WOLFF	2.857%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14	SHIRLEY DRELICH	2.041%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15	TZIONA ZEFFREN	2.857%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			WHEATON CARE CENTER	WHEATON				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2.23	5.58%	Alloc. Salary	$ 4,131	22-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	4.72	8.58%	Al Sal/Al Fees	17,156	17-7	2
3											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	$ 21,287		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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	$ 4,057	$	80,173	$ 260	1
2	02	Food	Patient Days	1,251,572	31	18,150		80,173	1,163	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		80,173	870	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		80,173	1,962	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		80,173	8,097	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		80,173	5,381	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		80,173	15,346	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		80,173	2,859	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		80,173	19,575	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		80,173	448	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		80,173	2,198	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		80,173	2,362	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		80,173	7,280	13
14	32	Interest	Patient Days	1,251,572	31	26,010		80,173	1,666	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		80,173	4,243	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		80,173	1,292	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 75,002	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	217,811	217,811	80,173	13,953	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		384	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		80,173	1,324	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			40	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	80,173	29,094	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	80,173	170,711	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		21,339	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		80,173	36,802	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			4,760	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					$ 4,662,721	$ 3,975,053		$ 278,407	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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	758,409	19	$ 1,549	$	80,173	$ 164	1
2	05	Utilities	Patient Days	758,409	19	2,849		80,173	301	2
3	06	Maintenance	Patient Days	758,409	19	2,348		80,173	248	3
4	19	Professional Fees	Patient Days	758,409	19	15,090		80,173	1,595	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042		80,173	427	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285		80,173	2,461	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158		80,173	2,237	7
8	26	Insurance	Patient Days	758,409	19	8,431		80,173	891	8
9	30	Depreciation	Patient Days	758,409	19	19,889		80,173	2,103	9
10	32	Interest	Patient Days	758,409	19	563,670		80,173	59,587	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558		80,173	799	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	80,173	8,006	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645		80,173	914	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	80,173	73,760	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	80,173	33,413	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731		80,173	12,234	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	80,173	116,716	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	80,173	45,144	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785		80,173	18,477	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,589,719	$ 2,620,691		$ 379,477	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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	Various Equipment	Direct Allocation						8,604	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					$	$		$ 8,604	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 240 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			$	$		$ 395,373	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					$	$		$ 395,373	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 259,472	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					$	$		$ 259,472	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 4,696	1
2	39	Ancillary Expense	Direct Allocation						900	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					$	$		$ 5,596	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	White Oak Nursing Center		X	Mortgage	$78,544.00	03/01/97	$ 7,441,383	$ 4,380,966	11/1/21	12.0000	$ 599,615	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$78,544.00		$ 7,441,383	$ 4,380,966			$ 599,615	9
	B. Non-Facility Related*											
10	Interest Income		X								(73,972)	10
11	Allocated from EC Consulting	X									1,666	11
12	Allocated from EC Clinical	X									59,587	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,719)	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 4,380,966			$ 586,896	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.)**

**** 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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 168,867	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.)		$ 370,383	2
3. Under or (over) accrual (line 2 minus line 1).		$ 201,516	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 95,606	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.)**		$ 43,967	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.		$ 341,089	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	308,829	8
	2010	217,313	9
	2011	338,703	10
	2012	352,195	11
	2013	365,341	12

Beginning Accrual Adjusted to include 1st Installment paid Prior Year, and reduce it by an early paymen
Allocated from Extended Care Consulting, LLC = $4,243
Allocated from Extended Care Clinical, LLC = $799

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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	$ 365,341.32	$ 365,341.32
2.	See Attached	2201 Main Allocation	$ 162,082.08	$ 4,802.16
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 527,423.40	$ 370,143.48

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			24,295	2
3	TOTALS			$ 427,164	3

