

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0031765

Facility Name: Briar Place

Address: 6800 West Joliet Road Indian Head Park 60525
 Number City Zip Code

County: Cook

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

HFS ID Number: 363472799001

Date of Initial License for Current Owners: 11/01/86

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>25,864</u>	<u>1,034</u>	<u>5,045</u>	<u>31,943</u>	8
9	SNF/PED					9
10	ICF	<u>42,320</u>	<u>1,691</u>	<u>2,384</u>	<u>46,395</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,184</u>	<u>2,725</u>	<u>7,429</u>	<u>78,338</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.51%

D. How many bed-hold days during this year were paid by the Department?

2,339 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/1/86

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/1/86 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 80 and days of care provided 4,367

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	348,651	41,799	13,102	403,552		403,552	6,402	409,954			1
2	Food Purchase		326,718		326,718		326,718	(2,874)	323,844			2
3	Housekeeping	213,718	50,024		263,742		263,742	(4,252)	259,490			3
4	Laundry	110,333	36,468		146,801		146,801	(6)	146,795			4
5	Heat and Other Utilities			214,841	214,841		214,841	3,195	218,036			5
6	Maintenance	249,351		143,194	392,545		392,545	12,559	405,104			6
7	Other (specify):*							2,445	2,445			7
8	TOTAL General Services	922,053	455,009	371,137	1,748,199		1,748,199	17,469	1,765,668			8
	B. Health Care and Programs											
9	Medical Director			14,585	14,585		14,585		14,585			9
10	Nursing and Medical Records	2,370,530	134,941	38,809	2,544,280		2,544,280	(50,613)	2,493,667			10
10a	Therapy	129,377		1,584	130,961		130,961	3,598	134,559			10a
11	Activities	99,542	8,936	2,597	111,075		111,075		111,075			11
12	Social Services	286,304	2,696	1,165	290,165		290,165	16,447	306,612			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,037	7,037			15
16	TOTAL Health Care and Programs	2,885,753	146,573	58,740	3,091,066		3,091,066	(23,531)	3,067,535			16
	C. General Administration											
17	Administrative	119,820			119,820		119,820	59,459	179,279			17
18	Directors Fees											18
19	Professional Services			478,233	478,233	(11,290)	466,943	(389,318)	77,625			19
20	Dues, Fees, Subscriptions & Promotions			91,041	91,041		91,041	693	91,734			20
21	Clerical & General Office Expenses	81,038	27,146	177,051	285,235		285,235	108,603	393,838			21
22	Employee Benefits & Payroll Taxes			577,292	577,292		577,292	(6,500)	570,792			22
23	Inservice Training & Education			628	628		628		628			23
24	Travel and Seminar			2,962	2,962		2,962	5,187	8,149			24
25	Other Admin. Staff Transportation			18,450	18,450		18,450	(7,703)	10,747			25
26	Insurance-Prop.Liab.Malpractice			228,223	228,223		228,223	(640)	227,583			26
27	Other (specify):*							41,575	41,575			27
28	TOTAL General Administration	200,858	27,146	1,573,880	1,801,884	(11,290)	1,790,594	(188,644)	1,601,950			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,008,664	628,728	2,003,757	6,641,149	(11,290)	6,629,859	(194,705)	6,435,154			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Briar Place #0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			124,115	124,115		124,115	366,139	490,254			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(336)	(336)		(336)	356,813	356,477			32
33	Real Estate Taxes			279,393	279,393	11,290	290,683	2,776	293,459			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(937,008)	5,522			34
35	Rent-Equipment & Vehicles			1,830	1,830		1,830	1,503	3,333			35
36	Other (specify):*											36
37	TOTAL Ownership			1,347,532	1,347,532	11,290	1,358,822	(209,777)	1,149,045			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		230,782	200,683	431,465		431,465	(9,770)	421,695			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		230,782	327,703	558,485		558,485	(9,770)	548,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,008,664	859,510	3,678,992	8,547,166		8,547,166	(414,252)	8,132,914			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	184,151	30		9
10	Interest and Other Investment Income	(472,436)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(113)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(88,191)	21		24
25	Fund Raising, Advertising and Promotional	(7,282)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,964)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(226)	20		28
29	Other-Attach Schedule	(91,366)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (494,427)		\$	30

