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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0031765

Facility Name: Briar Place Ltd.

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,140		1,694	21,834	8
9	SNF/PED					9
10	ICF	32,705	842	23,894	57,441	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,845	842	25,588	79,275	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.62%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 11/1/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/1986 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 1,694

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	448,325	89,828	15,561	553,714		553,714	15,951	569,665			1
2	Food Purchase		513,629		513,629		513,629	800	514,429			2
3	Housekeeping	273,696	67,530	417	341,643		341,643	1,987	343,630			3
4	Laundry	65,587	27,632	14,345	107,564		107,564		107,564			4
5	Heat and Other Utilities			174,764	174,764		174,764	2,436	177,200			5
6	Maintenance	247,357		217,258	464,615		464,615	16,791	481,406			6
7	Other (specify):*							4,426	4,426			7
8	**TOTAL General Services**	1,034,965	698,619	422,345	2,155,929		2,155,929	42,391	2,198,320			8
	B. Health Care and Programs											
9	Medical Director			21,364	21,364		21,364		21,364			9
10	Nursing and Medical Records	2,510,640	123,884	514,168	3,148,692		3,148,692	63,139	3,211,831			10
10a	Therapy	189,372		822	190,194		190,194		190,194			10a
11	Activities	166,105	15,876		181,981		181,981		181,981			11
12	Social Services	554,597	12,889		567,486		567,486	56,376	623,862			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	38,927			38,927		38,927	17,784	56,711			15
16	**TOTAL Health Care and Programs**	3,459,641	152,649	536,354	4,148,644		4,148,644	137,299	4,285,943			16
	C. General Administration											
17	Administrative	184,322			184,322		184,322	168,722	353,044			17
18	Directors Fees											18
19	Professional Services			645,740	645,740		645,740	(517,742)	127,998			19
20	Dues, Fees, Subscriptions & Promotions			127,203	127,203		127,203	(18,650)	108,553			20
21	Clerical & General Office Expenses	76,227	38,942	375,422	490,591		490,591	(104,695)	385,896			21
22	Employee Benefits & Payroll Taxes			968,286	968,286		968,286	(11,127)	957,159			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,843	4,843		4,843	2,092	6,935			24
25	Other Admin. Staff Transportation			3,013	3,013		3,013	1,462	4,475			25
26	Insurance-Prop.Liab.Malpractice			243,516	243,516		243,516	3,683	247,199			26
27	Other (specify):*							66,449	66,449			27
28	**TOTAL General Administration**	260,549	38,942	2,368,023	2,667,514		2,667,514	(409,805)	2,257,709			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,755,155	890,210	3,326,722	8,972,087		8,972,087	(230,115)	8,741,972			29

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

Facility Name & ID Number Briar Place Ltd. #0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			151,967	151,967		151,967	164,679	316,646			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,769	34,769		34,769	176,666	211,435			32
33	Real Estate Taxes			326,578	326,578		326,578	7,415	333,993			33
34	Rent-Facility & Grounds			954,000	954,000		954,000	(954,000)				34
35	Rent-Equipment & Vehicles			14,194	14,194		14,194	1,616	15,810			35
36	Other (specify):*			1,624	1,624		1,624	(1,624)				36
37	**TOTAL Ownership**			1,483,132	1,483,132		1,483,132	(605,248)	877,884			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,089	458,736	551,825		551,825	(6,471)	545,354			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			594,914	594,914		594,914		594,914			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		93,089	1,053,650	1,146,739		1,146,739	(6,471)	1,140,268			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,755,155	983,299	5,863,504	11,601,958		11,601,958	(841,835)	10,760,123			45

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(73,061)	30		9
10	Interest and Other Investment Income	(24,698)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	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	(2,783)	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	(306,654)	21		24
25	Fund Raising, Advertising and Promotional	(7,034)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(681,226)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,095,510)		$	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)	253,675		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 253,675		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (841,835)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (98)	21	1
2	Patient Clothing	(121)	10	2
3	Theft Loss	(2,189)	21	3
4	Collection Expense	(5,400)	21	4
5	Amortization	(1,624)	36	5
6	Veterans Expense	(2,361)	10	6
7	PAC Dues	(14,593)	20	7
8	Non-Allowable Legal	(975)	19	8
9	Capitalized R&M	(2,588)	6	9
10	Building Company - Management Fees	(12,250)	19	10
11	Building Company - Administrative Expense	(200)	21	11
12	Building Company - Bank Charges	(102)	21	12
13	Building Company - Amortization	(8,754)	36	13
14	Building Company - State Taxes	(1,500)	21	14
15	Building Company - Loan Early Termination Exp.	(560,430)	36	15
16	Building Company - Other Interest	(64,540)	32	16
17	Government relations	(3,501)	19	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**	(681,226)		49

Briar Place Ltd.