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		1997	1976	$ 6,414,314	$ 164,470	39	$ 164,470	$ (0)	$ 3,038,970	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20			5,000	9
10	Various			1987	138,915		20			138,915	10
11	Various			1988	9,885		20			9,885	11
12	Various			1989	5,410		20			5,410	12
13	Various			1990	42,578		20			42,578	13
14	Various			1991	11,813		20			11,813	14
15	Various			1992	11,426		20			11,426	15
16	Various			1993	8,851		20			8,851	16
17	Various			1994	25,632		20	759	759	25,453	17
18	Various			1995	50,028		20	2,500	2,500	48,898	18
19	Various			1996	161,111		20	8,056	8,056	144,316	19
20	Various			1997	165,320		20	8,266	8,266	147,357	20
21	Various			1998	189,177		20	9,459	9,459	157,018	21
22	Various			1999	21,736		20	1,070	1,070	16,572	22
23	Various			2000	122,845		20	6,114	6,114	88,596	23
24	Various			2001	51,096		20	2,555	2,555	34,717	24
25	Various			2002	68,816		20	315	315	68,088	25
26	Various			2003	117,820		20	1,846	1,846	104,480	26
27	Various			2004	41,864		20	1,677	1,677	35,969	27
28	Various			2005	50,621		20	3,062	3,062	46,896	28
29	Various			2006	89,874		20	6,688	6,688	79,145	29
30	Various			2007	96,414		20	6,382	6,382	81,577	30
31	Various			2008	49,099		20	2,890	2,890	34,763	31
32	Various			2009	62,307		20	6,771	6,771	37,163	32
33	Various			2010	219,458		20	22,776	22,776	100,830	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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)		106,173	6,706		6,706		73,467	68
69	Financial Statement Depreciation			87,568			(87,568)		69
70	TOTAL (lines 4 thru 69)		$ 8,337,582	$ 258,744		$ 262,362	$ 3,618	$ 4,598,153	70

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 8,337,582	$ 258,744		$ 262,362	$ 3,618	$ 4,598,153	1
2	Water Heater	2011	6,710		20	671	671	2,684	2
3	Rebuild Air Handler	2011	3,500		20	700	700	2,683	3
4	Install Filter Housing On Recirculating Pumps	2011	4,700		20	940	940	3,447	4
5	Elevator Repairs	2011	2,776		20	278	278	948	5
6	Valve & Pump Repair	2011	4,435		20	444	444	1,515	6
7	Walk In Freezer Door	2011	3,600		20	360	360	1,140	7
8	Boiler Valve Repair	2011	2,617		20	131	131	414	8
9	Piping & Valves	2012	16,928		20	1,693	1,693	5,078	9
10	Boiler Repair	2012	4,500		20	225	225	600	10
11	Install Surplus Ats	2012	5,635		20	564	564	1,503	11
12	Concrete Patio-Walkway & Drainage Pipe	2012	12,500		20	834	834	2,084	12
13	Addt'L Concrete Work & Soding	2012	5,600		20	374	374	934	13
14	Replacement Of 2 Boilers	2012	126,500		20	12,650	12,650	29,517	14
15	Piping Insulation	2012	4,015		20	402	402	836	15
16	Cubicle Curtains	2013	11,033		20	2,207	2,207	3,494	16
17	New Ramp	2013	19,800		20	1,980	1,980	2,640	17
18	Cooling Tower Repairs	2013	6,646		20	665	665	831	18
19	Sealcoating	2013	6,200		20	620	620	775	19
20	Water Heater	2013	7,722		20	772	772	901	20
21	Railings For New Ramp	2013	10,800		20	2,160	2,160	2,340	21
22	Elevator Solid State Doors	2014	23,640		20	1,084	1,084	1,084	22
23	161 Lineal Ft Fencing	2014	10,779		20	419	419	419	23
24	Fencing	2014	16,146		20	359	359	359	24
25	Install Oil Cooler In Two Hydraulic Elevators	2014	12,770		20	213	213	213	25
26	East & West Stairway Structural Work	2014	23,400		20	98	98	98	26
27	South Elevator Power Supply & Transformer	2014	6,791		20	340	340	340	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	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)		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	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)		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	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)		$ 8,697,326	$ 258,744		$ 293,540	$ 34,796	$ 4,665,028	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main,LLC	2002	28,174	722	39	722		8,880	3