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	2	
		Amount	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)	80,175		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 80,175		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (414,252)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Brief Place
 ID# 0031765
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Misc. Income	\$ (1,004)	21	1
2 Int'l. Divid. Income	244	19	2
3 Theft Loss	(458)	21	3
4 Collection Expense	(70)	21	4
5 Veterans Expense	(75,666)	19	5
6 Non-Allowable Professional Fees	(6,066)	19	6
7 Prior Year Legal Fees	(119)	19	7
8 Capitalized Auto Expense	(7,742)	25	8
9			9
10			10
11			11
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98			98
99			99
100			100
101 Total	(91,366)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			662				5,415	335			(10)	6,402	1
2	Food Purchase	(113)							(2,761)				(2,874)	2
3	Housekeeping											(4,252)	(4,252)	3
4	Laundry											(6)	(6)	4
5	Heat and Other Utilities			3,023			135		37				3,195	5
6	Maintenance			4,585	7,836		89		60	192		(203)	12,559	6
7	Other (specify):*				1,133	386		926					2,445	7
8	TOTAL General Services	(113)		8,270	8,969	386	224	6,341	(2,329)	192		(4,471)	17,469	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(75,907)						29,001				(3,707)	(50,613)	10
10a	Therapy							3,598					3,598	10a
11	Activities													11
12	Social Services				3,160			13,287					16,447	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				580			6,457					7,037	15
16	TOTAL Health Care and Programs	(75,907)			3,740			52,343				(3,707)	(23,531)	16
	C. General Administration													
17	Administrative			2,951	6,548			49,379	581				59,459	17
18	Directors Fees													18
19	Professional Services	(6,185)		(262,879)			(120,271)		17				(389,318)	19
20	Fees, Subscriptions & Promotions	(7,508)		8,124			55		26			(4)	693	20
21	Clerical & General Office Expenses	(108,687)		16,974	186,118	(552)	42	13,918	790				108,603	21
22	Employee Benefits & Payroll Taxes					(5,130)					(1,105)	(265)	(6,500)	22
23	Inservice Training & Education													23
24	Travel and Seminar			5,128			59						5,187	24
25	Other Admin. Staff Transportation	(7,742)							39				(7,703)	25
26	Insurance-Prop.Liab.Malpractice			(729)			31		58				(640)	26
27	Other (specify):*				28,735	4,025		8,622	193				41,575	27
28	TOTAL General Administration	(130,122)		(230,431)	221,401	(1,657)	(120,084)	71,919	1,704		(1,105)	(268)	(188,644)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(206,142)		(222,161)	234,110	(1,271)	(119,860)	130,603	(625)	192	(1,105)	(8,446)	(194,705)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place# 0031765 Report Period Beginning:01/01/06 Ending: 12/31/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	184,151	164,470	14,588			402		13	2,515			366,139	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(472,436)	793,616	34,214			1,147		1	271			356,813	32
33	Real Estate Taxes			2,499			264		13				2,776	33
34	Rent-Facility & Grounds		(942,530)	5,522									(937,008)	34
35	Rent-Equipment & Vehicles			1,479					24				1,503	35
36	Other (specify):*													36
37	TOTAL Ownership	(288,285)	15,556	58,302			1,813		51	2,786			(209,777)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(2,228)	(5,460)		(2,082)	(9,770)	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								(2,228)	(5,460)		(2,082)	(9,770)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(494,427)	15,556	(163,859)	234,110	(1,271)	(118,047)	130,603	(2,802)	(2,482)	(1,105)	(10,528)	(414,252)	45

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				GWH Limited Partnership		

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 942,530	GWH Limited Partnership	100.00%	\$	\$ (942,530)	1
2	V	30 Depreciation				164,470	164,470	2
3	V	32 Interest				793,616	793,616	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 942,530			\$ 958,086	\$ * 15,556	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place# 0031765Report Period Beginning: 01/01/06Ending: 12/31/06

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 662	662	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	3,023	3,023	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	4,585	4,585	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	2,951	2,951	19	
20	V	19	Professional Fees	285,269	Care Centers, Inc.	100.00%	22,390	(262,879)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	8,124	8,124	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	16,974	16,974	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	5,128	5,128	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(729)	(729)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	14,588	14,588	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	34,214	34,214	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,499	2,499	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,522	5,522	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,479	1,479	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			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			\$ 285,269			\$ 121,410	\$ * (163,859)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	7,836	7,836	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,133	1,133	16
17	V	10	Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	12	Social Service Salary	1,165	Care Centers, Inc.	100.00%	4,325	3,160	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	580	580	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	6,548	6,548	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	186,118	186,118	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	28,735	28,735	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,165			\$ 235,275	\$ * 234,110	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	3,307	Care Centers, Inc.	100.00%	3,307		15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	386	386	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21 Office Salary	30,891	Care Centers, Inc.	100.00%	30,339	(552)	22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	4,025	4,025	23
24	V							24
25	V	22 Employee Benefits	5,130				(5,130)	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		\$ 39,328			\$ 38,057	\$ * (1,271)	39

