

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/07 Ending: 12/31/07

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>26,141</u>	<u>1,027</u>	<u>3,109</u>	<u>30,277</u>	8
9	SNF/PED					9
10	ICF	<u>42,773</u>	<u>1,680</u>	<u>3,553</u>	<u>48,006</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,914</u>	<u>2,707</u>	<u>6,662</u>	<u>78,283</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.45%

D. How many bed-hold days during this year were paid by the Department? 2,234 (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 11/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/86 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 2,098

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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	341,092	37,909	11,525	390,526		390,526	3,596	394,122		1
2	Food Purchase		326,677		326,677		326,677	289	326,966		2
3	Housekeeping	208,863	50,119		258,982		258,982	(3,376)	255,606		3
4	Laundry	111,347	28,822		140,169		140,169		140,169		4
5	Heat and Other Utilities			201,836	201,836		201,836	3,161	204,997		5
6	Maintenance	264,523		163,692	428,215		428,215	13,505	441,720		6
7	Other (specify):*							2,235	2,235		7
8	TOTAL General Services	925,825	443,527	377,053	1,746,405		1,746,405	19,410	1,765,815		8
	B. Health Care and Programs										
9	Medical Director			16,013	16,013		16,013		16,013		9
10	Nursing and Medical Records	2,392,412	140,223	9,212	2,541,847		2,541,847	(50,717)	2,491,130		10
10a	Therapy	166,147		468	166,615		166,615	3,474	170,089		10a
11	Activities	113,593	14,199	2,392	130,184		130,184		130,184		11
12	Social Services	300,041	101		300,142		300,142	9,976	310,118		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,405	6,405		15
16	TOTAL Health Care and Programs	2,972,193	154,523	28,085	3,154,801		3,154,801	(30,862)	3,123,939		16
	C. General Administration										
17	Administrative	120,318			120,318		120,318	78,547	198,865		17
18	Directors Fees										18
19	Professional Services			478,875	478,875		478,875	(417,750)	61,125		19
20	Dues, Fees, Subscriptions & Promotions			79,328	79,328		79,328	(15,583)	63,745		20
21	Clerical & General Office Expenses	85,705	22,924	172,708	281,337		281,337	103,687	385,024		21
22	Employee Benefits & Payroll Taxes			611,363	611,363		611,363	(5,512)	605,851		22
23	Inservice Training & Education			4,362	4,362		4,362		4,362		23
24	Travel and Seminar			2,507	2,507		2,507	1,670	4,177		24
25	Other Admin. Staff Transportation			11,267	11,267		11,267	1,850	13,117		25
26	Insurance-Prop.Liab.Malpractice			228,262	228,262		228,262	2,060	230,322		26
27	Other (specify):*							46,274	46,274		27
28	TOTAL General Administration	206,023	22,924	1,588,672	1,817,619		1,817,619	(204,757)	1,612,862		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,104,041	620,974	1,993,810	6,718,825		6,718,825	(216,209)	6,502,616		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			124,790	124,790	124,790	367,948	492,738			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						189,553	189,553			32
33	Real Estate Taxes			291,284	291,284	291,284	3,732	295,016			33
34	Rent-Facility & Grounds			942,530	942,530	942,530	(938,689)	3,841			34
35	Rent-Equipment & Vehicles			4,181	4,181	4,181	635	4,816			35
36	Other (specify):*										36
37	TOTAL Ownership			1,362,785	1,362,785	1,362,785	(376,821)	985,964			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		171,855	32,038	203,893	203,893	(22,644)	181,249			39
40	Barber and Beauty Shops			10	10	10		10			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			127,020	127,020	127,020		127,020			42
43	Other (specify):*						3,434	3,434			43
44	TOTAL Special Cost Centers		171,855	159,068	330,923	330,923	(19,210)	311,713			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,104,041	792,829	3,515,663	8,412,533	8,412,533	(612,240)	7,800,293			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:

01/01/07

Ending:

12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	176,038	30		9
10	Interest and Other Investment Income	(636,429)	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	(149)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,762)	21		24
25	Fund Raising, Advertising and Promotional	(8,339)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(32,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(891)	20		28
29	Other-Attach Schedule	(126,147)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (698,792)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	86,552		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 86,552		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (612,240)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Brief Place
 ID# 0031765
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Miscellaneous Income	\$ (12,473) 21 1
2	Bury Debt Income	(34) 10 2
3	Patient Clothing	(50) 10 3
4	Theft Loss	(11) 21 4
5	Collection Expense	(120) 21 5
6	V/A Pharmacy	(82,791) 10 6
7	PPA - Professional Fees	(3,958) 19 7
8	PPA - Dues & Subscriptions	(12,126) 20 8
9	CCRF Dues	(2,760) 20 9
10	Out of State and Prior Period Seminar	(609) 24 10
11	Prior Period Legal Fees	(11,203) 19 11
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101	Total	(126,147) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			326	4,627	(1,338)			(19)				3,596	1
2	Food Purchase	(113)		402									289	2
3	Housekeeping			613	62	3			(4,054)				(3,376)	3
4	Laundry													4
5	Heat and Other Utilities			2,921	158	82							3,161	5
6	Maintenance			13,828	20	34		200	(577)				13,505	6
7	Other (specify):*			1,796	439								2,235	7
8	TOTAL General Services	(113)		19,886	5,306	(1,219)		200	(4,650)				19,410	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(82,875)			35,954	(95)			(3,701)				(50,717)	10
10a	Therapy				3,474								3,474	10a
11	Activities													11
12	Social Services				9,976								9,976	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,405								6,405	15
16	TOTAL Health Care and Programs	(82,875)			55,809	(95)			(3,701)				(30,862)	16
	C. General Administration													
17	Administrative			13,940	63,133	676	798						78,547	17
18	Directors Fees													18
19	Professional Services	(15,161)		(279,475)	(123,168)	9	45						(417,750)	19
20	Fees, Subscriptions & Promotions	(24,128)		8,418	39	51	37						(15,583)	20
21	Clerical & General Office Expenses	(115,515)		205,202	16,342	1,133	274	(3,749)					103,687	21
22	Employee Benefits & Payroll Taxes			(5,025)	(59)				(428)				(5,512)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(609)		1,424	758		97						1,670	24
25	Other Admin. Staff Transportation			1,843		7							1,850	25
26	Insurance-Prop.Liab.Malpractice			1,868	20	74	98						2,060	26
27	Other (specify):*			35,175	10,732	270	97						46,274	27
28	TOTAL General Administration	(155,413)		(16,630)	(32,203)	2,220	1,446	(3,749)	(428)				(204,757)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(238,401)		3,256	28,912	906	1,446	(3,549)	(8,779)				(216,209)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place# 0031765

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	176,038	164,470	23,815	1,000	58	52	2,515					367,948	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(636,429)	774,730	44,935	4,307	97	486	1,427					189,553	32
33	Real Estate Taxes			3,486	235	11							3,732	33
34	Rent-Facility & Grounds		(942,530)	3,765		76							(938,689)	34
35	Rent-Equipment & Vehicles			496	7	19	113						635	35
36	Other (specify):*													36
37	TOTAL Ownership	(460,391)	(3,330)	76,497	5,549	261	651	3,942					(376,821)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(8,100)	(6,915)	(5,015)	(2,614)				(22,644)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*						3,434						3,434	43
44	TOTAL Special Cost Centers					(8,100)	(3,481)	(5,015)	(2,614)				(19,210)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(698,792)	(3,330)	79,753	34,461	(6,933)	(1,384)	(4,622)	(11,393)				(612,240)	45

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		
				G W H Limited Partnership		Building Co.

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	G W H Limited Partnership	100.00%	\$	\$ (942,530)	1
2	V	30 Depreciation				164,470	164,470	2
3	V	32 Interest				774,730	774,730	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			\$ 939,200	\$ * (3,330)	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: 01/01/07Ending: 12/31/07