4	Allocated from Extended Care Clinical 2201 Main,LLC	2002	5,305	136	39	136		1,672	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting, LLC	2007	295	15	20	15		118	9
10	Allocated from Extended Care Consulting, LLC	2009	176	9	20	9		53	10
11	Allocated from Extended Care Consulting, LLC	2010	1,728	86	20	86		432	11
12	Allocated from Extended Care Consulting, LLC	2011	622	31	20	31		125	12
13	Allocated from Extended Care Consulting, LLC	2012	205	10	20	10		31	13
14	Allocated from Extended Care Consulting, LLC	2014	2,841	142	20	142		142	14
15									15
16	Allocated from Extended Care Consulting 2201 Main,LLC	2002	23,274	1,984	20	1,984		23,274	16
17	Allocated from Extended Care Consulting 2201 Main,LLC	2003	27,427	2,338	20	2,338		27,427	17
18	Allocated from Extended Care Consulting 2201 Main,LLC	2005	1,363	145	20	145		1,215	18
19	Allocated from Extended Care Consulting 2201 Main,LLC	2009	246	12	20	12		74	19
20	Allocated from Extended Care Consulting 2201 Main,LLC	2014	3,927	196	20	196		196	20
21									21
22	Allocated from Extended Care Clinical 2201 Main,LLC	2002	4,383	374	20	374		4,383	22
23	Allocated from Extended Care Clinical 2201 Main,LLC	2003	5,165	440	20	440		5,165	23
24	Allocated from Extended Care Clinical 2201 Main,LLC	2005	257	27	20	27		229	24
25	Allocated from Extended Care Clinical 2201 Main,LLC	2009	46	2	20	2		14	25
26	Allocated from Extended Care Clinical 2201 Main,LLC	2014	739	37	20	37		37	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 106,173	$ 6,706		$ 6,706	$	$ 73,467	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 106,173	$ 6,706		$ 6,706	$	$ 73,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 106,173	$ 6,706		$ 6,706	$	$ 73,467	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 346,855	$ 789	$ 9,719	$ 8,930	10	$ 316,607	71
72	Current Year Purchases	54,882	474	3,512	3,038	10	3,512	72
73	Fully Depreciated Assets	1,994,667				10	1,994,667	73
74								74
75	TOTALS	$ 2,396,405	$ 1,263	$ 13,231	$ 11,968		$ 2,314,787	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	$	$	$	5	$ 122,319	76
77		Allocated from Extended Care C	2014	11,560	327	327		5	10,254	77
78		Allocated from Extended Care C	2012	5,431	1,086	1,086		5	2,692	78
79										79
80	TOTALS			$ 139,310	$ 1,413	$ 1,413	$		$ 135,265	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)	$ 11,660,204	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 261,420	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,184	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 46,764	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,115,080	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 # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				1,200			5
6								6
7	TOTAL				$ 1,200 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,211 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	Facility	Toyota	$ 655.17	$ 7,862	17
18					18
19					19
20					20
21	TOTAL		$ 655.17	$ 7,862	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.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 197,488	$		$ 197,488	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			15,405			15,405	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			215,906			215,906	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				178,652		178,652	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					9,445	45,659		55,104	13
14	TOTAL			$		$ 438,244	$ 224,311		$ 662,555	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.