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

Facility Name & ID Number Briar Place# 0031765Report Period Beginning: 01/01/06Ending: 12/31/06

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$ 120,852	Care Centers Clinical, Inc.	100.00%	\$ 581	\$ (120,271)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	55	55	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	42	42	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	59	59	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	402	402	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	1,147	1,147	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	135	135	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	89	89	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	31	31	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	264	264	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 120,852			\$ 2,805	\$ * (118,047)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 5,415	\$ 5,415	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	926	926	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	29,001	29,001	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,598	3,598	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	13,287	13,287	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	6,457	6,457	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	49,379	49,379	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	13,918	13,918	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	8,622	8,622	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		\$				\$ 130,603	\$ * 130,603	39

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

Facility Name & ID Number Briar Place# 0031765Report Period Beginning: 01/01/06Ending: 12/31/06

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$		Care Centers Health Systems	100.00%	\$ 335	\$ 335	15
16	V	02	Food		3,142	Care Centers Health Systems	100.00%	381	(2,761)	16
17	V	05	Utilities			Care Centers Health Systems	100.00%	37	37	17
18	V	06	Maintenance			Care Centers Health Systems	100.00%	60	60	18
19	V	17	Administration			Care Centers Health Systems	100.00%	88	88	19
20	V	19	Professional Fees			Care Centers Health Systems	100.00%	17	17	20
21	V	20	Dues & Subscriptions			Care Centers Health Systems	100.00%	26	26	21
22	V	21	Office & Clerical			Care Centers Health Systems	100.00%	55	55	22
23	V	25	Auto Expenses			Care Centers Health Systems	100.00%	39	39	23
24	V	26	Insurance			Care Centers Health Systems	100.00%	58	58	24
25	V	30	Depreciation			Care Centers Health Systems	100.00%	13	13	25
26	V	32	Interest Expense			Care Centers Health Systems	100.00%	1	1	26
27	V	33	Real Estate Taxes			Care Centers Health Systems	100.00%	13	13	27
28	V	35	Rent - Equipment & Auto			Care Centers Health Systems	100.00%	24	24	28
29	V	39	Ancillary Enteral Supplies		5,839	Care Centers Health Systems	100.00%	3,611	(2,228)	29
30	V	17	Administrative-Salary			Care Centers Health Systems	100.00%	493	493	30
31	V	21	Office & Clerical-Salary			Care Centers Health Systems	100.00%	735	735	31
32	V	27	Emp. Ben. - Gen. Admin.			Care Centers Health Systems	100.00%	193	193	32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$	8,981			\$ 6,179	\$ * (2,802)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 192	\$ 192	15
16	V	30	Depreciation		Vent Lease, LLC.	100.00%	2,515	2,515	16
17	V	32	Interest		Vent Lease, LLC.	100.00%	271	271	17
18	V	39	Vent/Ancillary Reimbursement	5,460	Vent Lease, LLC.	100.00%		(5,460)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 5,460			\$ 2,978	\$ * (2,482)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 54,585	\$ 54,585	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	55,690	CCS EMPLOYEE BENEFIT GROUP	100.00%		(55,690)	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			\$ 55,690			\$ 54,585	\$ * (1,105)	39

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

Facility Name & ID Number Briar Place# 0031765Report Period Beginning: 01/01/06Ending: 12/31/06