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%	\$ 326	\$ 326	15	
16	V	02	Food		Care Centers, Inc.	100.00%	402	402	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	613	613	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	2,921	2,921	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	4,817	4,817	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	2,918	2,918	20	
21	V	19	Professional Fees	294,876	Care Centers, Inc.	100.00%	15,401	(279,475)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	8,418	8,418	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	24,397	24,397	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	1,424	1,424	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,843	1,843	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,868	1,868	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	23,815	23,815	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	44,935	44,935	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,486	3,486	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,765	3,765	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	496	496	31	
32	V	06	Maintenance	1,998	Care Centers, Inc.	100.00%	11,009	9,011	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,796	1,796	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	11,022	11,022	34	
35	V	21	Office and Clerical	32,058	Care Centers, Inc.	100.00%	212,863	180,805	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	35,175	35,175	36	
37	V	22	Employee Benefits	5,025	Care Centers, Inc.	100.00%		(5,025)	37	
38	V								38	
39	Total			\$ 333,957			\$ 413,710	\$ * 79,753	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: 01/01/07 Ending: 12/31/07

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	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 62	\$ 62	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	158	158	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	20	20	17	
18	V	19	Professional Fees	125,802	Care Centers Clinical, Inc.	100.00%	2,634	(123,168)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	39	39	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	154	154	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	758	758	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	20	20	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	1,000	1,000	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	4,307	4,307	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	235	235	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	7	7	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	4,627	4,627	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	439	439	28	
29	V	10	Nursing Salary	392	Care Centers Clinical, Inc.	100.00%	36,346	35,954	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,474	3,474	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	9,976	9,976	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	6,405	6,405	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	63,133	63,133	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	16,188	16,188	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	10,732	10,732	35	
36	V	22	Employee Benefits	59	Care Centers Clinical, Inc.	100.00%		(59)	36	
37	V								37	
38	V								38	
39	Total			\$ 126,253			\$ 160,714	\$ * 34,461	39	

* 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: 01/01/07Ending: 12/31/07