ID# 0031765

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			293		15,658							15,951	1
2	Food Purchase	(54)		854									800	2
3	Housekeeping			1,766		221							1,987	3
4	Laundry													4
5	Heat and Other Utilities			2,188		248							2,436	5
6	Maintenance	(2,588)		6,027	12,931	427		(6)					16,791	6
7	Other (specify):*				2,233	2,193							4,426	7
8	**TOTAL General Services**	(2,642)		11,128	15,164	18,747		(6)					42,391	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,482)				70,619		(4,998)					63,139	10
10a	Therapy													10a
11	Activities													11
12	Social Services					56,376							56,376	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					17,784							17,784	15
16	**TOTAL Health Care and Programs**	(2,482)				144,779		(4,998)					137,299	16
	C. General Administration													
17	Administrative			4,510	25,933	138,279							168,722	17
18	Directors Fees													18
19	Professional Services	(16,726)	12,250	(384,550)		(128,802)		86					(517,742)	19
20	Fees, Subscriptions & Promotions	(21,627)		1,311		1,666							(18,650)	20
21	Clerical & General Office Expenses	(318,926)	1,802	12,959	162,198	37,278		(6)					(104,695)	21
22	Employee Benefits & Payroll Taxes				(11,127)								(11,127)	22
23	Inservice Training & Education													23
24	Travel and Seminar			56		2,036							2,092	24
25	Other Admin. Staff Transportation			1,462									1,462	25
26	Insurance-Prop.Liab.Malpractice			2,638		1,045							3,683	26
27	Other (specify):*				42,252	24,197							66,449	27
28	**TOTAL General Administration**	(357,279)	14,052	(361,614)	219,256	75,699		81					(409,805)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(362,403)	14,052	(350,486)	234,420	239,225		(4,923)					(230,115)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(73,061)	233,248	3,751		741							164,679	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(89,238)	242,144	23,491		269							176,666	32
33	Real Estate Taxes			6,592		823							7,415	33
34	Rent-Facility & Grounds		(954,000)										(954,000)	34
35	Rent-Equipment & Vehicles			1,616									1,616	35
36	Other (specify):*	(570,808)	569,184										(1,624)	36
37	**TOTAL Ownership**	(733,107)	90,576	35,450		1,833							(605,248)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(6,471)					(6,471)	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**							(6,471)					(6,471)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,095,510)	104,628	(315,036)	234,420	241,058		(11,395)					(841,835)	45

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	19	Management Fees		G.W.H. Limited Partnership	100.00%	12,250	12,250	2
3	V	21	Administrative Expense		G.W.H. Limited Partnership	100.00%	200	200	3
4	V	21	Bank Charges		G.W.H. Limited Partnership	100.00%	102	102	4
5	V	30	Depreciation		G.W.H. Limited Partnership	100.00%	233,248	233,248	5
6	V	36	Amortization		G.W.H. Limited Partnership	100.00%	8,754	8,754	6
7	V	21	State Taxes		G.W.H. Limited Partnership	100.00%	1,500	1,500	7
8	V	32	Interest (Mortgage)		G.W.H. Limited Partnership	100.00%	177,604	177,604	8
9	V	32	Interest (Other)		G.W.H. Limited Partnership	100.00%	64,540	64,540	9
10	V	36	Loan Early Termination Expense		G.W.H. Limited Partnership	100.00%	560,430	560,430	10
11	V								11
12	V								12
13	V								13
14	Total			$ 954,000			$ 1,058,628	$ * 104,628	14