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$ 122	Xcel Supply, LLC	100.00%	\$ 112	\$ (10)	15
16	V	03 Housekeeping	52,428	Xcel Supply, LLC	100.00%	48,177	(4,252)	16
17	V	04 Laundry	70	Xcel Supply, LLC	100.00%	65	(6)	17
18	V	06 Repairs & Maintenance	2,508	Xcel Supply, LLC	100.00%	2,305	(203)	18
19	V	10 Nursing	45,708	Xcel Supply, LLC	100.00%	42,002	(3,707)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions	46	Xcel Supply, LLC	100.00%	42	(4)	22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	3,264	Xcel Supply, LLC	100.00%	2,999	(265)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	25,674	Xcel Supply, LLC	100.00%	23,592	(2,082)	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		\$ 129,821			\$ 119,293	\$ * (10,528)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	31.43%	See Attached	1.64	3.55%	Alloc Salary	\$ 2,686	17-7	1
2	Gale Rothner	Relative	Administrative		See Attached	1.72	4.92%	Alloc Salary	3,837	17-7	2
3	Mark Steinberg	Owner	Administrative	2.04%	See Attached	2.71	4.93%	Alloc Salary	6,570	17-7	3
4	Noah Wolff	Owner	Administrative	11.84%	See Attached	10.00	25.64%				4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,093		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,592,658	31	\$ 13,468	\$ 78,338	\$ 662	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	78,338	3,023	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	78,338	4,585	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	78,338	2,951	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	78,338	22,390	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	78,338	8,124	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	78,338	16,974	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	78,338	5,128	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	78,338	(729)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	78,338	14,588	11
12	32	Interest	Patient Days	1,592,658	31	695,586	78,338	34,214	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	78,338	2,499	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	78,338	5,522	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	78,338	1,479	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 121,410	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		Patient Days	1,592,658	31			78,338		1
2	06	Maintenance Salary	1,592,658	31	159,318	159,318	78,338	7,836	2
3	07	Emp. Ben. - Gen. Serv.	1,592,658	31	23,038		78,338	1,133	3
4	10	Nursing Salary	1,592,658	31			78,338		4
5	10a	Rehab Salary	1,592,658	31			78,338		5
6	12	Social Service Salary	1,592,658	31	87,938	87,938	78,338	4,325	6
7	15	Emp. Ben. - Healthcare	1,592,658	31	11,794		78,338	580	7
8	17	Administration Salary	1,592,658	31	133,122	133,122	78,338	6,548	8
9	21	Office Salary	1,592,658	31	3,783,895	3,783,895	78,338	186,118	9
10	27	Emp. Ben. - Gen. Admin.	1,592,658	31	584,195		78,338	28,735	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,783,299	\$ 4,164,272		\$ 235,275	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3	06	Maintenance Salary	Direct Allocation	26	366,540	366,540		3,307	3
4	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795			386	4
5									5
6									6
7									7
8									8
9									9
10	21	Office Salary	Direct Allocation	23	418,249	418,249		30,339	10
11	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744			4,025	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				\$ 916,329	\$ 784,790		\$ 38,057	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 78,338	\$ 581	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	78,338	55	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	78,338	42	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	78,338	59	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	78,338	402	5
6	32	Interest	Patient Days	1,592,658	30	23,321	78,338	1,147	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	78,338	135	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	78,338	89	8
9	26	Insurance	Patient Days	1,592,658	30	623	78,338	31	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	78,338	264	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					\$ 57,020	\$	\$ 2,805	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Care Centers Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary Salary	Patient Days	1,592,658	30	110,093	110,093	78,338	5,415	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	78,338	926	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		78,338	29,001	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	78,338	3,598	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	78,338	13,287	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		78,338	6,457	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		78,338	49,379	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	78,338	13,918	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		78,338	8,622	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					\$ 2,655,265	\$ 755,172		\$ 130,603	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

Name of Related Organization Care Centers Health Systems
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,455,454	33	91,698	8,981	335	1
2	02	Food	Billable Income	2,455,454	33	104,128	8,981	381	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	8,981	37	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	8,981	60	4
5	17	Administration	Billable Income	2,455,454	33	24,000	8,981	88	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	8,981	17	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	8,981	26	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	8,981	55	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	8,981	39	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	8,981	58	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	8,981	13	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	8,981	1	12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	8,981	13	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	8,981	24	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	8,981	3,611	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	8,981	493	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	735	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	193	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 6,179	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 5,460	\$ 192	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	5,460	2,515	2
3	32	Interest	Direct Billing	868,537	31	43,063	5,460	271	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 2,978	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 54,585	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				\$	\$		\$ 54,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary						\$ 112	1
2	03	Housekeeping						48,177	2
3	04	Laundry						65	3
4	06	Repairs & Maintenance						2,305	4
5	10	Nursing						42,002	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom						42	8
9	21	Clerical & General Office							9
10	22	Employee Benefits						2,999	10
11	24	Seminars & Education							11
12	39	Ancillary						23,592	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							\$ 119,293	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10												
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
													YES	NO				Original	Balance			
	A. Directly Facility Related																					
	Long-Term																					
1	White Oak Nursing Center		X	Mortgage	\$78,544.00	3/1/97	\$ 7,441,383	\$ 6,531,333	11/01/21	12.0000	\$ 793,616	1										
2	Premier Bank		X	Auto Loan							17	2										
3	Write-off auto loan		X								(353)	3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	Allocated Care Centers		X								35,362	6										
7	Allocated Vent Lease		X								271	7										
8	See Supplemental Schedule											8										
9	TOTAL Facility Related				\$78,544.00		\$ 7,441,383	\$ 6,531,333			\$ 828,913	9										
	B. Non-Facility Related*																					
10	Interest Income										(472,436)	10										
11												11										
12												12										
13	See Supplemental Schedule											13										
14	TOTAL Non-Facility Related						\$	\$			(472,436)	14										
15	TOTALS (line 9+line14)						\$ 7,441,383	\$ 6,531,333			\$ 356,477	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 301,600	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.)		\$ 286,169	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (15,431)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 297,600	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.)		\$ 11,290	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.		\$ 293,459	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	261,097	8
	2002	288,228	9
	2003	279,622	10
	2004	287,275	11
	2005	283,393	12
<u>2006 Accrual = 2005 Tax \$283,393 x 1.05 = \$297,600 (rounded)</u>			
<u>Allocation from Care Centers \$2776</u>			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-20-102-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>283,392.69</u>	\$ <u>283,392.69</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>116,388.47</u>	\$ <u>2,461.70</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>399,781.16</u>	\$ <u>285,854.39</u>

