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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0031765

Facility Name: Briar Place Ltd.

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1986

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	27,280		4,015	31,295	8
9	SNF/PED					9
10	ICF	44,299	1,160	2,068	47,527	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,579	1,160	6,083	78,822	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.08%

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 2,033

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	442,254	73,732	15,126	531,112		531,112	14,710	545,822			1
2	Food Purchase		502,511		502,511		502,511	622	503,133			2
3	Housekeeping	298,929	78,505		377,434		377,434	2,028	379,462			3
4	Laundry	75,795	51,091	3,180	130,066		130,066		130,066			4
5	Heat and Other Utilities			197,391	197,391		197,391	3,049	200,440			5
6	Maintenance	264,114		293,192	557,306		557,306	2,814	560,120			6
7	Other (specify):*							8,090	8,090			7
8	**TOTAL General Services**	1,081,092	705,839	508,889	2,295,820		2,295,820	31,313	2,327,133			8
	B. Health Care and Programs											
9	Medical Director			22,512	22,512		22,512		22,512			9
10	Nursing and Medical Records	2,785,219	215,114	264,965	3,265,298		3,265,298	19,674	3,284,972			10
10a	Therapy	271,720			271,720		271,720		271,720			10a
11	Activities	163,960	22,454		186,414		186,414		186,414			11
12	Social Services	443,514	6,120		449,634		449,634	41,228	490,862			12
13	CNA Training											13
14	Program Transportation			556	556		556		556			14
15	Other (specify):*							14,138	14,138			15
16	**TOTAL Health Care and Programs**	3,664,413	243,688	288,033	4,196,134		4,196,134	75,040	4,271,174			16
	C. General Administration											
17	Administrative	176,010			176,010		176,010	144,843	320,853			17
18	Directors Fees											18
19	Professional Services			672,083	672,083	(54,891)	617,192	(520,790)	96,402			19
20	Dues, Fees, Subscriptions & Promotions			94,914	94,914		94,914	(17,246)	77,668			20
21	Clerical & General Office Expenses	76,386	31,092	446,805	554,283		554,283	(125,653)	428,630			21
22	Employee Benefits & Payroll Taxes			882,535	882,535		882,535	(17,330)	865,205			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,618	7,618		7,618	2,408	10,026			24
25	Other Admin. Staff Transportation			9,267	9,267		9,267	2,239	11,506			25
26	Insurance-Prop.Liab.Malpractice			237,358	237,358		237,358	3,178	240,536			26
27	Other (specify):*							56,681	56,681			27
28	**TOTAL General Administration**	252,396	31,092	2,350,580	2,634,068	(54,891)	2,579,177	(471,670)	2,107,507			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,997,901	980,619	3,147,502	9,126,022	(54,891)	9,071,131	(365,318)	8,705,814			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 Ltd. #0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			87,226	87,226		87,226	217,920	305,146			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5	5		5	499,788	499,793			32
33	Real Estate Taxes			346,650	346,650	54,891	401,541	8,054	409,595			33
34	Rent-Facility & Grounds			955,200	955,200		955,200	(954,000)	1,200			34
35	Rent-Equipment & Vehicles			11,042	11,042		11,042	1,336	12,378			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,400,123	1,400,123	54,891	1,455,014	(226,902)	1,228,111			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,259	494,846	649,105		649,105	(514)	648,591			39
40	Barber and Beauty Shops			180	180		180		180			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			586,687	586,687		586,687		586,687			42
43	Other (specify):*	8,223			8,223		8,223	(8,223)				43
44	**TOTAL Special Cost Centers**	8,223	154,259	1,081,713	1,244,195		1,244,195	(8,737)	1,235,458			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,006,124	1,134,878	5,629,338	11,770,340		11,770,340	(600,957)	11,169,383			45

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(20,148)	30		9
10	Interest and Other Investment Income	(17,126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(73)	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	(33)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(339,066)	21		24
25	Fund Raising, Advertising and Promotional	(8,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,014)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(120,600)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (507,616)		$	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)	(93,341)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (93,341)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (600,957)		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