STATE OF ILLINOIS

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 538,166	$ 538,166	1
2	Cash-Patient Deposits	43,025	43,025	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,501,080	1,501,080	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	283,339	283,339	6
7	Other Prepaid Expenses	12,917	12,917	7
8	Accounts Receivable (owners or related parties)	740,458	740,458	8
9	Other(specify):	424,781	541,552	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,543,766	$ 3,660,537	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	19,800	6,434,114	14
15	Leasehold Improvements, at Historical Cost	1,836,573	1,836,573	15
16	Equipment, at Historical Cost	1,283,400	2,508,400	16
17	Accumulated Depreciation (book methods)	(2,661,039)	(6,812,234)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 478,734	$ 4,368,922	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,022,500	$ 8,029,459	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,057,486	$ 2,303,983	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,438	42,438	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	377,356	377,356	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,073	19,073	31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,955	95,606	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,673,308	$ 2,838,456	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,380,966	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			220,320	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,601,286	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,673,308	$ 7,439,742	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,349,192	$ 589,717	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,022,500	$ 8,029,459	48

*(See instructions.)

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 736,472	1
2	Restatements (describe):		2
3	**Prior year bad debt adjustment**	(5,761)	3
4	**Rounding**	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 730,713	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	916,634	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	(298,155)	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)**	$ 618,479	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)**	$ 1,349,192	24 *

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 11,872,995	1
2	Discounts and Allowances for all Levels	(1,882,337)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,990,658	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,654,136	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,654,136	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	272,553	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,653	19
20	Radiology and X-Ray	1,656	20
21	Other Medical Services	30,489	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 313,351	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73,972	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73,972	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	52	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,032,169	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,147,792	31
32	Health Care	3,828,183	32
33	General Administration	2,518,601	33
	B. Capital Expense		
34	Ownership	1,349,629	34
	C. Ancillary Expense		
35	Special Cost Centers	676,708	35
36	Provider Participation Fee	594,622	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,115,535	40
41	**Income before Income Taxes (line 30 minus line 40)****	916,634	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 916,634	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,121,600	44
45	Private Pay - Net Inpatient Revenue	282,721	45
46	Medicare - Net Inpatient Revenue	8,492	46
47	Other-(specify) Hospice	234,972	47
48	Other-(specify) Veteran, Insurance	342,873	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,990,658	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.**

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2,021	2,205	$ 112,056	$ 50.82	1
2	Assistant Director of Nursing	1,178	1,331	50,131	37.66	2
3	Registered Nurses	19,793	21,940	728,088	33.19	3
4	Licensed Practical Nurses	32,630	35,777	926,831	25.91	4
5	CNAs & Orderlies	55,899	61,511	803,203	13.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,272	13,537	222,846	16.46	8
9	Activity Director	3,213	3,476	57,631	16.58	9
10	Activity Assistants	11,558	12,364	110,634	8.95	10
11	Social Service Workers	20,273	22,220	378,069	17.01	11
12	Dietician					12
13	Food Service Supervisor	1,782	2,077	49,783	23.97	13
14	Head Cook	1,761	1,910	38,076	19.94	14
15	Cook Helpers/Assistants	6,463	7,308	120,651	16.51	15
16	Dishwashers	20,083	21,811	221,422	10.15	16
17	Maintenance Workers	19,513	20,917	254,023	12.14	17
18	Housekeepers	24,092	26,789	280,978	10.49	18
19	Laundry	5,092	5,652	56,834	10.06	19
20	Administrator	2,095	2,118	119,241	56.30	20
21	Assistant Administrator	2,004	2,034	56,518	27.79	21
22	Other Administrative					22
23	Office Manager	1,888	2,069	56,719	27.41	23
24	Clerical	3,954	4,394	49,710	11.31	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	1,830	2,092	38,607	18.45	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,579	2,906	42,521	14.63	33
34	TOTAL (lines 1 - 33)	251,973	276,438	$ 4,774,572 *	$ 17.27	34

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

** See instructions.

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	310	$ 15,552	01-03	35
36	Medical Director	Monthly	17,489	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,512	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	93	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	312	$ 49,646		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	9	376	10-03	51
52	Certified Nurse Assistants/Aides	3,472	88,371	10-03	52
53	TOTAL (lines 50 - 52)	3,481	$ 88,747		53

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Delnaz Vazidfar	Administrator	0.00%	$ 119,241
Debra Rembert	Asst. Admin	0.00%	56,518
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,759

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	$ 49,705
Netrix	Accounting	622
Extended Care Consulting	Home Office Expense	390,348
Extended Care Clinical	Home Office Expense	130,116
Personnel Planners	Unemployment Consultant	4,775
Pro Payroll Solutions	Payroll Processing	24,998
E-Health Data Solutions	MDS Software	2,385
AIS Assessment	MDS Consulting	1,329
Ability Network	Medicare Billing	1,854
National Datacare Corporation	Resident Fund Processing	3,014
Plante & Moran	Accounting	703
See Supplemental Schedule		87,445
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 697,294

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,609
Unemployment Compensation Insurance	93,783
FICA Taxes	363,278
Employee Health Insurance	203,762
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	15,773
Other Employee Welfare	9,115
Holiday Expense	2,795
TOTAL (agree to Schedule V, line 22, col.8)	$ 806,115

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,597
Health Care Worker Background Check	
(Indicate # of checks performed 243)	3,227
Patient Background Checks	
Dues & Subscriptions	12,875
Licenses & Fees	12,006
Allocated from EC Consulting	2,859
Allocated from EC Clinical	427
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,991

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,053
Allocated from EC Consulting	448
Allocated from EC Clinical	2,237
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,738

**See instructions.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. **ICLTC $21,692 ; Alliance of Healthcare $775**

(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. $ **16,608** 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. $ **594,622**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.