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Briar Place

0031765 Report Period Beginning:

01/01/06 Ending:

12/31/06

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1997	\$ 402,069	1
2	Allocation - CCI - 2201 Main LLC			17,344	2
3	TOTALS			\$ 419,413	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	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	1,616	1,616	138,077	10
11	Various		1988		9,885		20	519	519	9,721	11
12	Various		1989		5,410		20	264	264	4,576	12
13	Various		1990		42,578		20	2,130	2,130	35,262	13
14	Various		1991		11,813		20	591	591	9,358	14
15	Various		1992		11,426		20	571	571	8,186	15
16	Various		1993		8,851		20	443	443	7,722	16
17	Various		1994		25,632		20	1,282	1,282	15,724	17
18	Various		1995		50,028		20	2,502	2,502	28,890	18
19	Various		1996		161,111		20	8,053	8,053	79,873	19
20	Various		1997		165,320		20	8,266	8,266	81,235	20
21	Various		1998		185,999		20	9,301	9,301	80,065	21
22	Various		1999		23,879		20	1,177	1,177	8,823	22
23	Various		2000		122,845		20	6,171	6,171	39,472	23
24	Various		2001		51,096		20	2,554	2,554	14,279	24
25	Various		2002		69,506		20	6,774	6,774	32,784	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		7,041,541	164,470		183,266	18,796	1,648,026	67
68		68,068	1,927		2,822	895	11,232	68
69			124,118			(124,118)		69
70		\$ 8,198,903	\$ 290,515		\$ 238,302	\$ (52,213)	\$ 2,258,292	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,198,903	\$ 290,515		\$ 238,302	\$ (52,213)	\$ 2,258,292	1
2	Digital Card-Phone	2003	573		20	57	57	229	2
3	Duct-Gener Rm	2003	1,480		20	74	74	296	3
4	Plumbing Work	2003	5,470		20	274	274	1,094	4
5	Panic Devices	2003	1,402		20	140	140	561	5
6	Hospital Latch	2003	1,856		20	186	186	742	6
7	Refractory Replace.	2003	3,228		20	323	323	1,291	7
8	Ignition Module	2003	570		20	29	29	114	8
9	Repair Frozen Coils	2003	1,660		20	83	83	332	9
10	Repair Leak Turbo Charger	2003	1,450		20	73	73	290	10
11	Rep. Walk In Freezer	2003	524		20	26	26	105	11
12	New Windows	2003	66,234		20	6,623	6,623	25,942	12
13	Paint	2003	1,015		20	101	101	397	13
14	Part For Boiler	2003	697		20	35	35	136	14
15	Plumbing Repair	2003	1,010		20	101	101	396	15
16	Coils	2003	4,900		20	327	327	1,252	16
17	Testing Of Coils For Leaks	2003	720		20	48	48	184	17
18	Generator	2003	1,449		20	72	72	278	18
19	Generator	2003	1,960		20	98	98	376	19
20	Paint Job	2003	931		20	93	93	349	20
21	Replaced Refractory Tiles	2003	3,228		20	161	161	605	21
22	Boiler	2003	1,290		20	64	64	242	22
23	A/C Parts	2003	586		20	29	29	105	23
24	Void	2003	(925)		20	(92)	(92)	(331)	24
25	Plumbing Equipment	2003	658		20	66	66	230	25
26	Fresh Air Dampers	2003	3,000		20	150	150	525	26
27	A/C Repair	2003	1,486		20	74	74	254	27
28	Generator	2003	1,132		20	57	57	193	28
29	Tar Coating On Parking Lot	2003	2,471		20	247	247	844	29
30	Paint	2003	685		20	69	69	228	30
31	Fence Repair	2003	550		20	55	55	183	31
32	4 New Doors	2003	3,650		20	365	365	1,217	32
33	Repair Of Air Handling Unit	2003	1,342		20	67	67	218	33
34	TOTAL (lines 1 thru 33)		\$ 8,315,185	\$ 290,515		\$ 248,377	\$ (42,138)	\$ 2,297,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,315,185	\$ 290,515		\$ 248,377	\$ (42,138)	\$ 2,297,169	1
2	Installed Detector & Door Screen	2003	1,526		20	76	76	248	2
3	Water Heater Repair	2003	585		20	29	29	95	3
4	Generator Maintenance	2004	1,223		20	245	245	693	4
5	Labor & Equip. For Plumbing	2004	735		20	147	147	392	5
6	Retiling Of Shower Stalls	2004	5,000		20	500	500	1,292	6
7	Installation Of Sprinkler Heads	2004	9,300		20	930	930	2,403	7
8	Parts For Doors	2004	1,925		20	192	192	449	8
9	Repair On Sewage Pump	2004	1,243		20	249	249	580	9
10	Dp On New 2Nd Floor Showers	2004	4,000		20	400	400	867	10
11	Generator Repair	2004	620		20	124	124	269	11
12	Sprinkler System Repair	2004	2,295		20	459	459	994	12
13	Glass Frames & Door Hinges	2004	748		20	150	150	312	13
14	Glass Frames & Door Hinges	2004	518		20	104	104	216	14
15	Fire Dampers	2004	581		20	83	83	173	15
16	Installation Of Window	2004	1,275		20	255	255	531	16
17	Painting	2004	774		20	39	39	116	17
18	Gas Valve Repair	2004	733		20	37	37	104	18
19	Painting	2004	1,065		20	53	53	151	19
20	Plaster & Paint Rooms	2004	7,000		20	350	350	846	20
21	Asphalt Patching	2004	1,200		20	60	60	145	21
22	Walk-In Cooler Repair	2004	870		20	44	44	102	22
23	Air Filters	2004	758		20	38	38	82	23
24	Remodeling Of 2Nd Floor	2005	9,050		20	905	905	1,735	24
25	New Water Pump For Air Conditioner	2005	5,142		20	1,028	1,028	1,714	25
26	New Patio Awning	2005	7,900		20	790	790	1,185	26
27	Generator Repairs	2005	3,520		20	704	704	1,056	27