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, Inc.	100.00%	\$ 411	\$ 411	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	3	3	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	82	82	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	34	34	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	9	9	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	51	51	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	177	177	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	39	39	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	74	74	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	58	58	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	97	97	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	11	11	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	76	76	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	19	19	28	
29	V	01	Dietary	2,604	Care Centers Health Systems, Inc.	100.00%	855	(1,749)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing	141	Care Centers Health Systems, Inc.	100.00%	46	(95)	32	
33	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33	
34	V	25	Other Admin. Staff Transport.	47	Care Centers Health Systems, Inc.	100.00%	15	(32)	34	
35	V	39	Ancillary	12,059	Care Centers Health Systems, Inc.	100.00%	3,959	(8,100)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	676	676	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	956	956	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	270	270	38	
39	Total			\$ 14,851			\$ 7,918	\$ * (6,933)	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		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	17	Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 56	\$ 56	15	
16	V	19	Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	45	45	16	
17	V	20	Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	37	37	17	
18	V	21	Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	274	274	18	
19	V	24	Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	97	97	19	
20	V	26	Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	98	98	20	
21	V	30	Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	52	52	21	
22	V	32	Interest		Therapy Works Rehabilitation Services, LLC	100.00%	486	486	22	
23	V	35	Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	113	113	23	
24	V	39	Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	1,310	1,310	24	
25	V	17	Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	742	742	25	
26	V	27	Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	97	97	26	
27	V	39	Ancillary	32,061	Therapy Works Rehabilitation Services, LLC	100.00%	23,836	(8,225)	27	
28	V	43	Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	3,434	3,434	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			\$ 32,061			\$ 30,677	\$ * (1,384)	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	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 200	\$ 200	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	1,574	1,574	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	132	132	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	941	941	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,295	1,295	20
21	V	21	Office and Clerical	3,749	Vent Lease, LLC.	100.00%		(3,749)	21
22	V	39	Ancillary	5,015	Vent Lease, LLC.	100.00%		(5,015)	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		\$ 8,764				\$ 4,142	\$ * (4,622)	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	1 Dietary	\$ 239	Xcel Supply, LLC	100.00%	\$ 220	\$ (19)	15
16	V	3 Housekeeping	50,272	Xcel Supply, LLC	100.00%	46,218	(4,054)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance	7,163	Xcel Supply, LLC	100.00%	6,586	(577)	18
19	V	10 Nursing	45,880	Xcel Supply, LLC	100.00%	42,179	(3,701)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	5,306	Xcel Supply, LLC	100.00%	4,878	(428)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	32,415	Xcel Supply, LLC	100.00%	29,801	(2,614)	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		\$ 141,275			\$ 129,882	\$ * (11,393)	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 77,934	\$ 77,934	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	77,934	CCS Employee Benefits Group			(77,934)	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			\$ 77,934			\$ 77,934	\$ *	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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	1.60	3.47%		\$	17-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	2.63	4.78%	Alloc. Salary	6,465	17-7	2
3	Noah Wolff	Owner	Administrative	11.84%	See Attached	10.00	27.78%			17-7	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.48	1.20%	Alloc. Salary	671	22-7	4
5	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.42	1.20%	Alloc. Salary	369	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,505		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: 01/01/07 Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 77,767	\$ 326	1
2	2	Food	Patient Days	1,625,640	33	8,403	77,767	402	2
3	3	Housekeeping	Patient Days	1,625,640	33	12,807	77,767	613	3
4	5	Utilities	Patient Days	1,625,640	33	61,054	77,767	2,921	4
5	6	Maintenance	Patient Days	1,625,640	33	100,693	77,767	4,817	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	77,767	2,918	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	77,767	15,401	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	77,767	8,418	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	77,767	24,397	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	77,767	1,424	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	77,767	1,843	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	77,767	1,868	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	77,767	23,815	13
14	32	Interest	Patient Days	1,625,640	33	939,326	77,767	44,935	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	77,767	3,486	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	77,767	3,765	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	77,767	496	17
18	6	Maintenance	Patient Days	1,625,640	33	187,019	187,019	8,947	18
19	6	Maintenance	Direct Allocation			456,812	456,812	2,062	19
20	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	77,767	1,796	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	11,022	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	180,805	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	32,058	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	77,767	35,175	24
25	TOTALS					\$ 8,891,187	\$ 5,143,113	\$ 413,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Center 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	3	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 77,767	\$ 62	1	
2	5	Utilities	Patient Days	1,625,640	32	3,307	77,767	158	2	
3	6	Maintenance	Patient Days	1,625,640	32	410	77,767	20	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	77,767	2,634	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	77,767	39	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	77,767	154	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	77,767	758	7	
8	26	Insurance	Patient Days	1,625,640	32	409	77,767	20	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	77,767	1,000	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	77,767	4,307	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	77,767	235	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	77,767	7	12	
13	1	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	77,767	4,627	13
14	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	77,767	439	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	77,767	35,941	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	77,767	3,474	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	77,767	9,976	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	77,767	6,368	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	77,767	63,133	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	77,767	16,188	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	77,767	10,732	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		405	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845			23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			37	24
25	TOTALS					\$ 3,374,560	\$ 2,809,548	\$ 160,714	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Health Systems, 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	Dietary	Gross Billable Income	4,431,674	33	94,358	19,319	411	1	
2	3	Housekeeping	Gross Billable Income	4,431,674	33	663	19,319	3	2	
3	5	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	19,319	82	3	
4	6	Maintenance	Gross Billable Income	4,431,674	33	7,696	19,319	34	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	19,319	9	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	19,319	51	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	19,319	177	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	19,319	39	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	19,319	74	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	19,319	58	10	
11	32	Insurance	Gross Billable Income	4,431,674	33	22,225	19,319	97	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	19,319	11	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	19,319	76	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	19,319	19	14	
15	1	Dietary	Direct Billable Income	341,879	33	112,243	2,604	855	15	
16	2	Food	Direct Billable Income	25	33	8			16	
17	3	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	141	46	18	
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394	47	15	20	
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	12,059	3,959	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	19,319	676	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	19,319	956	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	19,319	270	24	
25	TOTALS					\$ 2,152,813	\$ 374,301	\$ 7,918	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 Fax Number (847) 905-4040

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	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 28,988	\$ 56	1
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	28,988	45	2
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	28,988	37	3
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	28,988	274	4
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	28,988	97	5
6	26	Insurance	Billable Income	4,671,432	16	15,816	28,988	98	6
7	30	Depreciation	Billable Income	4,671,432	16	8,410	28,988	52	7
8	32	Interest	Billable Income	4,671,432	16	78,317	28,988	486	8
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	28,988	113	9
10	39	Ancillary	Billable Income	4,671,432	16	211,187	28,988	1,310	10
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	742	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	28,988	97	12
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	23,836	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	28,988	3,434	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,943,773	\$ 3,960,830	\$ 30,677	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/07

Ending: 12/31/07

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	6	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 5,015	\$ 200	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	5,015		2
3	30	Depreciation	Direct Billing	892,186	27	280,000	5,015	1,574	3
4	32	Interest	Direct Billing	892,186	27	23,404	5,015	132	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	77,767	941	5
6	32	Interest	Patient Days	1,625,640	33	27,081	77,767	1,295	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					\$ 385,763	\$	\$ 4,142	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	1	Dietary	Direct Allocation			\$		\$ 220	1
2	3	Housekeeping	Direct Allocation					46,218	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					6,586	4
5	10	Nursing	Direct Allocation					42,179	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					4,878	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					29,801	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					\$	\$	129,882	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/07

Ending: 12/31/07

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		\$	\$		\$ 77,934	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				\$	\$		\$ 77,934	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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:

01/01/07

Ending:

12/31/07

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	\$ 6,363,532	11/01/21	12.0000	\$ 774,730	1										
2												2										
3	Auto Loan		X					20,353				3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6												6										
7												7										
8	See Supplemental Schedule											8										
9	TOTAL Facility Related				\$78,544.00		\$ 7,441,383	\$ 6,383,885			\$ 774,730	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(636,429)	10										
11												11										
12												12										
13	See Supplemental Schedule										51,252	13										
14	TOTAL Non-Facility Related						\$	\$			(585,177)	14										
15	TOTALS (line 9+line14)						\$ 7,441,383	\$ 6,383,885			\$ 189,553	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

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:

01/01/07

Ending:

12/31/07

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15	Allocate Care Centers, Inc.		X				\$	\$			\$	44,935	15						
16	Allocate CC Clinical		X									4,307	16						
17	Allocate CC Health Sys.		X									97	17						
18	Allocate Therapy Works		X									486	18						
19	Allocate Vent Lease LLC		X									1,427	19						
20	TOTAL Non-Facility Related											51,252	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

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<u>297,600</u>	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.)			\$	<u>291,016</u>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(6,584)</u>	3																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>301,600</u>	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>295,016</u>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2002	<u>288,228</u>	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2006	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
2003	<u>279,622</u>	9																						
2004	<u>287,275</u>	10																						
2005	<u>283,393</u>	11																						
2006	<u>287,284</u>	12																						
<u>2007 Accrual = \$287,284 x 1.035 (Rounded)</u>																								
<u>Allocated from Care Centers - \$3,629.70</u>																								

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-20-102-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>287,283.95</u>	\$ <u>287,283.95</u>
2. <u>See Attached</u>	<u>Care Centers, Inc. Allocation</u>	\$ <u>46,662.50</u>	\$ <u>2,232.23</u>
3. <u>See Attached</u>	<u>Care Centers Clinical, Inc.</u>	\$ <u>4,834.42</u>	\$ <u>231.27</u>
4. <u>See Attached</u>	<u>Care Centers Health Sys. Alloc.</u>	\$ <u>2,476.87</u>	\$ <u>10.80</u>
5. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>24,152.48</u>	\$ <u>1,155.40</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>365,410.22</u>	\$ <u>290,913.65</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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	Allocate Care Centers, Inc.			19,176	2
3	TOTALS			\$ 421,245	3

SEE ACCOUNTANTS' COMPILATION REPORT

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			138,077	10
11	Various			1988	9,885		20	101	101	9,822	11
12	Various			1989	5,410		20	264	264	4,839	12
13	Various			1990	42,578		20	2,130	2,130	37,392	13
14	Various			1991	11,813		20	591	591	9,948	14
15	Various			1992	11,426		20	571	571	8,757	15
16	Various			1993	8,851		20	443	443	8,165	16
17	Various			1994	25,632		20	1,282	1,282	17,004	17
18	Various			1995	50,028		20	2,502	2,502	31,392	18
19	Various			1996	161,111		20	8,053	8,053	87,929	19
20	Various			1997	165,320		20	8,266	8,266	89,499	20
21	Various			1998	185,999		20	9,301	9,301	89,366	21
22	Various			1999	23,879		20	1,177	1,177	10,001	22
23	Various			2000	122,845		20	6,171	6,171	45,640	23
24	Various			2001	51,096		20	2,554	2,554	16,840	24
25	Various			2002	69,506		20	6,774	6,774	39,560	25
26	Various			2003	118,393		20	10,180	10,180	49,401	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:

01/01/07

Ending:

12/31/07

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
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,414,314	164,470		183,266	18,796	1,831,292	67
68		92,264	5,664		5,664		35,440	68
69			124,790			(124,790)		69
70		\$ 7,714,265	\$ 294,924		\$ 249,290	\$ (45,634)	\$ 2,565,351	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

0031765

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 7,714,265	\$ 294,924		\$ 249,290	\$ (45,634)	\$ 2,565,351	1
2	Generator Maintenance	2004	1,223		20	245	245	938	2
3	Labor & Equip. For Plumbing	2004	735		20	147	147	539	3
4	Refiling Of Shower Stalls	2004	5,000		20	500	500	1,792	4
5	Installation Of Sprinkler Heads	2004	9,300		20	930	930	3,333	5
6	Parts For Doors	2004	1,925		20	192	192	642	6
7	Repair On Sewage Pump	2004	1,243		20	249	249	829	7
8	Dp On New 2Nd Floor Showers	2004	4,000		20	400	400	1,267	8
9	Generator Repair	2004	620		20	124	124	393	9
10	Sprinkler System Repair	2004	2,295		20	459	459	1,453	10
11	Glass Frames & Door Hinges	2004	748		20	150	150	462	11
12	Glass Frames & Door Hinges	2004	518		20	104	104	320	12
13	Fire Dampers	2004	581		20	83	83	256	13
14	Installation Of Window	2004	1,275		20	255	255	786	14
15	Painting	2004	774		20	39	39	155	15
16	Gas Valve Repair	2004	733		20	37	37	140	16
17	Painting	2004	1,065		20	53	53	204	17
18	Plaster & Paint Rooms	2004	7,000		20	350	350	1,196	18
19	Asphalt Patching	2004	1,200		20	60	60	205	19
20	Walk-In Cooler Repair	2004	870		20	44	44	145	20
21	Air Filters	2004	758		20	38	38	120	21
22	Remodeling Of 2Nd Floor	2005	9,050		20	905	905	2,640	22
23	New Water Pump For Air Conditioner	2005	5,142		20	1,028	1,028	2,742	23
24	New Patio Awning	2005	7,900		20	790	790	1,975	24
25	Generator Repairs	2005	3,520		20	704	704	1,760	25
26	Repalced Compressor On A/C Chiller	2005	5,496		20	1,099	1,099	2,656	26
27	Installed Norstar Mics Phone System	2005	15,250		20	3,050	3,050	7,117	27
28	Furnish & Install Door Protection	2005	1,725		20	86	86	223	28
29	Replace Sprinkler Heads	2005	2,105		20	105	105	281	29
30	Camera & Monitor	2005	2,093		20	105	105	270	30
31	Installation Of New Grease Trap For Kitchen (Reinput)	2005	10,710		20	1,071	1,071	3,035	31
32	Patio Roof Repair-Sundek Of Illinois	2006	19,985		20	1,999	1,999	3,331	32
33	Bruno'S Tuckpointing- Tuckpointing Repairs	2006	2,840		20	284	284	450	33
34	TOTAL (lines 1 thru 33)		\$ 7,841,944	\$ 294,924		\$ 264,975	\$ (29,949)	\$ 2,607,006	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,841,944	\$ 294,924		\$ 264,975	\$ (29,949)	\$ 2,607,006	1
2	Tuckpointing Repairs- Brunos'S Tuckpointing	2006	4,439		20	444	444	703	2
3	Stainless Steel Cab For 2 Elevators- Valley Elevator	2006	9,975		20	1,995	1,995	3,824	3
4	Emergency Generator Repairs- Lionheart Engineering	2006	5,513		20	551	551	873	4
5	Replaced Panel Board For Fire Alarm System- Fox Valley Fire & S	2006	2,765		20	553	553	830	5
6	Tiling Of Floor And Walls - 1St Floor	2006	5,500		20	550	550	642	6
7	Tiling Of Floor And Walls - 2Nd Floor	2006	11,200		20	1,120	1,120	1,307	7
8	Work On New Ventilation System	2006	17,400		20	1,740	1,740	2,030	8
9	Water Heater	2006	6,474		20	1,295	1,295	1,511	9
10	Cubicle Curtains	2006	3,783		20	757	757	820	10
11	Cubicle Curtains	2007	18,969		20	3,478	3,478	3,478	11
12	New Vent Sys--First Pymnt In Nov 06	2007	7,495		20	625	625	625	12
13	New Bearings In Hvac System	2007	5,725		20	763	763	763	13
14	Repave Parking Lot	2007	53,500		20	3,567	3,567	3,567	14
15	Parking Lot - Additional Work	2007	2,825		20	118	118	118	15
16	Upgrade Walk In Freezer	2007	7,900		20	527	527	527	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)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,005,407	\$ 294,924		\$ 283,058	\$ (11,866)	\$ 2,628,624	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:

01/01/07

Ending:

12/31/07

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	\$ 6,414,314	\$ 164,470	39	\$ 183,266	\$ 18,796	\$ 1,831,292	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:

01/01/07

Ending:

12/31/07

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)	\$	6,414,314	\$	164,470	\$	183,266	\$	18,796	\$	1,831,292	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Beds*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	Allocate Care Centers, Inc. 2201 Main LLC	2002	2002	\$ 5,899	\$ 546	39	\$ 546	\$	\$ 2,881	4
5	Allocate Care Centers, Inc. - CCI Building		1996	36,122	926	39	926		10,227	5
6	Allocate Care Centers Clinical, Inc.	2002	2002	2,207	57	39	57		299	6
7	Allocate Care Centers Health Systems, Inc.	2002	2002	103	3	39	3		14	7
8										8
	Improvement Type**									
9	Allocate Care Centers, Inc. 2201 Main LLC		2002	17,598	1,608	20	1,608		8,057	9
10	Allocate Care Centers, Inc. 2201 Main LLC		2003	20,738	1,895	20	1,895		9,494	10
11	Allocate Care Centers, Inc. 2201 Main LLC		2005	1,030	110	20	110		262	11
12										12
13	Allocate Care Centers, Inc.		2007	220	15	20	15		15	13
14										14
15	Allocate Care Centers, Inc. - CCI Building		1996	609	-	20	-		609	15
16	Allocate Care Centers, Inc. - CCI Building		1997	3,469	112	20	112		1,650	16
17										17
18	Allocate Care Centers Clinical, Inc.		2002	1,823	167	20	167		835	18
19	Allocate Care Centers Clinical, Inc.		2003	2,149	196	20	196		984	19
20	Allocate Care Centers Clinical, Inc.		2005	107	11	20	11		27	20
21										21
22	Allocate Care Centers Health Systems, Inc.		2002	85	8	20	8		39	22
23	Allocate Care Centers Health Systems, Inc.		2003	100	9	20	9		46	23
24	Allocate Care Centers Health Systems, Inc.		2005	5	1	20	1		1	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:

01/01/07

Ending:

12/31/07

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)	\$	92,264	\$	5,664	\$	5,664	\$	35,440	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 # 0031765 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 1,943,253	\$ 18,763	\$ 189,251	\$ 170,488	10	\$ 1,938,233	71
72	Current Year Purchases	25,745	171	3,142	2,971	10	3,142	72
73	Fully Depreciated Assets	259,473				10	259,473	73
74								74
75	TOTALS	\$ 2,228,471	\$ 18,934	\$ 192,393	\$ 173,459		\$ 2,200,848	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	2007	\$ 122,319	\$	\$ 14,445	\$ 14,445	5	\$ 86,829	76
77		Allocate Care Centers, Inc.	2007	40,188	2,332	2,332		5	33,013	77
78		Allocate Care Centers Clinical	2007	3,439	508	508		5	650	78
79		Allocate Care Centers Health Sys.	2007	55	2	2		5	2	79
80	TOTALS			\$ 166,001	\$ 2,842	\$ 17,287	\$ 14,445		\$ 120,494	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)	\$ 10,821,124	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 316,700	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 492,738	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 176,038	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,949,966	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	<u>Allocate Care Centers, Inc.</u>				<u>3,765</u>			5
6	<u>Allocate Care Centers Health Systems, Inc.</u>				<u>76</u>			6
7	TOTAL				\$ 3,841			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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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: \$ 4,816

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	\$		\$ 4,131	\$		\$ 4,131	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,210			3,210	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			24,720			24,720	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				108,867		108,867	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					(23)	62,988		62,965	13
14	TOTAL			\$		\$ 32,038	\$ 171,855		\$ 203,893	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: 01/01/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ (269,563)	\$ (268,913)	1
2	Cash-Patient Deposits	67,885	67,885	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	959,406	959,406	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	268,796	268,796	6
7	Other Prepaid Expenses	103,876	103,876	7
8	Accounts Receivable (owners or related parties)	1,280,820	1,060,500	8
9	Other(specify): <u>See Attached Schedule</u>	7,665,175	7,665,175	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,076,395	\$ 9,856,725	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		703,717	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,291,640	1,291,640	15
16	Equipment, at Historical Cost	1,193,908	2,418,908	16
17	Accumulated Depreciation (book methods)	(1,983,760)	(4,983,665)	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)	\$ 501,788	\$ 5,844,914	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,578,183	\$ 15,701,639	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,514,653	\$ 1,816,302	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,463	44,463	28
29	Short-Term Notes Payable	6,245	6,245	29
30	Accrued Salaries Payable	161,804	161,804	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,944	6,944	31
32	Accrued Real Estate Taxes(Sch.IX-B)	301,600	301,600	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>	261,417	261,417	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,297,126	\$ 2,598,775	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,108	14,108	39
40	Mortgage Payable		6,363,532	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)	\$ 14,108	\$ 6,377,640	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,311,234	\$ 8,976,415	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,266,949	\$ 6,725,224	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,578,183	\$ 15,701,639	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,835,574	1
2	Restatements (describe):		2
3	See Attached	(378,162)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,457,412	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,808,377	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)	\$ 1,809,537	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)	\$ 8,266,949	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 9,550,596	1
2	Discounts and Allowances for all Levels	(285,358)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,265,238	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,213	6
7	Oxygen	1,455	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 103,668	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	173,139	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,880	19
20	Radiology and X-Ray	7,076	20
21	Other Medical Services	2,223	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 202,318	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	636,429	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 636,429	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,257	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,257	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,220,910	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,746,405	31
32	Health Care	3,154,801	32
33	General Administration	1,817,619	33
B. Capital Expense			
34	Ownership	1,362,785	34
C. Ancillary Expense			
35	Special Cost Centers	203,903	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)*	\$ 8,412,533	40
41	Income before Income Taxes (line 30 minus line 40)**	1,808,377	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,808,377	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:

01/01/07

Ending:

12/31/07

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	1,463	1,787	\$ 64,655	\$ 36.18	1
2	Assistant Director of Nursing	1,135	1,277	42,973	33.65	2
3	Registered Nurses	20,717	22,716	668,279	29.42	3
4	Licensed Practical Nurses	27,199	29,090	753,970	25.92	4
5	CNAs & Orderlies	69,132	74,149	827,833	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,825	10,755	166,147	15.45	8
9	Activity Director	1,814	2,024	24,225	11.97	9
10	Activity Assistants	10,073	10,815	89,368	8.26	10
11	Social Service Workers	20,149	21,727	300,041	13.81	11
12	Dietician	1,527	1,664	22,299	13.40	12
13	Food Service Supervisor	1,928	2,236	43,698	19.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,586	5,981	83,838	14.02	15
16	Dishwashers	20,862	22,382	191,257	8.55	16
17	Maintenance Workers	18,261	19,934	264,523	13.27	17
18	Housekeepers	23,938	25,273	208,863	8.26	18
19	Laundry	10,848	11,915	111,347	9.35	19
20	Administrator	2,043	2,195	86,917	39.60	20
21	Assistant Administrator	1,465	1,662	33,401	20.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,635	6,154	85,705	13.93	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	1,972	2,173	34,702	15.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	255,572	275,909	\$ 4,104,041 *	\$ 14.87	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	265	\$ 11,525	01-03	35
36	Medical Director	Monthly	16,013	09-03	36
37	Medical Records Consultant	13	906	10-03	37
38	Nurse Consultant	107	5,096	10-03	38
39	Pharmacist Consultant	Monthly	3,210	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	48	2,392	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Therapy Consultant	12	468	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	445	\$ 39,610		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

Report Period Beginning: 01/01/07 Ending:

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
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

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. IL Council On LTC \$12,667
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,774 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (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. \$ 100% ln 14
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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