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 293	$ 293	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	854	854	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,766	1,766	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,188	2,188	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	6,027	6,027	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,510	4,510	20
21	V	19	Professional Fees	390,348	Extended Care Consulting, LLC	100.00%	5,798	(384,550)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,311	1,311	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	12,959	12,959	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	56	56	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,462	1,462	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,638	2,638	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,751	3,751	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	23,491	23,491	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	6,592	6,592	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,616	1,616	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 390,348			$ 75,312	$ * (315,036)	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	12,931	$ 12,931	15
16	V	06	Maintenance (Direct)	11,908	Extended Care Consulting, LLC	100.00%	11,908		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,199	1,199	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,034	1,034	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	25,933	25,933	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	162,198	162,198	22
23	V	21	Office and Clerical (Direct)	25,182	Extended Care Consulting, LLC	100.00%	25,182		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	36,351	36,351	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,901	5,901	25
26	V	22	Employee Benefits	11,127	Extended Care Consulting, LLC	100.00%		(11,127)	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			$ 48,217			$ 282,637	$ * 234,420	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 221	$ 221	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	248	248	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	427	427	17
18	V	19	Professional Fees	130,116	Extended Care Clinical, LLC	100.00%	1,314	(128,802)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1,666	1,666	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,769	2,769	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,036	2,036	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	1,045	1,045	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	741	741	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	269	269	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	823	823	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	15,658	15,658	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	2,193	2,193	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	70,619	70,619	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	56,376	56,376	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	17,784	17,784	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	138,279	138,279	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	34,509	34,509	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	24,197	24,197	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,116			$ 371,174	$ * 241,058	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10,370	Vent Lease LLC	100.00%	10,370	$	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			$ 10,370			$ 10,370	$ *	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 75	MAC Rx, LLC	100.00%	$ 69	$ (6)	15
16	V	10	Nursing and Medical Records	60,506	MAC Rx, LLC	100.00%	55,508	(4,998)	16
17	V	10A	Therapy		MAC Rx, LLC	100.00%			17
18	V	19	Professional Fees	(1,046)	MAC Rx, LLC	100.00%	(960)	86	18
19	V	21	Clerical & General Office Expenses	70	MAC Rx, LLC	100.00%	64	(6)	19
20	V	22	Employee Benefits		MAC Rx, LLC	100.00%			20
21	V	39	Ancillary	78,346	MAC Rx, LLC	100.00%	71,875	(6,471)	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			$ 137,951			$ 126,557	$ * (11,395)	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 475,358	$ 475,358	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	475,358	CCS Employee Benefits Group	100.00%		(475,358)	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			$ 475,358			$ 475,358	$ *	39

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ARI WOLFF	2.857%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	GWH LIMITED PARTNERSHIP	INDIAN HEAD PARK	BUILDING COMPANY	1
2	CELESTE GIANNINI TRUST DTD 3/13/00	1.020%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	CHERYL MAGENCE	3.469%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	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.C.	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	23.673%	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 SUPPLY	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	RANAN WOLFF	2.857%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13	SHIRLEY DRELICH	2.041%	LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				13
14	TZIONA ZEFFREN	2.857%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				14
15			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, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Mark Steinberg	Owner	Administrative	2.04%	See Attached	4.46	8.10%	Alloc Fee/Sal	$ 16,204	17-7	1
2	Adam Vales	Relative	Clerical	0	See Attached	2.11	5.28%	Alloc Salary	3,652	21-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 19,856		13

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	79,275	$ 293	1
2	02	Food	Patient Days	1,476,506	37	15,903		79,275	854	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		79,275	1,766	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		79,275	2,188	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		79,275	6,027	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		79,275	4,510	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		79,275	5,798	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		79,275	1,311	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		79,275	12,959	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		79,275	56	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		79,275	1,462	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		79,275	2,638	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		79,275	3,751	13
14	32	Interest	Patient Days	1,476,506	37	437,528		79,275	23,491	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		79,275	6,592	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		79,275	1,616	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 75,312	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	79,275	12,931	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		11,908	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		79,275	1,199	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			1,034	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	79,275	25,933	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	79,275	162,198	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		25,182	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		79,275	36,351	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			5,901	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					$ 5,426,248	$ 4,601,481		$ 282,637	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	781,509	20	$ 2,174	$	79,275	$ 221	1
2	05	Utilities	Patient Days	781,509	20	2,440		79,275	248	2
3	06	Maintenance	Patient Days	781,509	20	4,212		79,275	427	3
4	19	Professional Fees	Patient Days	781,509	20	12,959		79,275	1,314	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422		79,275	1,666	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302		79,275	2,769	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068		79,275	2,036	7
8	26	Insurance	Patient Days	781,509	20	10,303		79,275	1,045	8
9	30	Depreciation	Patient Days	781,509	20	7,302		79,275	741	9
10	32	Interest	Patient Days	781,509	20	2,656		79,275	269	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112		79,275	823	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	154,359	79,275	15,658	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616		79,275	2,193	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	696,174	79,275	70,619	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	555,767	79,275	56,376	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320		79,275	17,784	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	1,363,182	79,275	138,279	17
18	21	Office Salary	Patient Days	781,509	20	340,193	340,193	79,275	34,509	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538		79,275	24,197	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,659,098	$ 3,109,674		$ 371,174	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						10,370	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					$	$		$ 10,370	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance	Direct Allocation			$	$		$ 69	1
2	10	Nursing And Medical Records	Direct Allocation						55,508	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Fees	Direct Allocation						(960)	4
5	21	Clerical & General Office Expense	Direct Allocation						64	5
6	22	Employee Benefits	Direct Allocation							6
7	39	Ancillary	Direct Allocation						71,875	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					$	$		$ 126,557	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 475,358	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					$	$		$ 475,358	25

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Bank Leumi		X	Mortgage			$	$ 4,482,138			$ 177,604	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Daiwa		X	Line of Credit							34,769	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,482,138			$ 212,373	9
	B. Non-Facility Related*											
10	Interest Income		X								(24,698)	10
11	Alloc from Extended Care Consulting										23,491	11
12	Alloc from Extended Care Clinical										269	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (938)	14
15	TOTALS (line 9+line14)						$	$ 4,482,138			$ 211,435	15

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 158,132	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.)		$ 328,710	2
3. Under or (over) accrual (line 2 minus line 1).		$ 170,578	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 160,648	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.)**		$	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.		$ 331,226	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	352,195	8
	2013	365,341	9
	2014	311,912	10
	2015	316,264	11
	2016	321,295	12

2017 Accrual = 321,295 x 1.05 = 337,360 - 176,712 (2017 prepayment) = 160,648

The variance in line 7 above and line 33 on page 4 is the result of the prepayment of the 1st installment in both 2016 and 2017.

Allocated from Extended Care Consulting $6592

Allocated from Extended Care Clinical $823

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 321,294.86	$ 321,294.86
2.	See Attached	Alloc. From Care Center Building	$ 181,041.32	$ 6,591.58
3.	See Attached	Alloc. From Care Center Building	$ 181,041.32	$ 822.88
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 683,377.50	$ 328,709.32

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1997	$ 402,869	1
2	Allocated from Care Center Building			33,583	2
3	TOTALS			$ 436,452	3

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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)	$ 3,532,380	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20			4,987	9
10	Various			1987	138,915		20			138,076	10
11	Various			1988	9,885		20			9,822	11
12	Various			1989	5,410		20			5,410	12
13	Various			1990	42,578		20			42,575	13
14	Various			1991	11,813		20			11,811	14
15	Various			1992	11,426		20			11,423	15
16	Various			1993	8,851		20			8,851	16
17	Various			1994	25,632		20			25,453	17
18	Various			1995	50,028		20			50,004	18
19	Various			1996	161,111		20			158,048	19
20	Various			1997	165,320		20	2,743	2,743	164,684	20
21	Various			1998	189,177		20	9,458	9,458	185,394	21
22	Various			1999	21,736		20	1,070	1,070	19,782	22
23	Various			2000	122,845		20	6,114	6,114	106,939	23
24	Various			2001	51,096		20	2,555	2,555	42,382	24
25	Various			2002	68,816		20	98	98	68,816	25
26	Various			2003	117,820		20	1,846	1,846	110,019	26
27	Various			2004	41,864		20	620	620	37,829	27
28	Various			2005	50,621		20	296	296	48,433	28
29	Various			2006	89,874		20			89,874	29
30	Various			2007	96,414		20	2,073	2,073	96,414	30
31	Various			2008	49,099		20	2,890	2,890	43,432	31
32	Various			2009	62,307		20	5,583	5,583	53,911	32
33	Various			2010	219,458		20	21,115	21,115	164,453	33
34	Various			2011	28,338		20	1,883	1,883	20,551	34
35	Various			2012	175,678		20	16,740	16,740	90,772	35
36	Various			2013	62,201		20	8,403	8,403	36,191	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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54									54
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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)		164,237	2,449		2,449		110,072	68
69	Financial Statement Depreciation			151,967			(151,967)		69
70	TOTAL (lines 4 thru 69)		$ 8,661,863	$ 387,664		$ 250,407	$ (137,257)	$ 5,488,786	70