28	Repalced Compressor On A/C Chiller	2005	5,496		20	1,099	1,099	1,557	28
29	Installed Norstar Mics Phone System	2005	15,250		20	3,050	3,050	4,067	29
30	Furnish & Install Door Protection	2005	1,725		20	86	86	137	30
31	Replace Sprinkler Heads	2005	2,105		20	105	105	175	31
32	Camera & Monitor	2005	2,093		20	105	105	166	32
33	Installation Of New Grease Trap For Kitchen	2005	10,710		20	1,071	1,071	1,964	33
34	TOTAL (lines 1 thru 33)		\$ 8,422,150	\$ 290,515		\$ 261,884	\$ (28,631)	\$ 2,321,985	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,422,150	\$ 290,515		\$ 261,884	\$ (28,631)	\$ 2,321,985	1
2	Patio Roof Repair-Sundek Of Illinois	2006	19,985		20	1,332	1,332	1,332	2
3	Bruno'S Tuckpointing- Tuckpointing Repairs	2006	2,840		20	166	166	166	3
4	Tuckpointing Repairs- Brunos'S Tuckpointing	2006	4,439		20	259	259	259	4
5	Stainless Steel Cab For 2 Elevators- Valley Elevator	2006	9,975		20	1,829	1,829	1,829	5
6	Emergency Generator Repairs- Lionheart Engineering	2006	5,513		20	322	322	322	6
7	Replaced Panel Board For Fire Alarm System- Fox Valley Fire & S	2006	2,765		20	277	277	277	7
8	Tiling Of Floor And Walls - 1St Floor	2006	5,500		20	92	92	92	8
9	Tiling Of Floor And Walls - 2Nd Floor	2006	11,200		20	187	187	187	9
10	Work On New Ventilation System	2006	17,400		20	290	290	290	10
11	Water Heater	2006	6,474		20	216	216	216	11
12	Cubicle Curtains	2006	3,783		20	63	63	63	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		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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16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		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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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12N, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12P, Carried Forward	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,512,024	\$ 290,515		\$ 266,917	\$ (23,598)	\$ 2,327,018		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	\$ 7,041,541	\$ 164,470		\$ 183,266	\$ 18,796	\$ 1,648,026	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 7,041,541	\$ 164,470		\$ 183,266	\$ 18,796	\$ 1,648,026	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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		Allocation-Care Centers Clinical-2201 Main LLC	2002	2002	\$ 2,269	\$ 58	39	\$ 58	\$	\$ 250	4
5		Allocation - CCI - 2201 Main LLC	2002	2002	21,516	552	39	552		2,368	5
6		Allocaton Care Center Health Systems	2002	2002	115	3	39	3		13	6
7											7
8											8
		Improvement Type**									
9		Allocation-Care Centers Clinical-2201 Main LLC		2002	1,875	78	20	94	16	422	9
10		Allocation-Care Centers Clinical-2201 Main LLC		2003	2,209	42	20	110	68	387	10
11		Allocation-Care Centers Clinical-2201 Main LLC		2005	110	5	20	6	1	8	11
12											12
13		Allocation - CCI - 2201 Main LLC		2002	17,774	739	20	889	150	3,999	13
14		Allocation - CCI - 2201 Main LLC		2003	20,946	398	20	1,047	649	3,666	14
15		Allocation - CCI - 2201 Main LLC		2005	1,041	46	20	52	6	78	15
16											16
17		Allocation - CCI Health Systems		2002	95	4	20	5	1	21	17
18		Allocation - CCI Health Systems		2003	112	2	20	6	4	20	18
19		Allocation - CCI Health Systems		2005	6		20				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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		68,068	1,927		2,822	895	11,232	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,967,087	\$ 14,944	\$ 207,491	\$ 192,547	10	\$ 1,777,082	71
72	Current Year Purchases	478	72	72		10	72	72
73	Fully Depreciated Assets	236,825				10	236,825	73
74								74
75	TOTALS	\$ 2,204,390	\$ 15,016	\$ 207,563	\$ 192,547		\$ 2,013,979	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		AUTOS - SEE ATTACHED		\$ 119,568	\$	\$ 12,729	\$ 12,729	5	\$ 74,092	76
77		Allocated CC Clinical	2005	2,151	146	146		5	146	77
78		Allocated Care Centers Inc		35,370	429	2,902	2,473	5	25,303	78
79										79
80	TOTALS			\$ 157,089	\$ 575	\$ 15,777	\$ 15,202		\$ 99,541	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,292,916	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,106	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 490,257	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 184,151	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,440,538	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Allocation from Care Centers				5,522			5
6								6
7	TOTAL				\$ 5,522			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: _____ *