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (257)	10	1
2	Collection Expense	(5,588)	21	2
3	Theft Loss	(240)	21	3
4	Veterans Expense	(50,307)	10	4
5	Lobbying	(1,288)	21	5
6	Marketing Salary	(8,223)	43	6
7	Additional R&M	1,438	06	7
8	Bldg Co. - Management Fees	(12,250)	17	8
9	Bldg Co. - Misc Admin Expense	(355)	21	9
10	Non-Allowable Legal Fees	(10,160)	19	10
11	Capitalized R&M	(22,748)	06	11
12	PAC Dues	(10,622)	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(120,600)		49

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			261		14,449							14,710	1
2	Food Purchase	(73)		695									622	2
3	Housekeeping			1,832		196							2,028	3
4	Laundry													4
5	Heat and Other Utilities			2,777		272							3,049	5
6	Maintenance	(21,310)		7,990	15,930	204							2,814	6
7	Other (specify):*				6,264	1,826							8,090	7
8	**TOTAL General Services**	(21,383)		13,555	22,194	16,947							31,313	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(50,564)				70,664				(426)			19,674	10
10a	Therapy													10a
11	Activities													11
12	Social Services					41,228							41,228	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					14,138							14,138	15
16	**TOTAL Health Care and Programs**	(50,564)				126,030				(426)			75,040	16
	C. General Administration													
17	Administrative	(12,250)	12,250	4,993	27,936	111,914							144,843	17
18	Directors Fees													18
19	Professional Services	(10,160)		(381,524)		(129,106)							(520,790)	19
20	Fees, Subscriptions & Promotions	(19,177)		1,637		294							(17,246)	20
21	Clerical & General Office Expenses	(348,584)	355	20,438	167,318	34,820							(125,653)	21
22	Employee Benefits & Payroll Taxes				(17,330)								(17,330)	22
23	Inservice Training & Education													23
24	Travel and Seminar			562		1,846							2,408	24
25	Other Admin. Staff Transportation			2,239									2,239	25
26	Insurance-Prop.Liab.Malpractice			2,284		894							3,178	26
27	Other (specify):*				38,457	18,224							56,681	27
28	**TOTAL General Administration**	(390,171)	12,605	(349,371)	216,381	38,886							(471,670)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(462,119)	12,605	(335,816)	238,575	181,863				(426)			(365,318)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(20,148)	233,248	3,620		1,200							217,920	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,126)	502,010	14,561		343							499,788	32
33	Real Estate Taxes			7,298		756							8,054	33
34	Rent-Facility & Grounds		(954,000)										(954,000)	34
35	Rent-Equipment & Vehicles			1,336									1,336	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(37,274)	(218,742)	26,815		2,299							(226,902)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(514)			(514)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(8,223)											(8,223)	43
44	**TOTAL Special Cost Centers**	(8,223)								(514)			(8,737)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(507,616)	(206,137)	(309,001)	238,575	184,162				(940)			(600,957)	45

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	33	Rental Income - Property Taxes	182,975	G. W. H. Limited Partnership	100.00%	182,975		2
3	V	21	Misc Admin Expense		G. W. H. Limited Partnership	100.00%	355	355	3
4	V	17	Management Fees		G. W. H. Limited Partnership	100.00%	12,250	12,250	4
5	V	30	Depreciation		G. W. H. Limited Partnership	100.00%	233,248	233,248	5
6	V	32	Interest		G. W. H. Limited Partnership	100.00%	502,010	502,010	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,136,975			$ 930,838	$ * (206,137)	14