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 8,661,863	$ 387,664		$ 250,407	$ (137,257)	$ 5,488,786	1
2	Elevator Solid State Doors	2014	23,640		20	1,182	1,182	4,630	2
3	161 Lineal Ft Fencing	2014	10,779		20	719	719	2,575	3
4	Sensor & Controller For Chiller	2014	4,053		20	203	203	726	4
5	Fencing	2014	16,146		20	1,076	1,076	3,588	5
6	Install Oil Cooler In 2 Hydraulic Elevators	2014	12,770		20	639	639	2,128	6
7	East & West Stairway Structural Work	2014	23,400		20	1,170	1,170	3,608	7
8	South Elevator Power Supply & Transformer	2014	6,791		20	340	340	1,075	8
9	Pump Replacement	2015	10,042		20	502	502	1,464	9
10	Door Lock	2015	4,094		20	205	205	546	10
11	Electrical For New Elevator C.B.	2015	10,487		20	524	524	1,311	11
12	Injection Pump	2015	5,866		20	293	293	684	12
13	Fan Coil Unit	2015	7,500		20	375	375	813	13
14	Boiler Pipe Repair	2015	2,806		20	140	140	409	14
15	Remove & Install 2 Control Boards In # 1 And # 2	2015	7,452		20	373	373	994	15
16	Fan Coil Units In Rooms # 101 And # 103	2015	3,915		20	196	196	424	16
17	Sprinkler System Services	2015	4,225		20	211	211	493	17
18	Fire Pump Repairs	2015	4,350		20	218	218	489	18
19	Water Heater	2016	7,639		20	382	382	732	19
20	Tuckpointing - North, South, East, West Sides	2016	17,500		20	875	875	1,240	20
21	Recover Awning	2016	7,800		20	390	390	553	21
22	Roof Recovery	2016	117,000		20	5,850	5,850	8,288	22
23	Fencing & Reconstruct Piers	2016	25,000		20	1,250	1,250	2,083	23
24	Concrete Repairs At Downspout Troughs & Stairs In Basement	2016	14,600		20	730	730	1,034	24
25	Replace Kitchen Traps	2016	8,600		20	430	430	502	25
26	Strip & Caulk All Windows	2016	18,600		20	930	930	1,318	26
27	Wheelchair Ramp Concrete Repair	2016	5,200		20	260	260	368	27
28	Tuckpointing - East Side	2016	2,600		20	130	130	173	28
29	Faux Masonry Sign	2016	22,738		20	1,137	1,137	1,326	29
30	Facade Renovation	2016	200,000		20	10,000	10,000	15,833	30
31	Lintel Repair Work - Steel, Bricks, Masonry	2016	340,000		20	17,000	17,000	24,083	31
32	Architecture Fees For Renovations	2016	12,073		20	604	604	1,006	32
33	Installed Pump, Pit And Pipes For Water Leak	2016	3,000		20	150	150	163	33
34	TOTAL (lines 1 thru 33)		$ 9,622,530	$ 387,664		$ 298,889	$ (88,775)	$ 5,573,444	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,622,530	$ 387,664		$ 298,889	$ (88,775)	$ 5,573,444	1
2	Replaced Defective Guides On Tape On South Passenger Elevator	2016	4,382		20	219	219	365	2
3	Removed Ceiling Tiles, Installed New Insulation, Sealed Joints & I	2016	5,000		20	250	250	333	3
4	Concrete & Asphalt Repairs	2017	11,500		20	767	767	767	4
5	Roof Repair - Seal Seams, Install Membrane, Repair Chimney	2017	3,000		20	138	138	138	5
6	Pipe Work - Replace Sewer Line	2017	4,500		20	150	150	150	6
7	2 Doors - Laundry Room And West Exit Doors	2017	2,925		20	12	12	12	7
8	Water Heater	2017	8,563		20	285	285	285	8
9	Exhaust Vents	2017	2,588		20	129	129	129	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)		$ 9,664,989	$ 387,664		$ 300,840	$ (86,824)	$ 5,575,624	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,664,989	$ 387,664		$ 300,840	$ (86,824)	$ 5,575,624	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
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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)		$ 9,664,989	$ 387,664		$ 300,840	$ (86,824)	$ 5,575,624	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 9,664,989	$ 387,664		$ 300,840	$ (86,824)	$ 5,575,624	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)		$ 9,664,989	$ 387,664		$ 300,840	$ (86,824)	$ 5,575,624	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Extended Care Consulting-Care Center Bldg	2002	41,142	1,055	39	1,055		16,132	3
4	Allocated from Extended Care Consulting-Dyer Bldg	2007	12,886	285	39	285		2,997	4
5	Allocated from Extended Care Clinical-Care Center Bldg	2002	5,136	132	39	132		2,014	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	247	12	20	12		136	9
10	Allocated from Extended Care Consulting	2009	148	7	20	7		67	10
11	Allocated from Extended Care Consulting	2010	1,449	72	20	72		579	11
12	Allocated from Extended Care Consulting	2011	521	26	20	26		183	12
13	Allocated from Extended Care Consulting	2012	172	9	20	9		52	13
14	Allocated from Extended Care Consulting	2014	2,381	119	20	119		476	14
15	Allocated from Extended Care Consulting	2016	2,855	143	20	143		286	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2002	33,987		20			33,987	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2003	40,052		20			40,052	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,990		20			1,990	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2009	359	18	20	18		162	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2014	3,446	172	20	172		689	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2015	566	28	20	28		183	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2016	2,237	112	20	112		224	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,876	194	20	194		194	23
24	Allocated from Extended Care Clinical-Care Center Bldg	2002	4,243		20			4,243	24
25	Allocated from Extended Care Clinical-Care Center Bldg	2003	5,000		20			5,000	25
26	Allocated from Extended Care Clinical-Care Center Bldg	2005	248		20			248	26
27	Allocated from Extended Care Clinical-Care Center Bldg	2009	45	2	20	2		20	27
28	Allocated from Extended Care Clinical-Care Center Bldg	2014	417	21	20	21		83	28
29	Allocated from Extended Care Clinical-Care Center Bldg	2015	71	4	20	4		23	29
30	Allocated from Extended Care Clinical-Care Center Bldg	2016	279	14	20	14		28	30
31	Allocated from Extended Care Clinical-Care Center Bldg	2017	484	24	20	24		24	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 164,237	$ 2,449		$ 2,449	$	$ 110,072	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 164,237	$ 2,449		$ 2,449	$	$ 110,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 164,237	$ 2,449		$ 2,449	$	$ 110,072	34

