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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0031765

Facility Name: Briar Place

Address: 6800 West Joliet (Number) | Indian Head Park (City) | 60525 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 1/27/1987

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: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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 # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,704	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,912	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,435		1,698	29,133	8
9	SNF/PED					9
10	ICF	44,550	1,534	3,533	49,617	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,985	1,534	5,231	78,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.74%

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 1,698

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	453,023	72,454	15,498	540,975		540,975	15,795	556,770			1
2	Food Purchase		496,786		496,786		496,786	542	497,328			2
3	Housekeeping	321,877	76,500	762	399,139		399,139	1,820	400,959			3
4	Laundry	101,399	20,592	4,792	126,783		126,783		126,783			4
5	Heat and Other Utilities			182,004	182,004		182,004	2,518	184,522			5
6	Maintenance	232,991		259,507	492,498		492,498	7,161	499,659			6
7	Other (specify):*							7,397	7,397			7
8	TOTAL General Services	1,109,290	666,332	462,563	2,238,185		2,238,185	35,233	2,273,418			8
	B. Health Care and Programs											
9	Medical Director			20,760	20,760		20,760		20,760			9
10	Nursing and Medical Records	2,907,118	198,466	178,217	3,283,801		3,283,801	34,797	3,318,598			10
10a	Therapy	260,803			260,803		260,803		260,803			10a
11	Activities	179,852	26,607		206,459		206,459		206,459			11
12	Social Services	611,356	5,961		617,317		617,317	37,526	654,843			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	20,437			20,437		20,437	14,091	34,528			15
16	TOTAL Health Care and Programs	3,979,566	231,034	198,977	4,409,577		4,409,577	86,414	4,495,991			16
	C. General Administration											
17	Administrative	166,674			166,674		166,674	157,625	324,299			17
18	Directors Fees											18
19	Professional Services			666,068	666,068	(1,628)	664,440	(516,933)	147,507			19
20	Dues, Fees, Subscriptions & Promotions			107,086	107,086		107,086	(15,572)	91,514			20
21	Clerical & General Office Expenses	75,213	32,497	462,230	569,940		569,940	(199,319)	370,621			21
22	Employee Benefits & Payroll Taxes			960,145	960,145		960,145	(17,740)	942,405			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,722	16,722		16,722	1,422	18,144			24
25	Other Admin. Staff Transportation			5,102	5,102		5,102	1,657	6,759			25
26	Insurance-Prop.Liab.Malpractice			229,168	229,168		229,168	3,849	233,017			26
27	Other (specify):*							61,308	61,308			27
28	TOTAL General Administration	241,887	32,497	2,446,521	2,720,905	(1,628)	2,719,277	(523,703)	2,195,574			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,330,743	929,863	3,108,061	9,368,667	(1,628)	9,367,039	(402,056)	8,964,983			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Briar Place #0031765 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			115,266	115,266		115,266	199,007	314,273			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,917	1,917		1,917	452,401	454,318			32
33	Real Estate Taxes			320,833	320,833	1,628	322,461	7,409	329,870			33
34	Rent-Facility & Grounds			954,910	954,910		954,910	(954,000)	910			34
35	Rent-Equipment & Vehicles			13,678	13,678		13,678	1,566	15,244			35
36	Other (specify):*			947	947		947	(947)				36
37	**TOTAL Ownership**			1,407,551	1,407,551	1,628	1,409,179	(294,564)	1,114,615			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,858	489,163	589,021		589,021	(5,140)	583,881			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			589,604	589,604		589,604		589,604			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		99,858	1,078,767	1,178,625		1,178,625	(5,140)	1,173,485			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,330,743	1,029,721	5,594,379	11,954,843		11,954,843	(701,760)	11,253,083			45

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(39,217)	30		9
10	Interest and Other Investment Income	(7,952)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(97)	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	(400)	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	(390,510)	21		24
25	Fund Raising, Advertising and Promotional	(10,690)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(910)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(81,262)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (531,038)		$	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)	(170,722)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (170,722)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (701,760)		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

ID# 0031765

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft Loss	$ (1,557)	21	1
2	Collection Expense	(5,398)	21	2
3	Amortization	(947)	36	3
4	Vetarans Expense	(25,399)	10	4
5	PAC Dues	(8,219)	20	5
6	Building Co - Management Fees	(12,250)	17	6
7	Building Co - Misc Admin Expenses	(430)	21	7
8	Capitalized R&M	(12,384)	06	8
9	Kopicki's Heritage Funeral	(325)	21	9
10	Lobbying Expense	(3,501)	21	10
11	Hallowell & James Funeral Home	(415)	21	11
12	Non Allowable Legal Fees	(7,200)	19	12
13	Building Co - State Taxes	(951)	21	13
14	Building Co - State Penalty	(105)	21	14
15	Other Income	(2,181)	21	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**	(81,262)		49

Briar Place

ID# 0031765

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			297		15,498							15,795	1
2	Food Purchase	(97)		639									542	2
3	Housekeeping			1,642		178							1,820	3
4	Laundry													4
5	Heat and Other Utilities			2,291		227							2,518	5
6	Maintenance	(12,384)		4,786	14,340	419							7,161	6
7	Other (specify):*				5,256	2,141							7,397	7
8	**TOTAL General Services**	(12,481)		9,655	19,596	18,463							35,233	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25,399)				64,476	(3,528)		(752)				34,797	10
10a	Therapy													10a
11	Activities													11
12	Social Services					37,526							37,526	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					14,091							14,091	15
16	**TOTAL Health Care and Programs**	(25,399)				116,093	(3,528)		(752)				86,414	16
	C. General Administration													
17	Administrative	(12,250)	12,250	4,791	27,272	125,562							157,625	17
18	Directors Fees													18
19	Professional Services	(7,200)		(380,784)		(128,949)							(516,933)	19
20	Fees, Subscriptions & Promotions	(18,909)		1,555		1,782							(15,572)	20
21	Clerical & General Office Expenses	(406,683)	1,486	9,652	165,264	30,962							(199,319)	21
22	Employee Benefits & Payroll Taxes				(17,740)								(17,740)	22
23	Inservice Training & Education													23
24	Travel and Seminar			244		1,178							1,422	24
25	Other Admin. Staff Transportation			1,657									1,657	25
26	Insurance-Prop.Liab.Malpractice			2,868		981							3,849	26
27	Other (specify):*				40,325	20,983							61,308	27
28	**TOTAL General Administration**	(445,042)	13,736	(360,017)	215,121	52,499							(523,703)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(482,922)	13,736	(350,362)	234,717	187,055	(3,528)		(752)				(402,056)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(39,217)	233,248	3,823		1,153							199,007	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,952)	446,140	13,881		332							452,401	32
33	Real Estate Taxes			6,686		723							7,409	33
34	Rent-Facility & Grounds		(954,000)										(954,000)	34
35	Rent-Equipment & Vehicles			1,566									1,566	35
36	Other (specify):*	(947)											(947)	36
37	**TOTAL Ownership**	(48,116)	(274,612)	25,956		2,208							(294,564)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(5,140)						(5,140)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(5,140)						(5,140)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(531,038)	(260,876)	(324,406)	234,717	189,263	(8,668)		(752)				(701,760)	45

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	320,833	G. W. H. Limited Partnership	100.00%		(320,833)	2
3	V	21	Misc Admin Expense		G. W. H. Limited Partnership	100.00%	430	430	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%	446,140	446,140	6
7	V	33	Real Estate Tax Expenses		G. W. H. Limited Partnership	100.00%	320,833	320,833	7
8	V	21	State Taxes		G. W. H. Limited Partnership	100.00%	951	951	8
9	V	21	State Tax Penatly and Interest		G. W. H. Limited Partnership	100.00%	105	105	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,274,833			$ 1,013,957	$ * (260,876)	14

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 297	$ 297	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	639	639	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,642	1,642	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,291	2,291	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,786	4,786	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,791	4,791	20
21	V	19	Professional Fees	390,348	Extended Care Consulting, LLC	100.00%	9,564	(380,784)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,555	1,555	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	9,652	9,652	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	244	244	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,657	1,657	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,868	2,868	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,823	3,823	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	13,881	13,881	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	6,686	6,686	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,566	1,566	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			$ 65,942	$ * (324,406)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	14,340	$ 14,340	15
16	V	06	Maintenance (Direct)	36,473	Extended Care Consulting, LLC	100.00%	36,473		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,344	1,344	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	3,912	3,912	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	27,272	27,272	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	165,264	165,264	22
23	V	21	Office and Clerical (Direct)	22,659	Extended Care Consulting, LLC	100.00%	22,659		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	35,215	35,215	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,110	5,110	25
26	V	22	Employee Benefits	17,740	Extended Care Consulting, LLC	100.00%		(17,740)	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			$ 76,872			$ 311,589	$ * 234,717	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 178	$ 178	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	227	227	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	419	419	17
18	V	19	Professional Fees	130,116	Extended Care Clinical, LLC	100.00%	1,167	(128,949)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,782	1,782	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	4,632	4,632	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,178	1,178	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	981	981	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,153	1,153	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	332	332	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	723	723	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	15,498	15,498	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	2,141	2,141	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	64,476	64,476	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	37,526	37,526	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	14,091	14,091	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	125,562	125,562	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	26,330	26,330	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	20,983	20,983	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,116			$ 319,379	$ * 189,263	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 48,982	MAC Rx, LLC	100.00%	$ 45,454	$ (3,528)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	71,373	MAC Rx, LLC	100.00%	66,233	(5,140)	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			$ 120,355			$ 111,687	$ * (8,668)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 418,231	$ 418,231	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	418,231	CCS Employee Benefits Group	100.00%		(418,231)	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			$ 418,231			$ 418,231	$ *	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Various Equipment	12,920	Vent Lease LLC	100.00%	12,168	$ (752)	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			$ 12,920			$ 12,168	$ * (752)	39

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 CEN	BEECHER	GWH LIMITED PARTNERSH	EVANSTON	BUILDING COMPANY	1
2	CELESTE GIANNINI TRUST DTD 3/13/00	1.020%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.	WILLOWBROOK	EXTENDED CARE CONSUL	EVANSTON	MGMT/BOOKKEEPING	2
3	CHERYL MAGENCE	3.469%	COUNTRYSIDE NURSING AND REHABILITATION CENTER	DOLTON	EXTENDED CARE CLINICA	EVANSTON	CLINICAL	3
4	ERIC ROTHNER	31.429%	GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	LAURI WOLFF POLEN	2.857%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.	PLAINFIELD	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	LORRAINE SUISSA	10.204%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	MARILYN WOLFF REVOCABLE TR DTD 1/89	15.761%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8	MARK STEINBERG	2.041%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPL	DES PLAINES	MEDICAL SUPPLIES	8
9	MARK SUISSA	10.204%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10	MEYER MAGENCE	3.469%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11	MICHAEL R. GIANNINI TRUST DTD	1.020%	MAJOR HOSPITAL SEBOS	HOBART, IN				11
12	NOAH WOLFF REVOCABLE TR DTD 1/89	7.913%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13	RANAN WOLFF	2.857%	PARK HOUSE NURSING AND REHABILITATION CENTER,I	CHICAGO				13
14	SHIRLEY DRELICH	2.041%	PRAIRIE MANOR NURSING & REHABILITATION CENTER,	CHICAGO HEIGHTS				14
15	TZIONA ZEFFREN	2.857%	PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				15
16			RAINBOW BEACH QOC, L.L.C.	CHICAGO				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, I	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	See Attached	2.12	5.31%	Alloc. Salary	$ 3,897	21-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	4.55	8.26%	Al Sal/Al Fee	16,466	17-7	2
3	Kimberly Rudolph	Relative	Clerical	0%	See Attached	0.43	5.70%	Alloc. Salary	133	21-7	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	$ 20,496		13

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,380,761	34	$ 5,206	$	78,750	$ 297	1
2	02	Food	Patient Days	1,380,761	34	11,203		78,750	639	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		78,750	1,642	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		78,750	2,291	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		78,750	4,786	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		78,750	4,791	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		78,750	9,564	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		78,750	1,555	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		78,750	9,652	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		78,750	244	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		78,750	1,657	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		78,750	2,868	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		78,750	3,823	13
14	32	Interest	Patient Days	1,380,761	34	243,379		78,750	13,881	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		78,750	6,686	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		78,750	1,566	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 65,942	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,380,761	34	251,431	251,431	78,750	14,340	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		36,473	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		78,750	1,344	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			3,912	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	78,750	27,272	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	78,750	165,264	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		22,659	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		78,750	35,215	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			5,110	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,222,483	$ 4,461,323		$ 311,589	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	818,091	19	$ 1,844	$	78,750	$ 178	1
2	05	Utilities	Patient Days	818,091	19	2,355		78,750	227	2
3	06	Maintenance	Patient Days	818,091	19	4,352		78,750	419	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		78,750	1,167	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		78,750	1,782	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		78,750	4,632	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		78,750	1,178	7
8	26	Insurance	Patient Days	818,091	19	10,196		78,750	981	8
9	30	Depreciation	Patient Days	818,091	19	11,978		78,750	1,153	9
10	32	Interest	Patient Days	818,091	19	3,446		78,750	332	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		78,750	723	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	78,750	15,498	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		78,750	2,141	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	78,750	64,476	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	78,750	37,526	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		78,750	14,091	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	78,750	125,562	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	78,750	26,330	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		78,750	20,983	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 319,379	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 45,454	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						66,233	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					$	$		$ 111,687	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 418,231	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					$	$		$ 418,231	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	10	Various Equipment	Direct Allocation						12,168	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					$	$		$ 12,168	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	White Oak Nursing Center		X	Mortgage			$ 7,441,383	$ 3,487,722			$ 446,140	1
2			X	Line of Credit				732,454			1,917	2
3												3
4												4
5					-							5
	Working Capital											
6												6
7												7
8					-							8
9	TOTAL Facility Related						$ 7,441,383	$ 4,220,176			$ 448,057	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,952)	10
11	Alloc. Extended Care Consultin	X		Interest							13,881	11
12	Alloc Extended Care Clinical	X		Interest							332	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 6,261	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 4,220,176			$ 454,318	15

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 153,562	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.)		$ 323,673	2
3. Under or (over) accrual (line 2 minus line 1).		$ 170,111	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 158,132	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.)		$ 1,628	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 329,871	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	338,703	8
	2012	352,195	9
	2013	365,341	10
	2014	311,912	11
	2015	316,264	12

2016 Accrual = $316,264 x 1.05 (rounded) = $332,077 - prepaid 2016 1st installment of $173945 = 158,132

Allocated from Extended Care Consulting = $6686

Allocated from Extended Care Clinical = $723

Beginning Accrual Adjusted $3448

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 316,263.67	$ 316,263.67
2.	See Attachment	Allocated from 2201 Main	$ 167,518.13	$ 6,686.27
3.	See Attachment	Allocated from Care Centers Bldg	$ 167,518.13	$ 722.55
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 651,299.93	$ 323,672.49

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Alloc from EC Clinical Bldg/Consulting Bldg			36,266	2
3	TOTALS			$ 439,135	3

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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)	$ 3,367,910	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20			5,000	9
10	Various			1987	138,915		20			138,915	10
11	Various			1988	9,885		20			9,885	11
12	Various			1989	5,410		20			5,410	12
13	Various			1990	42,578		20			42,578	13
14	Various			1991	11,813		20			11,813	14
15	Various			1992	11,426		20			11,426	15
16	Various			1993	8,851		20			8,851	16
17	Various			1994	25,632		20			25,632	17
18	Various			1995	50,028		20			50,028	18
19	Various			1996	161,111		20	5,677	5,677	158,048	19
20	Various			1997	165,320		20	6,341	6,341	161,941	20
21	Various			1998	189,177		20	9,459	9,459	175,936	21
22	Various			1999	21,736		20	1,070	1,070	18,712	22
23	Various			2000	122,845		20	6,114	6,114	100,824	23
24	Various			2001	51,096		20	2,555	2,555	39,827	24
25	Various			2002	68,816		20	315	315	68,718	25
26	Various			2003	117,820		20	1,846	1,846	108,172	26
27	Various			2004	41,864		20	620	620	37,209	27
28	Various			2005	50,621		20	296	296	48,137	28
29	Various			2006	89,874		20	4,041	4,041	89,874	29
30	Various			2007	96,414		20	6,382	6,382	94,341	30
31	Various			2008	49,099		20	2,890	2,890	40,542	31
32	Various			2009	62,307		20	5,583	5,583	48,329	32
33	Various			2010	219,458		20	21,115	21,115	143,337	33
34	Various			2011	28,338		20	2,313	2,313	18,668	34
35	Various			2012	175,678		20	16,740	16,740	74,032	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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)		172,177	2,396		2,396		116,013	68
69	Financial Statement Depreciation			115,266			(115,266)		69
70	TOTAL (lines 4 thru 69)		$ 8,607,602	$ 350,910		$ 260,223	$ (90,687)	$ 5,220,106	70

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 8,607,602	$ 350,910		$ 260,223	$ (90,687)	$ 5,220,106	1
2	Cubicle Curtains	2013	11,033		20	2,207	2,207	7,907	2
3	New Ramp	2013	19,800		20	1,980	1,980	6,600	3
4	Cooling Tower	2013	6,646		20	665	665	2,160	4
5	Sealcoating	2013	6,200		20	620	620	2,015	5
6	Water Heater	2013	7,722		20	772	772	2,445	6
7	Railings	2013	10,800		20	2,160	2,160	6,660	7
8	Elevator Solid State Doors	2014	23,640		20	1,182	1,182	3,448	8
9	161 Lineal Ft Fencing	2014	10,779		20	719	719	1,856	9
10	Sensor & Controller For Chiller	2014	4,053		20	203	203	524	10
11	Fencing	2014	16,146		20	1,076	1,076	2,512	11
12	Install Oil Cooler In 2 Hydraulic Elevators	2014	12,770		20	639	639	1,490	12
13	East & West Stairway Structural Work	2014	23,400		20	1,170	1,170	2,438	13
14	South Elevator Power Supply & Transformer	2014	6,791		20	340	340	736	14
15	Pump Replacement	2015	10,042		20	502	502	962	15
16	Door Lock	2015	4,094		20	205	205	341	16
17	Electrical For New Elevator C.B.	2015	10,487		20	524	524	787	17
18	Injection Pump	2015	5,866		20	293	293	391	18
19	Fan Coil Unit	2015	7,500		20	375	375	438	19
20	Boiler Pipe Repair	2015	2,806		20	140	140	269	20
21	Remove & Install 2 Control Boards In # 1 And # 2	2015	7,452		20	373	373	621	21
22	Fan Coil Units In Rooms # 101 And # 103	2015	3,915		20	196	196	228	22
23	Sprinkler System Services	2015	4,225		20	211	211	282	23
24	Fire Pump Repairs	2015	4,350		20	218	218	272	24
25	Water Heater	2016	7,639		20	350	350	350	25
26	Tuckpointing - North, South, East, West Sides	2016	17,500		20	365	365	365	26
27	Recover Awning	2016	7,800		20	163	163	163	27
28	Roof Recovery	2016	117,000		20	2,438	2,438	2,438	28
29	Fencing & Reconstruct Piers	2016	25,000		20	833	833	833	29
30	Concrete Repairs At Downspout Troughs And Stairs In Basement	2016	14,600		20	304	304	304	30
31	Replace Kitchen Traps	2016	8,600		20	72	72	72	31
32	Strip & Caulk All Windows	2016	18,600		20	388	388	388	32
33	Wheelchair Ramp Concrete Repair	2016	5,200		20	108	108	108	33
34	TOTAL (lines 1 thru 33)		$ 9,050,059	$ 350,910		$ 282,010	$ (68,900)	$ 5,270,506	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 9,050,059	$ 350,910		$ 282,010	$ (68,900)	$ 5,270,506	1
2	Tuckpointing East Side	2016	2,600		20	43	43	43	2
3	Faux Masonry Sign	2016	12,068		20	189	189	189	3
4	Facade Renovation	2016	200,000		20	5,833	5,833	5,833	4
5	Lintel Repair Work - Steel, Bricks, Masonry	2016	340,000		20	7,083	7,083	7,083	5
6	Architecture Fees For Renovations	2016	12,073		20	402	402	402	6
7	Faux Masonry Sign - Project Completion Difference	2016	10,670		20	534	534	534	7
8	Installed Pump, Pit And Pipes For Water Leak	2016	3,000		20	150	150	150	8
9	Replaced Defective Guides On Tape On South Passenger Elevator	2016	4,382		20	219	219	219	9
10	Removed Ceiling Tiles, Installed New Insulation, Sealed Joints An	2016	5,000		20	250	250	250	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)		$ 9,639,852	$ 350,910		$ 296,715	$ (54,195)	$ 5,285,211	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 9,639,852	$ 350,910		$ 296,715	$ (54,195)	$ 5,285,211	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)		$ 9,639,852	$ 350,910		$ 296,715	$ (54,195)	$ 5,285,211	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 9,639,852	$ 350,910		$ 296,715	$ (54,195)	$ 5,285,211	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)		$ 9,639,852	$ 350,910		$ 296,715	$ (54,195)	$ 5,285,211	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	45,103	1,156	39	1,156		16,528	3
4	Allocated from Extended Care Clinical LLC	2002	4,874	125	39	125		1,786	4
5	Allocated from Extended Care Consulting LLC - Dyer Bldg	2016	13,688	303	39	303		2,880	5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Extended Care Consulting LLC	2007	262	13	20	13		131	10
11	Allocated from Extended Care Consulting LLC	2009	157	8	20	8		63	11
12	Allocated from Extended Care Consulting LLC	2010	1,539	77	20	77		539	12
13	Allocated from Extended Care Consulting LLC	2011	554	28	20	28		166	13
14	Allocated from Extended Care Consulting LLC	2012	183	9	20	9		46	14
15	Allocated from Extended Care Consulting LLC	2014	2,530	126	20	126		380	15
16	Allocated from Extended Care Consulting LLC	2016	3,033	152	20	152		152	16
17									17
18	Allocated from 2201 Main/Care Center Building LLC	2002	37,258		20			37,258	18
19	Allocated from 2201 Main/Care Center Building LLC	2003	43,908		20			43,908	19
20	Allocated from 2201 Main/Care Center Building LLC	2005	2,182	4	20	4		2,182	20
21	Allocated from 2201 Main/Care Center Building LLC	2009	394	20	20	20		157	21
22	Allocated from 2201 Main/Care Center Building LLC	2014	3,661	183	20	183		549	22
23	Allocated from 2201 Main/Care Center Building LLC	2015	621	31	20	31		62	23
24	Allocated from 2201 Main/Care Center Building LLC	2016	2,452	123	20	123		123	24
25									25
26									26
27	Allocated from Extended Care Clinical LLC	2002	4,026		20			4,026	27
28	Allocated from Extended Care Clinical LLC	2003	4,745		20			4,745	28
29	Allocated from Extended Care Clinical LLC	2005	236		20			236	29
30	Allocated from Extended Care Clinical LLC	2009	43	2	20	2		17	30
31	Allocated from Extended Care Clinical LLC	2014	396	20	20	20		59	31
32	Allocated from Extended Care Clinical LLC	2015	67	3	20	3		7	32
33	Allocated from Extended Care Clinical LLC	2016	265	13	20	13		13	33
34	TOTAL (lines 1 thru 33)		$ 172,177	$ 2,396		$ 2,396	$	$ 116,013	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 172,177	$ 2,396		$ 2,396	$	$ 116,013	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)		$ 172,177	$ 2,396		$ 2,396	$	$ 116,013	34

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 376,689	$ 1,300	$ 16,278	$ 14,978	10	$ 329,139	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,003,196				10	2,003,196	73
74								74
75	TOTALS	$ 2,379,886	$ 1,300	$ 16,278	$ 14,978		$ 2,332,335	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	Alloc - Extended Care Consulting			10,293	291	291		5	9,711	77
78	Alloc - Extended Care Clinical			4,946	989	989		5	4,429	78
79										79
80	TOTALS			$ 137,558	$ 1,280	$ 1,280	$		$ 136,459	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)	$ 12,596,431	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 353,490	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 314,273	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,217)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,754,005	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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				910			5
6								6
7	TOTAL				$ 910 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 7,382 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	$ 7,862	17
18					18
19					19
20					20
21	TOTAL		$ 665	$ 7,862	21

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	$		$ 188,626	$		$ 188,626	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			68,064			68,064	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			229,558			229,558	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				83,497		83,497	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					2,915	16,361		19,276	13
14	TOTAL			$		$ 489,163	$ 99,858		$ 589,021	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.

Facility Name & ID Number Briar Place **#** 0031765 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 110,757	$ 115,005	1
2	Cash-Patient Deposits	47,810	47,810	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,488,445	1,488,445	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	320,603	320,603	6
7	Other Prepaid Expenses	10,622	10,622	7
8	Accounts Receivable (owners or related parties)	842,008	842,008	8
9	Other(specify): See Attached Schedule	9,076	23,861	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,829,321	$ 2,848,354	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	2,667,527	2,667,527	15
16	Equipment, at Historical Cost	1,283,401	2,508,401	16
17	Accumulated Depreciation (book methods)	(2,863,531)	(8,704,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	3,925	3,925	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,111,122	$ 3,311,137	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,940,443	$ 6,159,491	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,089,238	$ 2,089,238	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,771	41,771	28
29	Short-Term Notes Payable	732,454	732,454	29
30	Accrued Salaries Payable	464,448	464,448	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,767	23,767	31
32	Accrued Real Estate Taxes(Sch.IX-B)	175,864	158,132	32
33	Accrued Interest Payable		34,877	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	27,284	257,604	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,554,826	$ 3,802,291	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,487,722	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)**	$	$ 3,487,722	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,554,826	$ 7,290,013	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 385,617	$ (1,130,522)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,940,443	$ 6,159,491	48

***(See instructions.)**

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,229,585	1
2	Restatements (describe):		2
3	**Rounding**	8	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,229,593	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(549,976)	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)**	$ (843,976)	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)**	$ 385,617	24 *

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 11,143,843	1
2	Discounts and Allowances for all Levels	(1,440,129)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,703,714	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,511,090	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,511,090	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	100,132	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,513	19
20	Radiology and X-Ray	2,380	20
21	Other Medical Services	50,497	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 167,522	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,952	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,952	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	14,589	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,589	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,404,867	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,238,185	31
32	Health Care	4,409,577	32
33	General Administration	2,720,905	33
	B. Capital Expense		
34	Ownership	1,407,551	34
	C. Ancillary Expense		
35	Special Cost Centers	589,021	35
36	Provider Participation Fee	589,604	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,954,843	40
41	**Income before Income Taxes (line 30 minus line 40)****	(549,976)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (549,976)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,174,907	44
45	Private Pay - Net Inpatient Revenue	261,556	45
46	Medicare - Net Inpatient Revenue	(43,294)	46
47	Other-(specify) Hospice	46,932	47
48	Other-(specify) VA, Insurance	263,613	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,703,714	49

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

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,641	1,730	$ 85,080	$ 49.18	1
2	Assistant Director of Nursing	1,910	2,140	84,996	39.72	2
3	Registered Nurses	16,128	18,027	653,750	36.27	3
4	Licensed Practical Nurses	38,425	42,635	1,232,439	28.91	4
5	CNAs & Orderlies	48,444	55,594	773,832	13.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,010	13,688	260,803	19.05	8
9	Activity Director	4,381	4,402	76,709	17.43	9
10	Activity Assistants	9,890	11,011	103,143	9.37	10
11	Social Service Workers	33,563	37,063	611,356	16.50	11
12	Dietician					12
13	Food Service Supervisor	3,752	4,208	89,304	21.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,046	30,394	363,719	11.97	15
16	Dishwashers					16
17	Maintenance Workers	15,264	17,400	232,991	13.39	17
18	Housekeepers	27,048	29,956	321,877	10.74	18
19	Laundry	8,248	9,055	101,399	11.20	19
20	Administrator	2,085	2,251	104,290	46.33	20
21	Assistant Administrator	1,734	1,825	62,384	34.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,629	5,128	75,213	14.67	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	1,895	2,165	41,523	19.18	31
32	Other Health Care(specify)					32
33	Other(specify)	3,841	4,452	55,934	12.56	33
34	TOTAL (lines 1 - 33)	260,934	293,124	$ 5,330,742 *	$ 18.19	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	289	$ 15,498	01-03	35
36	Medical Director	Monthly	20,760	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,960	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)	289	$ 53,218		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	209	8,314	10-03	51
52	Certified Nurse Assistants/Aides	6,141	152,943	10-03	52
53	TOTAL (lines 50 - 52)	6,350	$ 161,257		53

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0	$ 104,290
Lisa Hardaman	Assnt Admin.	0	25,577
Niki Mehta	Assnt Admin.	0	36,807
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 166,674

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
Pro Payroll Services	Data Processing	$ 29,706
Ehealth Data Solutions	Data Processing	795
Achieve	Data Processing	26,813
Harland Technology Services	Data Processing	180
Ability Network	Data Processing	3,288
National Datacare Corp	Data Processing	3,540
Marcum LLP	Accounting Fees	26,126
Legal Services	See Attachment	22,291
Personal Planners	Unemployement Consult	2,550
ECC Consulting	Home Office Expense	390,348
ECC Clinical	Home Office Expense	130,116
See Supplemental Schedule		30,314
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 666,067

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 139,866
Unemployment Compensation Insurance	80,770
FICA Taxes	406,676
Employee Health Insurance	304,306
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	10,787
TOTAL (agree to Schedule V, line 22, col.8)	$ 942,405

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	55,896
Health Care Worker Background Check	1,185
(Indicate # of checks performed 119)	
Patient Background Checks 168	1,715
Licenses and Fees	8,336
Dues and Subscriptions	19,055
Alloc Extended Care Consulting	1,555
Alloc Extended Care Clincial	1,782
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 91,514

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,722
Allocated Extended Care Consulting	244
Allocated Extended Care Clinical	1,178
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,144

**See instructions.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **ILCLTC $24,905**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **25,017** 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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **589,604**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

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

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

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