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 261	$ 261	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	695	695	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,832	1,832	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,777	2,777	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	7,990	7,990	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,993	4,993	20
21	V	19	Professional Fees	390,348	Extended Care Consulting, LLC	100.00%	8,824	(381,524)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,637	1,637	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	20,438	20,438	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	562	562	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	2,239	2,239	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,284	2,284	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,620	3,620	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	14,561	14,561	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	7,298	7,298	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,336	1,336	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			$ 81,347	$ * (309,001)	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	15,930	$ 15,930	15
16	V	06	Maintenance (Direct)	35,411	Extended Care Consulting, LLC	100.00%	35,411		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,371	1,371	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	4,893	4,893	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	27,936	27,936	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	167,318	167,318	22
23	V	21	Office and Clerical (Direct)	22,357	Extended Care Consulting, LLC	100.00%	22,357		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	33,519	33,519	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,938	4,938	25
26	V	22	Employee Benefits	17,330	Extended Care Consulting, LLC	100.00%		(17,330)	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			$ 75,098			$ 313,673	$ * 238,575	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 196	$ 196	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	272	272	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	204	204	17
18	V	19	Professional Fees	130,116	Extended Care Clinical, LLC	100.00%	1,010	(129,106)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	294	294	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,502	2,502	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,846	1,846	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	894	894	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,200	1,200	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	343	343	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	756	756	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	14,449	14,449	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,826	1,826	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	70,664	70,664	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	41,228	41,228	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	14,138	14,138	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	111,914	111,914	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	32,318	32,318	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	18,224	18,224	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,116			$ 314,278	$ * 184,162	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	15,520	Vent Lease LLC	100.00%	15,520	$	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			$ 15,520			$ 15,520	$ *	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 269,827	Tri Care Rehab	100.00%	$ 269,827	$	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			$ 269,827			$ 269,827	$ *	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 355,301	$ 355,301	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	355,301	CCS Employee Benefits Group	100.00%		(355,301)	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			$ 355,301			$ 355,301	$ *	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 32,264	MAC Rx, LLC	100.00%	$ 31,838	$ (426)	15
16	V	39	Ancillary	38,905	MAC Rx, LLC	100.00%	38,391	(514)	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			$ 71,169			$ 70,229	$ * (940)	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	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 CENTERS BUILDING LLC	EVANSTON	BLDG COMPANY	4
5	LAURI WOLFF POLEN	2.857%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTALATOR RENTAL	5
6	LORRAINE SUISSA	10.204%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRICARE REHAB	HILLSIDE	THERAPY	6
7	MARILYN WOLFF REVOCABLE TR DTD 1/89	11.837%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8	MARK STEINBERG	2.041%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9	MARK SUISSA	10.204%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL	DES PLAINES	MEDICAL SUPPLIES	9
10	MEYER MAGENCE	3.469%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				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			PARC AT JOLIET	JOLIET				25
26			SPRING CREEK	JOLIET				26
27			ESTATES OF HYDE PARK	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2.25	5.63%	Alloc. Salary	$ 3,812	22-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	4.54	8.25%	Al Sal/Al Fees	16,803	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	$ 20,615		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	78,822	$ 261	1
2	02	Food	Patient Days	1,326,152	31	11,689		78,822	695	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		78,822	1,832	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		78,822	2,777	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		78,822	7,990	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		78,822	4,993	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		78,822	8,824	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		78,822	1,637	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		78,822	20,438	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		78,822	562	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		78,822	2,239	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		78,822	2,284	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		78,822	3,620	13
14	32	Interest	Patient Days	1,326,152	31	244,990		78,822	14,561	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		78,822	7,298	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		78,822	1,336	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 81,347	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	78,822	15,930	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		35,411	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		78,822	1,371	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			4,893	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	78,822	27,936	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	78,822	167,318	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		22,357	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		78,822	33,519	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			4,938	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					$ 4,964,932	$ 4,280,758		$ 313,673	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	794,254	19	$ 1,974	$	78,822	$ 196	1
2	05	Utilities	Patient Days	794,254	19	2,745		78,822	272	2
3	06	Maintenance	Patient Days	794,254	19	2,053		78,822	204	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		78,822	1,010	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		78,822	294	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		78,822	2,502	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		78,822	1,846	7
8	26	Insurance	Patient Days	794,254	19	9,008		78,822	894	8
9	30	Depreciation	Patient Days	794,254	19	12,096		78,822	1,200	9
10	32	Interest	Patient Days	794,254	19	3,455		78,822	343	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		78,822	756	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	78,822	14,449	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		78,822	1,826	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	78,822	70,664	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	78,822	41,228	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		78,822	14,138	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	78,822	111,914	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	78,822	32,318	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		78,822	18,224	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 314,278	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						15,520	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					$	$		$ 15,520	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 269,827	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					$	$		$ 269,827	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 355,301	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					$	$		$ 355,301	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 31,838	1
2	39	Ancillary	Direct Allocation						38,391	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					$	$		$ 70,229	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	White Oak Nursing Center		X	Mortgage	$78,544.00	3/1/1997	$ 7,441,383	$ 3,979,197	11/1/2021	12.0000	$ 502,010	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest										5	6
7												7
8												8
9	TOTAL Facility Related				$78,544.00		$ 7,441,383	$ 3,979,197			$ 502,015	9
	B. Non-Facility Related*											
10	Interest Income		X								(17,126)	10
11	Allocated from EC Consulting										14,561	11
12	Allocated from EC Clinical										343	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,222)	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 3,979,197			$ 499,793	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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 121,218	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.)		$ 319,966	2
3. Under or (over) accrual (line 2 minus line 1).		$ 198,748	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 155,955	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.**		$ 54,891	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** $ 163,675 **For** 2012, 2013 **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.		$ 409,594	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	217,313	8
	2011	338,703	9
	2012	352,195	10
	2013	365,341	11
	2014	311,912	12