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 365,305	$ 1,224	$ 14,987	$ 13,763	10	$ 333,112	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	2,003,318				10	2,003,318	73
74								74
75	TOTALS	$ 2,368,624	$ 1,224	$ 14,987	$ 13,763		$ 2,336,430	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		Various Autos & Repairs (see attached)		$ 122,319	$	$	$	5	$ 122,319	76
77		Allocated from Extended Care Consulting		9,689	274	274		5	9,416	77
78		Allocated from Extended Care Clinical		5,212	544	544		5	5,212	78
79										79
80	TOTALS			$ 137,220	$ 818	$ 818	$		$ 136,947	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)	$ 12,607,284	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 389,706	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 316,645	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (73,061)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,049,001	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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								5
6								6
7	TOTAL				$ **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 7,948 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota	$ 655	$ 7,862	17
18					18
19					19
20					20
21	TOTAL		$ 655	$ 7,862	21

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

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

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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	$		$ 168,808	$		$ 168,808	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			45,236			45,236	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			243,916			243,916	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				78,356		78,356	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					776	14,733		15,509	13
14	TOTAL			$		$ 458,736	$ 93,089		$ 551,825	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Briar Place Ltd. **#** 0031765 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 94,924	$ 396,763	1
2	Cash-Patient Deposits	44,516	44,516	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	651,765	651,765	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,403	100,403	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)	109,906	639,586	8
9	Other(specify): See Attached Schedule	436,292	445,686	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,439,796	$ 2,280,709	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	2,689,452	2,689,452	15
16	Equipment, at Historical Cost	1,291,964	2,516,964	16
17	Accumulated Depreciation (book methods)	(3,015,498)	(9,090,114)	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	2,301	59,198	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 988,019	$ 3,011,683	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,427,815	$ 5,292,392	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,375,283	$ 1,378,489	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,501	41,501	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	388,312	388,312	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,528	21,528	31
32	Accrued Real Estate Taxes(Sch.IX-B)	160,648	160,648	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	45,017	45,017	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,032,289	$ 2,035,495	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,482,138	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)**	$	$ 4,482,138	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,032,289	$ 6,517,633	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 395,526	$ (1,225,241)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,427,815	$ 5,292,392	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 385,617	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 385,618	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	131,708	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	(121,800)	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)**	$ 9,908	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)**	$ 395,526	24 *

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

Facility Name & ID Number Briar Place Ltd. # 0031765 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 11,030,338	1
2	Discounts and Allowances for all Levels	(1,423,448)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,606,890	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,456,375	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,456,375	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	583,863	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,702	19
20	Radiology and X-Ray	4,410	20
21	Other Medical Services	43,630	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 645,605	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,698	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,698	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	98	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 98	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,733,666	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,155,929	31
32	Health Care	4,148,644	32
33	General Administration	2,667,514	33
	B. Capital Expense		
34	Ownership	1,483,132	34
	C. Ancillary Expense		
35	Special Cost Centers	551,825	35
36	Provider Participation Fee	594,914	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,601,958	40
41	**Income before Income Taxes (line 30 minus line 40)****	131,708	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 131,708	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,089,390	44
45	Private Pay - Net Inpatient Revenue	164,084	45
46	Medicare - Net Inpatient Revenue	(42,140)	46
47	Other-(specify) Hospice	159,335	47
48	Other-(specify) VA, Insurance	236,221	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,606,890	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.**

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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	1,954	2,159	$ 100,382	$ 46.49	1
2	Assistant Director of Nursing	965	1,117	44,181	39.55	2
3	Registered Nurses	16,319	17,866	630,469	35.29	3
4	Licensed Practical Nurses	35,864	38,829	1,139,823	29.35	4
5	CNAs & Orderlies	32,733	36,452	521,525	14.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,571	10,491	189,372	18.05	8
9	Activity Director	3,201	3,632	69,775	19.21	9
10	Activity Assistants	9,659	10,415	96,330	9.25	10
11	Social Service Workers	28,928	31,363	554,597	17.68	11
12	Dietician					12
13	Food Service Supervisor	3,772	4,249	90,670	21.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,204	28,097	357,655	12.73	15
16	Dishwashers					16
17	Maintenance Workers	17,234	18,427	247,357	13.42	17
18	Housekeepers	22,414	24,581	273,696	11.13	18
19	Laundry	5,979	6,334	65,587	10.35	19
20	Administrator	2,078	2,159	108,268	50.15	20
21	Assistant Administrator	2,038	2,188	76,054	34.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,706	4,482	76,227	17.01	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	2,005	2,210	36,058	16.32	31
32	Other Health Care(specify)					32
33	Other(specify)	6,013	6,369	77,129	12.11	33
34	TOTAL (lines 1 - 33)	230,637	251,420	$ 4,755,155 *	$ 18.91	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	267	$ 15,561	01-03	35
36	Medical Director	Monthly	21,364	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	16	822	10a-03	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)	283	$ 37,747		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	75	$ 4,471	10-03	50
51	Licensed Practical Nurses	614	27,611	10-03	51
52	Certified Nurse Assistants/Aides	19,322	482,086	10-03	52
53	TOTAL (lines 50 - 52)	20,011	$ 514,168		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Elkaim	Administrator	0	$ 50,338
Addison Wilczak	Administrator	0	57,930
Lisa Hardaman	Asst Admin	0	76,054
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 184,322

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
Marcum LLP	Accounting	$ 39,964
Extended Care Consulting	Home Office Expense	390,348
Extended Care Clinical	Home Office Expense	130,116
Personnel Planners	Unemployment Consult	2,250
Paycor	Payroll Services	25,162
Matrixcare	Billing Software	26,968
Ability Network	Medicare Billing	4,517
National Datacare Corporation	Resident Fund Processing	3,622
Access One	Data Processing	909
Setec Security	Security Consultant	158
Kelleher, Helmrich	Management Consulting	689
See Supplemental Schedule		21,035
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 645,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,241
Unemployment Compensation Insurance	63,460
FICA Taxes	359,357
Employee Health Insurance	385,478
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	50
Other Employee Benefits	7,387
Holiday Expense	3,186
TOTAL (agree to Schedule V, line 22, col.8)	$ 957,159

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	54,593
Health Care Worker Background Check	
(Indicate # of checks performed 46)	
Patient Background Checks	2,437
Dues & Subscriptions	35,083
Licenses & Fees	11,473
Allocated from Extended Care Consulting	1,311
Allocated from Extended Care Clinical	1,666
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 108,553

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,843
Allocated from Extended Care Consulting	56
Allocated from Extended Care Clinical	2,036
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,935

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $29,186**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,313** 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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **594,914**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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