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: \$ 3,333 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	\$		\$ 89,476	\$		\$ 89,476	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,054			3,054	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			108,153			108,153	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 prescripts				179,946		179,946	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						50,836		50,836	13
14	TOTAL			\$		\$ 200,683	\$ 230,782		\$ 431,465	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (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	\$ (201,397)	\$ (201,397)	1
2	Cash-Patient Deposits	58,333	58,333	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,834,290	2,131,890	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	266,535	266,535	6
7	Other Prepaid Expenses	2,963	2,963	7
8	Accounts Receivable (owners or related parties)	679,820	460,500	8
9	Other(specify): <u>See Attached Schedule</u>	5,783,047	5,783,047	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,423,591	\$ 8,501,871	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,208,851	1,208,851	15
16	Equipment, at Historical Cost	1,119,125	2,344,125	16
17	Accumulated Depreciation (book methods)	(1,853,850)	(4,689,285)	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): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 474,126	\$ 5,680,074	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,897,717	\$ 14,181,945	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,404,785	\$ 1,702,385	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,020	39,020	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,195	283,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,670	23,670	31
32	Accrued Real Estate Taxes(Sch.IX-B)	297,600	297,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	13,873	13,873	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,062,143	\$ 2,359,743	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,531,333	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,531,333	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,062,143	\$ 8,891,076	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,835,574	\$ 5,290,869	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,897,717	\$ 14,181,945	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,022,540	1
2	Restatements (describe):		2
3	Professional Fees	1,428	3
4	Accumulated Depreciation	(177)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,023,791	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,812,943	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(1,160)	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	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)	\$ 1,811,783	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)	\$ 6,835,574	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning: 01/01/06