Beginning accrual adjusted due to the prepayment of the 1st installment of 2015 tax. The 1st installment of the 2014 tax as paid last year.
Allocated from Extended Care Consulting, LLC = $7,298
Allocated from Extended Care Clinical, LLC = $756
2015 Accrual = 311,912 x 1.05 = 327,508 - 171,552 (1st installment of 2015 tax) = 155,956

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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	$ 311,912.47	$ 311,912.47
2.	See Attached	2201 Main Allocation	$ 165,913.23	$ 7,638.99
3.	See Attached	Alloc from Dyer Admin Office	$ 3,814.66	$ 226.73
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 481,640.36	$ 319,778.19

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT 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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			37,754	2
3	TOTALS			$ 440,623	3

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 233,248	39	$ 164,470	$ (68,778)	$ 3,203,440	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20			4,987	9
10	Various			1987	138,915		20			138,076	10
11	Various			1988	9,885		20			9,822	11
12	Various			1989	5,410		20			5,410	12
13	Various			1990	42,578		20			42,575	13
14	Various			1991	11,813		20			11,811	14
15	Various			1992	11,426		20			11,423	15
16	Various			1993	8,851		20			8,851	16
17	Various			1994	25,632		20			25,453	17
18	Various			1995	50,028		20	1,106	1,106	50,004	18
19	Various			1996	161,111		20	8,055	8,055	152,371	19
20	Various			1997	165,320		20	8,243	8,243	155,600	20
21	Various			1998	189,177		20	9,459	9,459	166,477	21
22	Various			1999	21,736		20	1,070	1,070	17,642	22
23	Various			2000	122,845		20	6,114	6,114	94,710	23
24	Various			2001	51,096		20	2,555	2,555	37,272	24
25	Various			2002	68,816		20	315	315	68,403	25
26	Various			2003	117,820		20	1,846	1,846	106,326	26
27	Various			2004	41,864		20	620	620	36,589	27
28	Various			2005	50,621		20	945	945	47,841	28
29	Various			2006	89,874		20	6,688	6,688	85,833	29
30	Various			2007	96,414		20	6,382	6,382	87,959	30
31	Various			2008	49,099		20	2,890	2,890	37,652	31
32	Various			2009	62,307		20	5,583	5,583	42,746	32
33	Various			2010	219,458		20	21,392	21,392	122,222	33
34	Various			2011	28,338		20	3,523	3,523	16,355	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		159,008	2,144		2,144		115,595	68
69	Financial Statement Depreciation			87,226			(87,226)		69
70	TOTAL (lines 4 thru 69)		$ 8,418,755	$ 322,618		$ 253,398	$ (69,220)	$ 4,903,444	70

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 8,418,755	$ 322,618		$ 253,398	$ (69,220)	$ 4,903,444	1
2	Piping & Valves	2012	16,928		20	1,693	1,693	6,771	2
3	Boiler Repair	2012	4,500		20	225	225	825	3
4	Install Surplus Ats	2012	5,635		20	564	564	2,066	4
5	Concrete Patio-Walkway & Drainage Pipe	2012	12,500		20	834	834	2,918	5
6	Addt'L Concrete Work & Soding	2012	5,600		20	374	374	1,307	6
7	Replacement Of 2 Boilers	2012	126,500		20	12,650	12,650	42,167	7
8	Piping Insulation	2012	4,015		20	402	402	1,238	8
9	Cubicle Curtains	2013	11,033		20	2,207	2,207	5,700	9
10	New Ramp	2013	19,800		20	1,980	1,980	4,620	10
11	Cooling Tower	2013	6,646		20	665	665	1,495	11
12	Sealcoating	2013	6,200		20	620	620	1,395	12
13	Water Heater	2013	7,722		20	772	772	1,673	13
14	Railings	2013	10,800		20	2,160	2,160	4,500	14
15	Elevator Solid State Doors	2014	23,640		20	1,182	1,182	2,266	15
16	161 Lineal Ft Fencing	2014	10,779		20	719	719	1,138	16
17	Sensor & Controller For Chiller	2014	4,053		20	203	203	321	17
18	Fencing	2014	16,146		20	1,076	1,076	1,435	18
19	Install Oil Cooler In 2 Hydraulic Elevators	2014	12,770		20	639	639	851	19
20	East & West Stairway Structural Work	2014	23,400		20	1,170	1,170	1,268	20
21	South Elevator Power Supply & Transformer	2014	6,791		20	340	340	396	21
22	Pump Replacement	2015	19,529		20	895	895	895	22
23	Pump Motor	2015	10,750		20	314	314	314	23
24	Door Lock	2015	4,094		20	136	136	136	24
25	Electrical For New Elevator C.B.	2015	10,487		20	262	262	262	25
26	Injection Pump	2015	5,866		20	98	98	98	26
27	Fan Coil Unit	2015	7,500		20	63	63	63	27
28	Refund Claim - Elevator	2015	(20,237)		20	(590)	(590)	(590)	28
29	Boiler Pipe Repair	2015	2,806		20	140	140	140	29
30	Removed And Installed Two Control Boards In Module #1 & #2	2015	7,452		20	373	373	373	30
31	Fan Coil Units In Rooms #101 And #103	2015	3,915		20	196	196	196	31
32	Sprinkler System Services	2015	4,225		20	211	211	211	32
33	Fire Pump Repairs	2015	4,350		20	218	218	218	33
34	TOTAL (lines 1 thru 33)		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	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)		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	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)		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	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)		$ 8,814,951	$ 322,618		$ 286,184	$ (36,434)	$ 4,990,108	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 Main/Care Center Building LLC	2002	47,003	1,205	35	1,205		16,019	3
4	Allocated from Extended Care Clinical LLC	2002	5,025	129	35	129		1,712	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting LLC	2007	273	14	20	14		123	10
11	Allocated from Extended Care Consulting LLC	2009	163	8	20	8		57	11
12	Allocated from Extended Care Consulting LLC	2010	1,604	80	20	80		481	12
13	Allocated from Extended Care Consulting LLC	2011	577	29	20	29		144	13
14	Allocated from Extended Care Consulting LLC	2012	190	10	20	10		38	14
15	Allocated from Extended Care Consulting LLC	2014	2,636	132	20	132		264	15
16									16
17	Allocated from 2201 Main/Care Center Building LLC	2002	38,828		20			38,828	17
18	Allocated from 2201 Main/Care Center Building LLC	2003	45,757		20			45,757	18
19	Allocated from 2201 Main/Care Center Building LLC	2005	2,273	242	20	242		2,269	19
20	Allocated from 2201 Main/Care Center Building LLC	2009	410	21	20	21		144	20
21	Allocated from 2201 Main/Care Center Building LLC	2014	3,815	191	20	191		382	21
22	Allocated from 2201 Main/Care Center Building LLC	2015	647	32	20	32		32	22
23									23
24	Allocated from Extended Care Clinical LLC	2002	4,151		20			4,151	24
25	Allocated from Extended Care Clinical LLC	2003	4,892		20			4,892	25
26	Allocated from Extended Care Clinical LLC	2005	243	26	20	26		243	26
27	Allocated from Extended Care Clinical LLC	2009	44	2	20	2		15	27
28	Allocated from Extended Care Clinical LLC	2014	408	20	20	20		41	28
29	Allocated from Extended Care Clinical LLC	2015	69	3	20	3		3	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 159,008	$ 2,144		$ 2,144	$	$ 115,595	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 159,008	$ 2,144		$ 2,144	$	$ 115,595	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)		$ 159,008	$ 2,144		$ 2,144	$	$ 115,595	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 385,849	$ 1,172	$ 17,416	$ 16,244	10	$ 325,806	71
72	Current Year Purchases	4,332	183	225	42	10	225	72
73	Fully Depreciated Assets	1,997,629				10	1,997,629	73
74								74
75	TOTALS	$ 2,387,811	$ 1,355	$ 17,641	$ 16,286		$ 2,323,660	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 Cc	2015	10,726	303	303		5	9,817	77
78		Allocated from Extended Care Cl	2012	5,099	1,020	1,020		5	3,547	78
79										79
80	TOTALS			$ 138,144	$ 1,323	$ 1,323	$		$ 135,683	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)	$ 11,781,528	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 325,296	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 305,148	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,148)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,449,451	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 4,516 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	$ 665.17	$ 7,862	17
18					18
19					19
20					20
21	TOTAL		$ 665.17	$ 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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 180,245	$		$ 180,245	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			62,596			62,596	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			234,799			234,799	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				141,129		141,129	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					17,206	13,130		30,336	13
14	TOTAL			$		$ 494,846	$ 154,259		$ 649,105	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 Ltd. **#** 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 **(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	$ 381,164	$ 381,164	1
2	Cash-Patient Deposits	48,040	48,040	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,638,641	1,638,641	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	281,043	281,043	6
7	Other Prepaid Expenses	8,182	8,182	7
8	Accounts Receivable (owners or related parties)	639,586	639,586	8
9	Other(specify):	330,950	144,127	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,327,606	$ 3,140,783	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	1,868,177	1,868,177	15
16	Equipment, at Historical Cost	1,283,401	2,508,401	16
17	Accumulated Depreciation (book methods)	(2,748,265)	(8,356,385)	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):	5,025	5,025	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 428,138	$ 2,861,401	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,755,744	$ 6,002,184	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,788,335	$ 1,824,278	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,135	42,135	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	443,481	443,481	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,493	20,493	31
32	Accrued Real Estate Taxes(Sch.IX-B)	187,431	155,955	32
33	Accrued Interest Payable		39,792	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	44,284	44,284	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,526,159	$ 2,570,418	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,979,197	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,979,197	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,526,159	$ 6,549,615	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,229,585	$ (547,431)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,755,744	$ 6,002,184	48

***(See instructions.)**

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,349,192	1
2	Restatements (describe):		2
3	**Reversal of prior year accounting fees entry**	23,800	3
4	**Rounding**	(4)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,372,988	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	150,597	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	(294,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (143,403)	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)**	$ 1,229,585	24 *

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

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	$ 11,587,982	1
2	Discounts and Allowances for all Levels	(1,892,165)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,695,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,828,090	6
7	Oxygen	395	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,828,485	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	171,670	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,532	19
20	Radiology and X-Ray	3,050	20
21	Other Medical Services	26,581	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 215,833	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,126	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,126	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	163,676	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 163,676	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,920,937	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,295,820	31
32	Health Care	4,196,134	32
33	General Administration	2,634,068	33
	B. Capital Expense		
34	Ownership	1,400,123	34
	C. Ancillary Expense		
35	Special Cost Centers	657,508	35
36	Provider Participation Fee	586,687	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,770,340	40
41	**Income before Income Taxes (line 30 minus line 40)****	150,597	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 150,597	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,018,827	44
45	Private Pay - Net Inpatient Revenue	236,176	45
46	Medicare - Net Inpatient Revenue	(26,460)	46
47	Other-(specify) Hospice	138,692	47
48	Other-(specify) Veterans	328,582	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,695,817	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 Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,027	2,187	$ 111,629	$ 51.04	1
2	Assistant Director of Nursing	1,775	1,951	74,710	38.29	2
3	Registered Nurses	18,350	20,122	690,230	34.30	3
4	Licensed Practical Nurses	35,348	39,004	1,075,177	27.57	4
5	CNAs & Orderlies	49,792	56,972	759,396	13.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,788	15,775	271,720	17.22	8
9	Activity Director	2,082	2,610	46,096	17.66	9
10	Activity Assistants	11,794	12,441	117,864	9.47	10
11	Social Service Workers	24,312	26,619	443,514	16.66	11
12	Dietician	1,987	2,336	41,174	17.63	12
13	Food Service Supervisor	1,951	2,223	54,721	24.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,721	8,025	128,720	16.04	15
16	Dishwashers	19,195	21,952	217,639	9.91	16
17	Maintenance Workers	19,124	20,489	264,114	12.89	17
18	Housekeepers	24,751	28,305	298,929	10.56	18
19	Laundry	6,028	6,718	75,795	11.28	19
20	Administrator	2,018	2,247	103,218	45.94	20
21	Assistant Administrator	2,049	2,189	72,792	33.25	21
22	Other Administrative					22
23	Office Manager	872	1,119	27,900	24.93	23
24	Clerical	3,419	3,615	48,486	13.41	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	1,946	2,183	41,331	18.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,483	2,710	40,969	15.12	33
34	TOTAL (lines 1 - 33)	251,812	281,792	$ 5,006,124 *	$ 17.77	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	298	$ 15,126	01-03	35
36	Medical Director	Monthly	22,512	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,673	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	298	$ 54,311		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	20	$ 990	10-03	50
51	Licensed Practical Nurses	8	320	10-03	51
52	Certified Nurse Assistants/Aides	9,756	246,982	10-03	52
53	TOTAL (lines 50 - 52)	9,784	$ 248,292		53

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0%	$ 103,218
Niki Mehta	Assist. Admin.	0%	72,792
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 176,010

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
FR&R/Marcum LLP	Accounting	$ 28,699
See Attached	Legal	81,951
Extended Care Consulting	Home Office Expense	390,348
Extended Care Clinical	Home Office Expense	130,116
Personnel Planners	Unemployment Consultant	2,888
Pro Payroll Solutions	Payroll Processing	24,328
E-Health Data Solutions	MDS Software	3,180
AIS Assessment	MDS Consulting	1,319
Ability Network	Medicare Billing	1,550
National Datacare Corporation	Resident Fund Processing	3,794
Acess One	Computer Services	818
See Supplemental Schedule		3,093
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 672,083

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,747
Unemployment Compensation Insurance	77,102
FICA Taxes	375,256
Employee Health Insurance	275,906
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	10,884
Other Employee Welfare	7,140
Holiday Expense	2,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 865,205

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,408
Health Care Worker Background Check	
(Indicate # of checks performed 424)	6,225
Patient Background Checks	
Dues & Subscriptions	32,353
Licenses & Fees	14,751
Allocated from EC Consulting	1,637
Allocated from EC Clinical	294
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 77,667

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,618
Allocated from EC Consulting	562
Allocated from EC Clinical	1,846
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,026

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $32,189**

(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 Yrd**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,713** 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 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. $ **586,687**
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 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.