Ending: 12/31/06

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,798,155	1
2	Discounts and Allowances for all Levels	(1,121,265)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,676,890	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	880,420	6
7	Oxygen	707	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 881,127	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	254,967	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,042	19
20	Radiology and X-Ray	6,600	20
21	Other Medical Services	17,802	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 328,411	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	472,436	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 472,436	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,245	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,245	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,360,109	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,748,199	31
32	Health Care	3,091,066	32
33	General Administration	1,801,884	33
B. Capital Expense			
34	Ownership	1,347,532	34
C. Ancillary Expense			
35	Special Cost Centers	431,465	35
36	Provider Participation Fee	127,020	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,547,166	40
41	Income before Income Taxes (line 30 minus line 40)**	1,812,943	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,812,943	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/06

Ending:

12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,872	2,169	\$ 75,487	\$ 34.80	1
2	Assistant Director of Nursing	1,011	1,123	37,648	33.52	2
3	Registered Nurses	21,038	22,809	660,282	28.95	3
4	Licensed Practical Nurses	26,804	28,684	735,124	25.63	4
5	CNAs & Orderlies	72,195	76,453	828,429	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,482	9,300	129,377	13.91	8
9	Activity Director	1,304	1,412	18,566	13.15	9
10	Activity Assistants	9,281	9,989	80,976	8.11	10
11	Social Service Workers	19,265	20,914	286,304	13.69	11
12	Dietician	1,700	1,924	28,863	15.00	12
13	Food Service Supervisor	1,838	2,160	41,010	18.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,463	6,305	85,903	13.62	15
16	Dishwashers	21,781	23,251	192,875	8.30	16
17	Maintenance Workers	18,000	19,697	249,351	12.66	17
18	Housekeepers	24,477	26,442	213,718	8.08	18
19	Laundry	11,388	12,142	110,333	9.09	19
20	Administrator	2,009	2,043	76,928	37.65	20
21	Assistant Administrator	1,990	2,064	42,892	20.78	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,961	6,451	81,038	12.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,599	2,169	33,560	15.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	257,458	277,501	\$ 4,008,664 *	\$ 14.45	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	306	\$ 13,102	01-03	35
36	Medical Director	monthly	14,585	09-03	36
37	Medical Records Consultant	11	455	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,274	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,597	11-03	44
45	Social Service Consultant				45
46	Other(specify) Therapy Consultant	monthly	1,584	10A-03	46
47	Psychiatrist Consultant	monthly	750	10-03	47
48	Admissions Consultant (CCI)		1,165	12-03	48
49	TOTAL (lines 35 - 48)	370	\$ 37,512		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	62	\$ 3,562	10-03	50
51	Licensed Practical Nurses	1,014	25,124	10-03	51
52	Certified Nurse Assistants/Aides	256	5,644	10-03	52
53	TOTAL (lines 50 - 52)	1,332	\$ 34,330		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Hilda Derzsy	Administrator	0	\$ 76,928	Workers' Compensation Insurance	\$ 90,297	IDPH License Fee	\$ 995			
Rosemarie Obregon	Asst. Admin	0	42,892	Unemployment Compensation Insurance	59,994	Advertising: Employee Recruitment	54,993			
				FICA Taxes	299,755	Health Care Worker Background Check	4,553			
				Employee Health Insurance	93,936	(Indicate # of checks performed <u>205</u>)				
				Employee Meals		Patient Background Checks <u>monthly</u>	720			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	13,209			
				Employee Physicals	3,410	Licenses & Fees	9,063			
				Other Employee Benefits	20,230	Advertising & Promotion	7,508			
				Holiday Expense	3,170	Allocation from Care Centers	8,201			
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 119,820							
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$				
							Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 570,792	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 91,734
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
Frost, Ruttenberg & Rothblatt	Accounting	\$ 8,503				\$	Out-of-State Travel	\$		
Care Centers, Inc.	Accounting	1,250								
Personnel Planners	Unemployment Consultant	3,563								
Care Centers, Inc.	Home Office Expense	400,671					In-State Travel			
ADP, Inc.	Payroll Services	10,674								
IIT / Sourcetek	Computer Service	715								
National Datacare Corp.	Computer Service	2,070								
eHealth Data Solutions	MDS Software	3,255					Seminar Expense	2,962		
Care Centers, Inc.	Other Professional Fees	4,200					Allocation from Care Centers	5,187		
National Hotline Services	Employee Compliance	150								
Various - See Attached	Legal	28,203								
See Supplemental Schedule		14,979					Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 8,149
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 478,233							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Briar Place

Report Period Beginning: 01/01/06 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

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 \$11,878
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (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? _____
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,345 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. \$ 127,020
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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT