



Facility Name & ID Number Briar Place

# 0031765 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>32,208</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>144</u>	Intermediate (ICF)	<u>144</u>	<u>52,704</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>84,912</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>26,451</u>	<u>874</u>	<u>3,378</u>	<u>30,703</u>	8
9	SNF/PED					9
10	ICF	<u>43,280</u>	<u>1,430</u>	<u>2,028</u>	<u>46,738</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>69,731</u>	<u>2,304</u>	<u>5,406</u>	<u>77,441</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.20%

D. How many bed-hold days during this year were paid by the Department? 2,414 (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 2,801

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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
	<b>A. General Services</b>										
1	Dietary	361,612	40,647	14,537	416,796		416,796	2,466	419,262		1
2	Food Purchase		358,614		358,614		358,614	554	359,168		2
3	Housekeeping	214,890	53,023		267,913		267,913	(4,001)	263,912		3
4	Laundry	113,253	34,418		147,671		147,671		147,671		4
5	Heat and Other Utilities			261,088	261,088		261,088	4,126	265,214		5
6	Maintenance	257,831		178,634	436,465		436,465	29,470	465,935		6
7	Other (specify):*							6,550	6,550		7
8	<b>TOTAL General Services</b>	<b>947,586</b>	<b>486,702</b>	<b>454,259</b>	<b>1,888,547</b>		<b>1,888,547</b>	<b>39,166</b>	<b>1,927,713</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,208	15,208		15,208		15,208		9
10	Nursing and Medical Records	2,574,845	164,302	13,054	2,752,201		2,752,201	(39,338)	2,712,863		10
10a	Therapy	171,629			171,629		171,629	3,507	175,136		10a
11	Activities	130,315	10,721	200	141,236		141,236		141,236		11
12	Social Services	341,551		6,793	348,344		348,344	20,397	368,741		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							9,441	9,441		15
16	<b>TOTAL Health Care and Programs</b>	<b>3,218,340</b>	<b>175,023</b>	<b>35,255</b>	<b>3,428,618</b>		<b>3,428,618</b>	<b>(5,993)</b>	<b>3,422,625</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	148,661			148,661		148,661	76,886	225,547		17
18	Directors Fees										18
19	Professional Services			494,226	494,226	(4,000)	490,226	(410,599)	79,627		19
20	Dues, Fees, Subscriptions & Promotions			67,826	67,826		67,826	(10,945)	56,881		20
21	Clerical & General Office Expenses	94,498	29,221	229,076	352,795		352,795	101,525	454,320		21
22	Employee Benefits & Payroll Taxes			626,932	626,932		626,932	(14,252)	612,680		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,389	11,389		11,389	2,601	13,990		24
25	Other Admin. Staff Transportation			11,948	11,948		11,948	1,946	13,894		25
26	Insurance-Prop.Liab.Malpractice			235,840	235,840		235,840	1,615	237,455		26
27	Other (specify):*							48,117	48,117		27
28	<b>TOTAL General Administration</b>	<b>243,159</b>	<b>29,221</b>	<b>1,677,237</b>	<b>1,949,617</b>	<b>(4,000)</b>	<b>1,945,617</b>	<b>(203,106)</b>	<b>1,742,511</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,409,085</b>	<b>690,946</b>	<b>2,166,751</b>	<b>7,266,782</b>	<b>(4,000)</b>	<b>7,262,782</b>	<b>(169,933)</b>	<b>7,092,849</b>		<b>29</b>

\*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: 01/01/08 Ending: 12/31/08

## 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	
	<b>D. Ownership</b>											
30	Depreciation			118,977	118,977		118,977	245,724	364,701			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							184,629	184,629			32
33	Real Estate Taxes			298,740	298,740	4,000	302,740	6,342	309,082			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(937,694)	4,836			34
35	Rent-Equipment & Vehicles			7,446	7,446		7,446	1,798	9,244			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,367,693	1,367,693	4,000	1,371,693	(499,201)	872,492			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,902	63,090	282,992		282,992	(23,881)	259,111			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,368	127,368		127,368		127,368			42
43	Other (specify):*			648	648		648	(648)				43
44	<b>TOTAL Special Cost Centers</b>		219,902	191,106	411,008		411,008	(24,529)	386,479			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,409,085	910,848	3,725,550	9,045,483		9,045,483	(693,662)	8,351,821			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: 01/01/08

Ending: 12/31/08

**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	49,119	30		9
10	Interest and Other Investment Income	(630,632)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(107)	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	(6,240)	21		18
19	Entertainment				19
20	Contributions	(1,196)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,974)	21		24
25	Fund Raising, Advertising and Promotional	(6,728)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(33,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,242)	20		28
29	Other-Attach Schedule	(110,647)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (811,646)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	117,984		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 117,984		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (693,662)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		52

SEE ACCOUNTANTS' COMPILATION REPORT

Briar Place

ID# 0031765

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Rev - Jury Duty	\$ (80)	10	1
2	Insurance Reimbursement	(41)	26	2
3	Income From Copies	(20)	21	3
4	Phone Commission	(35)	05	4
5	Reimbursement For Repairs	(124)	06	5
6	Donations	(99)	20	6
7	Office Supplies Refund	(51)	21	7
8	Collections Expense	(93)	21	8
9	Pharmacy - Veterans	(75,103)	10	9
10	PPA - Computer Expense	(15,461)	21	10
11	COPE Dues	(8,290)	20	11
12	Annual Report	(150)	20	12
13	Prior Period Legal Fees	(2,883)	19	13
14	Public Relations	(648)	43	14
15	Non-Allowable Employee Benefits	(6,406)	43	15
16	Guardianship Expense	(1,163)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(110,647)		49

Briar Place

ID# 0031765

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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)	
	<b>A. General Services</b>													
1	Dietary			653		4,793	(2,980)						2,466	1
2	Food Purchase	(107)		661									554	2
3	Housekeeping			647		71		(4,719)					(4,001)	3
4	Laundry													4
5	Heat and Other Utilities	(35)		3,933		164	64						4,126	5
6	Maintenance	(124)		4,966	24,013	21	11	(103)		686			29,470	6
7	Other (specify):*				5,930	620							6,550	7
8	<b>TOTAL General Services</b>	<b>(265)</b>		<b>10,860</b>	<b>29,943</b>	<b>5,669</b>	<b>(2,905)</b>	<b>(4,821)</b>		<b>686</b>			<b>39,166</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(75,183)				41,093		(5,248)					(39,338)	10
10a	Therapy					3,507							3,507	10a
11	Activities													11
12	Social Services					20,397							20,397	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					9,441							9,441	15
16	<b>TOTAL Health Care and Programs</b>	<b>(75,183)</b>				<b>74,438</b>		<b>(5,248)</b>					<b>(5,993)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			3,126	11,660	59,562	924				1,614		76,886	17
18	Directors Fees													18
19	Professional Services	(4,046)		(281,119)		(126,219)	35				750		(410,599)	19
20	Fees, Subscriptions & Promotions	(19,705)		8,653		12	31				64		(10,945)	20
21	Clerical & General Office Expenses	(123,839)	34	37,772	181,414	20,234	1,095	(471)		(15,290)	577		101,525	21
22	Employee Benefits & Payroll Taxes				(13,215)	(1,037)							(14,252)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,206		252					143		2,601	24
25	Other Admin. Staff Transportation			1,881			61			4			1,946	25
26	Insurance-Prop.Liab.Malpractice	(41)		1,364		22	75			14	181		1,615	26
27	Other (specify):*				37,400	10,271	255				191		48,117	27
28	<b>TOTAL General Administration</b>	<b>(147,631)</b>	<b>34</b>	<b>(226,117)</b>	<b>217,259</b>	<b>(36,903)</b>	<b>2,476</b>	<b>(471)</b>		<b>(15,272)</b>	<b>3,520</b>		<b>(203,106)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(223,079)</b>	<b>34</b>	<b>(215,257)</b>	<b>247,202</b>	<b>43,204</b>	<b>(429)</b>	<b>(10,541)</b>		<b>(14,586)</b>	<b>3,520</b>		<b>(169,933)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	49,119	164,470	17,987		1,208	68			12,765	107		245,724	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(630,632)	753,449	48,911		9,060	210			2,822	809		184,629	32
33	Real Estate Taxes			6,077		265							6,342	33
34	Rent-Facility & Grounds		(942,530)	4,615			221						(937,694)	34
35	Rent-Equipment & Vehicles			1,542			21				235		1,798	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(581,513)</b>	<b>(24,611)</b>	<b>79,132</b>		<b>10,533</b>	<b>520</b>			<b>15,587</b>	<b>1,151</b>		<b>(499,201)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,859)	(5,584)		(5,780)	(10,658)		(23,881)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,054)									6,406		(648)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(7,054)</b>					<b>(1,859)</b>	<b>(5,584)</b>		<b>(5,780)</b>	<b>(4,252)</b>		<b>(24,529)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(811,646)</b>	<b>(24,577)</b>	<b>(136,125)</b>	<b>247,202</b>	<b>53,737</b>	<b>(1,768)</b>	<b>(16,124)</b>		<b>(4,779)</b>	<b>419</b>		<b>(693,662)</b>	<b>45</b>

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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		\$	\$ (942,530)	1
2	V	21 Bank Fees		G W H Limited Partnership		34	34	2
3	V	30 Depreciation		G W H Limited Partnership		164,470	164,470	3
4	V	32 Interest		G W H Limited Partnership		753,449	753,449	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			\$ 917,953	\$ * (24,577)	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: 01/01/08Ending: 12/31/08

## 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. / Extended Care Consulting, LLC	100.00%	\$ 653	\$ 653	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	661	661	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	647	647	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,933	3,933	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,966	4,966	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,126	3,126	20	
21	V	19	Professional Fees	304,402	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	23,283	(281,119)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,653	8,653	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	37,772	37,772	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,206	2,206	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,881	1,881	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,364	1,364	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	17,987	17,987	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	48,911	48,911	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,077	6,077	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,615	4,615	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,542	1,542	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 304,402			\$ 168,277	\$ * (136,125)	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: 01/01/08Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	9,589	\$ 9,589	15
16	V	06	Maintenance (Direct)	3,427	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	17,851	14,424	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,011	3,011	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,919	2,919	18
19	V	17	Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	11,660	11,660	19
20	V	21	Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	181,415	181,415	20
21	V	21	Office and Clerical (Direct)	49,173	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	49,172	(1)	21
22	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	28,821	28,821	22
23	V	27	Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,579	8,579	23
24	V	22	Employee Benefits	13,215	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%		(13,215)	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			\$ 65,815			\$ 313,017	\$ * 247,202	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: 01/01/08 Ending: 12/31/08

## 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. / Extended Care Clinical, LLC	100.00%	\$ 71	\$ 71	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	164	164	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	21	21	17	
18	V	19	Professional Fees	128,069	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,850	(126,219)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	12	12	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	312	312	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	252	252	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	22	22	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,208	1,208	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,060	9,060	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	265	265	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4,793	4,793	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	620	620	27	
28	V	10	Nursing Salary	9,739	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	50,832	41,093	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,507	3,507	29	
30	V	12	Social Service Salary	1,442	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	21,839	20,397	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,441	9,441	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	59,562	59,562	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	19,922	19,922	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	10,271	10,271	34	
35	V	22	Employee Benefits	1,037	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%		(1,037)	35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 140,287			\$ 194,024	\$ * 53,737	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: 01/01/08Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 572	\$ 572	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	64	64	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	11	11	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	35	35	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	31	31	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	140	140	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	61	61	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	75	75	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	68	68	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	210	210	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	221	221	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	21	21	28
29	V	01 Dietary	5,628	Care Centers Health Systems, Inc.	100.00%	2,076	(3,552)	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		Care Centers Health Systems, Inc.	100.00%			32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	2,945	Care Centers Health Systems, Inc.	100.00%	1,086	(1,859)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	924	924	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	955	955	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	255	255	38
39	Total		\$ 8,573			\$ 6,805	\$ * (1,768)	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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	53,272	Xcel Supply, LLC	100.00%	48,553	(4,719)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance	1,160	Xcel Supply, LLC	100.00%	1,058	(103)	18
19	V	10 Nursing	59,251	Xcel Supply, LLC	100.00%	54,003	(5,248)	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	5,319	Xcel Supply, LLC	100.00%	4,848	(471)	23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	63,036	Xcel Supply, LLC	100.00%	57,452	(5,584)	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		\$ 182,038			\$ 165,914	\$ * (16,124)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 71,993	\$ 71,993	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	71,993	CCS Employee Benefits Group	100.00%		(71,993)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 71,993			\$ 71,993	\$ *	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%	\$ 686	\$ 686	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	77	77	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	4	4	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	14	14	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	2,282	2,282	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	385	385	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	10,483	10,483	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	2,437	2,437	22
23	V	21	Office and Clerical	15,367	Vent Lease, LLC.	100.00%		(15,367)	23
24	V	39	Ancillary	5,780	Vent Lease, LLC.	100.00%		(5,780)	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			\$ 21,147			\$ 16,368	\$ * (4,779)	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: 01/01/08Ending: 12/31/08

## 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%	\$ 171	\$ 171	15	
16	V	19	Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	750	750	16	
17	V	20	Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	64	64	17	
18	V	21	Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	577	577	18	
19	V	24	Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	143	143	19	
20	V	26	Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	181	181	20	
21	V	30	Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	107	107	21	
22	V	32	Interest		Therapy Works Rehabilitation Services, LLC	100.00%	809	809	22	
23	V	35	Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	235	235	23	
24	V	39	Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	5	5	24	
25	V	39	Ancillary (Direct)		Therapy Works Rehabilitation Services, LLC	100.00%			25	
26	V	17	Administrative Salaries		Therapy Works Rehabilitation Services, LLC	100.00%	1,443	1,443	26	
27	V	27	Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	191	191	27	
28	V	39	Ancillary Salaries	59,095	Therapy Works Rehabilitation Services, LLC	100.00%	48,432	(10,663)	28	
29	V	43	Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	6,406	6,406	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			\$ 59,095			\$ 59,514	\$ *	419	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	1.58	3.42%		\$	17-7	1
2	Mark Steinberg	Owner	Administrative	2.0400%	See Attached	2.60	4.72%	Alloc. Salary	7,237	17-7	2
3	Noah Wolff	Owner	Administrative	11.8400%	See Attached	8.00	28.57%			17-7	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.55	1.37%	Alloc. Salary	991	22-7	4
5	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.23	1.37%	Alloc. Salary	201	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,429		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:

01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,635,146	31	\$ 13,778	\$ 77,441	\$ 653	1
2	02	Food	Patient Days	1,635,146	31	13,971	77,441	661	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	77,441	647	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	77,441	3,933	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	77,441	4,966	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	77,441	3,126	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	77,441	23,283	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	77,441	8,653	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	77,441	37,772	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	77,441	2,206	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	77,441	1,881	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	77,441	1,364	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	77,441	17,987	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	77,441	48,911	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	77,441	6,077	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	77,441	4,615	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	77,441	1,542	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 168,277	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765 Report Period Beginning: 01/01/08

Ending: 12/31/08

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	77,441	9,589	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		17,851	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		77,441	3,011	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			2,919	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	77,441	11,660	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	77,441	181,415	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		49,172	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		77,441	28,821	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			8,579	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					\$ 6,211,280	\$ 5,395,924		\$ 313,017	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending: 12/31/08

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/Extended Care Clinical  
 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	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 77,441	\$ 71	1
2	05	Utilities	Patient Days	1,635,146	31	3,449	77,441	164	2
3	06	Maintenance	Patient Days	1,635,146	31	431	77,441	21	3
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	77,441	1,850	4
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	77,441	12	5
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	77,441	312	6
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	77,441	252	7
8	26	Insurance	Patient Days	1,635,146	31	465	77,441	22	8
9	30	Depreciation	Patient Days	1,635,146	31	25,565	77,441	1,208	9
10	32	Interest	Patient Days	1,635,146	31	191,164	77,441	9,060	10
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	77,441	265	11
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	4,793	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	77,441	620	13
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	41,093	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	3,507	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	20,397	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	77,441	8,404	17
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	59,562	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	19,922	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	77,441	10,271	20
21	10	Nursing Salary	Direct Allocation			401,447	401,447	9,739	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016	1,442	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816		1,037	23
24									24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 194,024	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers Health Systems, Inc.  
 Street Address 200 Howard  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 224) 612-5662  
 Fax Number ( 224) 612-5862

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	31	111,096		19,901	572	1
2	03	Housekeeping	Gross Billable Income	31			19,901		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		19,901	64	3
4	06	Maintenance	Gross Billable Income	31	2,136		19,901	11	4
5	19	Professional Fees	Gross Billable Income	31	6,873		19,901	35	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		19,901	31	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		19,901	140	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		19,901	61	8
9	26	Insurance	Gross Billable Income	31	14,568		19,901	75	9
10	30	Depreciation	Gross Billable Income	31	13,298		19,901	68	10
11	32	Interest	Gross Billable Income	31	40,850		19,901	210	11
12	33	Real Estate Taxes	Gross Billable Income	31			19,901		12
13	34	Rent - Building	Gross Billable Income	31	43,000		19,901	221	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		19,901	21	14
15	01	Dietary	Direct Billable Income	31	102,965		5,628	2,076	15
16	02	Food	Direct Billable Income	31	1,612				16
17	03	Housekeeping	Direct Billable Income	31					17
18	10	Nursing	Direct Billable Income	31					18
19	21	Clerical and General Office	Direct Billable Income	31					19
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20
21	39	Ancillary	Direct Billable Income	31	1,321,550		2,945	1,086	21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	19,901	924	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	19,901	955	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		19,901	255	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 6,805	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					48,553	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					1,058	4
5	10	Nursing	Direct Allocation					54,003	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					4,848	9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					57,452	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				\$	\$		\$ 165,914	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending: 12/31/08

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, Illinois 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		\$	\$		\$ 71,993	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				\$	\$		\$ 71,993	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	669,310	26	\$ 79,460	\$ 5,780	\$ 686	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	5,780	77	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	5,780	4	3
4	26	Insurance	Direct Billing	669,310	26	1,630	5,780	14	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	5,780	2,282	5
6	32	Interest	Direct Billing	669,310	26	44,568	5,780	385	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	77,441	10,483	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	77,441	2,437	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					\$ 672,138	\$	\$ 16,368	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 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

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	(4,665,397)	14	\$ 13,500	\$ (59,095)	\$ 171	1	
2	19	Professional Fees	Billable Income	(4,665,397)	14	59,199	(59,095)	750	2	
3	20	Dues and Subscriptions	Billable Income	(4,665,397)	14	5,081	(59,095)	64	3	
4	21	Office & Clerical	Billable Income	(4,665,397)	14	45,575	(59,095)	577	4	
5	24	Travel and Seminar	Billable Income	(4,665,397)	14	11,318	(59,095)	143	5	
6	26	Insurance	Billable Income	(4,665,397)	14	14,252	(59,095)	181	6	
7	30	Depreciation	Billable Income	(4,665,397)	14	8,410	(59,095)	107	7	
8	32	Interest	Billable Income	(4,665,397)	14	63,875	(59,095)	809	8	
9	35	Rent - Equipment	Billable Income	(4,665,397)	14	18,528	(59,095)	235	9	
10	39	Ancillary	Billable Income	(4,665,397)	14	389	(59,095)	5	10	
11	39	Ancillary (Direct)	Direct			143,969			11	
12	17	Administrative Salaries	Billable Income	(4,665,397)	14	113,937	113,937	(59,095)	1,443	12
13	27	Emp. Ben. - Gen. Admin.	Billable Income	(4,665,397)	14	15,069	(59,095)	191	13	
14	39	Ancillary Salaries	Billable Income	(4,665,397)	14	3,823,568	3,823,568	(59,095)	48,432	14
15	43	Emp. Ben. - Other	Billable Income	(4,665,397)	14	505,700	(59,095)	6,406	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,842,370	\$ 3,937,504	\$ 59,514	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765 Report Period Beginning: 01/01/08 Ending: 12/31/08

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 &amp; ID Number

Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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			
	<b>A. Directly Facility Related</b>																					
	<b>Long-Term</b>																					
1	White Oak Nursing Center		X	Mortgage	\$78,544.00	03/01/97	\$ 7,441,383	\$ 6,174,451	11/01/21	12.0000	\$ 753,449	1										
2	Auto Loan		X					15,005				2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	<b>Working Capital</b>																					
6												6										
7												7										
8	See Supplemental Schedule											8										
9	TOTAL Facility Related				\$78,544.00		\$ 7,441,383	\$ 6,189,456			\$ 753,449	9										
	<b>B. Non-Facility Related*</b>																					
10	Interest Income										(630,632)	10										
11	Allocated from CCI/ECC		X								48,911	11										
12	Allocated from CC/EC Clinical		X								9,060	12										
13	See Supplemental Schedule										3,841	13										
14	TOTAL Non-Facility Related						\$	\$			(568,820)	14										
15	TOTALS (line 9+line14)						\$ 7,441,383	\$ 6,189,456			\$ 184,629	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:

01/01/08

Ending:

12/31/08

**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
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	<b>TOTAL Long-Term</b>											7							
	<b>Working Capital</b>																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>											14							
	<b>B. Non-Facility Related*</b>																		
15	Allocated from CC Health Sys.		X				\$	\$			\$	210							
16	Allocated from Vent Lease		X									2,822							
17	Allocated from Therapy Works		X									809							
18												18							
19												19							
20	<b>TOTAL Non-Facility Related</b>											3,841							

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 301,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 299,182	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,418)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 307,500	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 4,000	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 309,082	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	279,622	8
	2004	287,275	9
	2005	283,393	10
	2006	287,284	11
	2007	292,840	12
<b>2008 Accrual = \$292,840 x 1.05 = \$307,500</b>			
<b>Allocated from CC/EC - \$6,077 CCI/ECC, \$265 CC/EC Clinical</b>			

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-20-102-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>292,839.80</u>	\$ <u>292,839.80</u>
2. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>1,550.36</u>
3. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>781.53</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>458,630.44</u>	\$ <u>295,171.69</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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:

01/01/08 Ending:

12/31/08

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	Allocated from CCI/ECC			19,495	2
3	TOTALS			\$ 421,564	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
	<b>Improvement Type**</b>										
9	Various			1986	5,000		20			4,987	9
10	Various			1987	138,915		20			138,077	10
11	Various			1988	9,885		20			9,822	11
12	Various			1989	5,410		20	264	264	5,103	12
13	Various			1990	42,578		20	2,130	2,130	39,520	13
14	Various			1991	11,813		20	591	591	10,539	14
15	Various			1992	11,426		20	571	571	9,328	15
16	Various			1993	8,851		20	443	443	8,607	16
17	Various			1994	25,632		20	1,282	1,282	18,287	17
18	Various			1995	50,028		20	2,502	2,502	33,893	18
19	Various			1996	161,111		20	8,053	8,053	95,981	19
20	Various			1997	165,320		20	8,266	8,266	97,760	20
21	Various			1998	185,999		20	9,301	9,301	98,664	21
22	Various			1999	23,879		20	1,177	1,177	11,177	22
23	Various			2000	122,845		20	6,171	6,171	51,808	23
24	Various			2001	51,096		20	2,554	2,554	19,390	24
25	Various			2002	69,506		20	6,774	6,774	46,333	25
26	Various			2003	118,393		20	10,180	10,180	59,585	26
27	Various			2004	41,863		20	4,459	4,459	19,630	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:

01/01/08

Ending:

12/31/08

**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		6,414,314	164,470		183,266	18,796	2,014,558	67
68		108,772	5,744		5,744		37,496	68
69			118,975			(118,975)		69
70		\$ 7,772,636	\$ 289,189		\$ 253,728	\$ (35,461)	\$ 2,830,545	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,772,636	\$ 289,189		\$ 253,728	\$ (35,461)	\$ 2,830,545	1
2	Remodeling Of 2Nd Floor	2005	9,050		20	905	905	3,545	2
3	New Water Pump For Air Conditioner	2005	5,142		20	1,028	1,028	3,771	3
4	New Patio Awning	2005	7,900		20	790	790	2,765	4
5	Generator Repairs	2005	3,520		20	704	704	2,464	5
6	Repalced Compressor On A/C Chiller	2005	5,496		20	1,099	1,099	3,756	6
7	Installed Norstar Mics Phone System	2005	15,250		20	3,050	3,050	10,166	7
8	Furnish & Install Door Protection	2005	1,725		20	86	86	309	8
9	Replace Sprinkler Heads	2005	2,105		20	105	105	386	9
10	Camera & Monitor	2005	2,093		20	105	105	375	10
11	Installation Of New Grease Trap For Kitchen (Reinput)	2005	10,710		20	1,071	1,071	4,106	11
12	Patio Roof Repair-Sundek Of Illinois	2006	19,985		20	1,999	1,999	5,329	12
13	Bruno'S Tuckpointing- Tuckpointing Repairs	2006	2,840		20	284	284	734	13
14	Tuckpointing Repairs- Brunos'S Tuckpointing	2006	4,439		20	444	444	1,147	14
15	Stainless Steel Cab For 2 Elevators- Valley Elevator	2006	9,975		20	1,995	1,995	5,819	15
16	Emergency Generator Repairs- Lionheart Engineering	2006	5,513		20	551	551	1,424	16
17	Replaced Panel Board For Fire Alarm System- Fox Valley Fire & S	2006	2,765		20	553	553	1,383	17
18	Tiling Of Floor And Walls - 1St Floor	2006	5,500		20	550	550	1,192	18
19	Tiling Of Floor And Walls - 2Nd Floor	2006	11,200		20	1,120	1,120	2,427	19
20	Work On New Ventilation System	2006	17,400		20	1,740	1,740	3,770	20
21	Water Heater	2006	6,474		20	1,295	1,295	2,805	21
22	Cubicle Curtains	2006	3,783		20	757	757	1,576	22
23	Cubicle Curtains	2007	18,969		20	3,794	3,794	7,271	23
24	New Vent Sys--First Pymnt In Nov 06	2007	7,495		20	750	750	1,374	24
25	New Bearings In Hvac System	2007	5,725		20	1,145	1,145	1,908	25
26	Repave Parking Lot	2007	53,500		20	5,350	5,350	8,917	26
27	Parking Lot - Additional Work	2007	2,825		20	283	283	400	27
28	Upgrade Walk In Freezer	2007	7,900		20	1,580	1,580	2,107	28
29	New Pumping Unit	2008	15,685		20	915	915	915	29
30	New Flooring	2008	13,167		20	512	512	512	30
31	New Alarm Coding	2008	4,435		20	185	185	185	31
32	Painting (Transfer From Home Office)	2008	11,345		20	1,891	1,891	1,891	32
33	Painting (Transfer From Home Office)	2008	4,467		20	372	372	372	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12J, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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15									15
16									16
17									17
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12L, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12M, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12N, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

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		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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)		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12P, Carried Forward</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,071,014	\$ 289,189		\$ 290,736	\$ 1,547	\$ 2,915,646	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:

01/01/08

Ending:

12/31/08

**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	\$ 2,014,558	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
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:

01/01/08

Ending:

12/31/08

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	6,414,314	\$	164,470	\$	183,266	\$	18,796	\$	2,014,558	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* <sup>*</sup>	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 2,371	\$ 61	39	\$ 61	\$	\$ 382	4
5	Allocated from CCI/ECC - CCI Building		1996	35,958	922	39	922		11,103	5
6	Allocated from CCI/Extended Care Consulting, LLC	2002	2002	21,694	556	39	556		3,500	6
7										7
8										8
	Improvement Type**									
9	Allocated from CCI/Extended Care Consulting, LLC		2002	17,921	1,638	20	1,638		8,205	9
10	Allocated from CCI/Extended Care Consulting, LLC		2003	21,120	1,930	20	1,930		9,669	10
11	Allocated from CCI/Extended Care Consulting, LLC		2005	1,049	112	20	112		267	11
12	Allocated from CCI/Extended Care Consulting, LLC		2007	219	11	20	11		26	12
13										13
14	Allocated from CCI/ECC- CCI Building		1996	606	-	20	-		606	14
15	Allocated from CCI/ECC- CCI Building		1997	3,453	112	20	112		1,755	15
16										16
17	Allocated from CC/EC Clinical, Inc.		2002	1,958	179	20	179		897	17
18	Allocated from CC/EC Clinical, Inc.		2003	2,308	211	20	211		1,057	18
19	Allocated from CC/EC Clinical, Inc.		2005	115	12	20	12		29	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:

01/01/08

Ending:

12/31/08

**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		
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54								54		
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56								56		
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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	<b>TOTAL (lines 4 thru 69)</b>	\$	108,772	\$	5,744	\$	5,744	\$	37,496	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: 01/01/08 Ending: 12/31/08

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	\$ 703,483	\$ 23,121	\$ 55,570	\$ 32,449	10	\$ 629,050	71
72	Current Year Purchases	7,474	20	3,425	3,405	10	3,425	72
73	Fully Depreciated Assets	1,524,703				10	1,524,703	73
74								74
75	TOTALS	\$ 2,235,660	\$ 23,141	\$ 58,995	\$ 35,854		\$ 2,157,178	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	2008	\$ 122,319	\$	\$ 11,718	\$ 11,718	5	\$ 98,546	76
77		Allocated from CCC/EC Clinical	2008	3,395	679	679		5	1,321	77
78		Allocated from CCI/ECC	2008	41,202	2,560	2,560		5	35,423	78
79		Allocated from CC Health Sys	2008	65	13	13		5	15	79
80	TOTALS			\$ 166,981	\$ 3,252	\$ 14,970	\$ 11,718		\$ 135,305	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)		\$ 10,895,219	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 315,582	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 364,701	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 49,119	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 5,208,129	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	Allocated from CCI/ECC				4,615			5
6	Allocated from CC Health Sys.				221			6
7	<b>TOTAL</b>				\$ 4,836			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 9,245 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	<b>TOTAL</b>		\$	\$	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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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

Facility Name & ID Number Briar Place# 0031765 Report Period Beginning:

01/01/08 Ending:

12/31/08

## 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	\$		\$ 8,503	\$		\$ 8,503	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			866			866	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			51,153			51,153	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				137,978		137,978	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					2,568	81,924		84,492	13
14	TOTAL			\$		\$ 63,090	\$ 219,902		\$ 282,992	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: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 650	\$ 1,266	1
2	Cash-Patient Deposits	70,768	70,768	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	977,218	977,218	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	259,552	259,552	6
7	Other Prepaid Expenses	103,180	103,180	7
8	Accounts Receivable (owners or related parties)	1,280,820	1,060,500	8
9	Other(specify): <u>See Attached Schedule</u>	9,566,384	9,566,384	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 12,258,572	\$ 12,038,868	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,340,739	1,340,739	15
16	Equipment, at Historical Cost	1,201,147	2,426,147	16
17	Accumulated Depreciation (book methods)	(2,102,810)	(5,267,185)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 439,076	\$ 5,316,084	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 12,697,648	\$ 17,354,952	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,866,209	\$ 1,866,208	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,850	53,850	28
29	Short-Term Notes Payable	15,005	15,005	29
30	Accrued Salaries Payable	192,667	192,667	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,539	10,539	31
32	Accrued Real Estate Taxes(Sch.IX-B)	307,500	307,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	261,486	261,486	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,707,256	\$ 2,707,255	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,174,451	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,174,451	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,707,256	\$ 8,881,706	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,990,392	\$ 8,473,246	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 12,697,648	\$ 17,354,952	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,266,952	1
2	Restatements (describe):		2
3	See Attached	20,993	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,287,945	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,702,447	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	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)	\$ 1,702,447	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 9,990,392	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Briar Place

# 0031765

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,102,963	1
2	Discounts and Allowances for all Levels	(378,148)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,724,815	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	125,007	6
7	Oxygen	4,978	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 129,985	8
<b>C. Other Operating Revenue</b>			
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	214,506	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,215	19
20	Radiology and X-Ray	5,200	20
21	Other Medical Services	15,227	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 261,148	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	630,632	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 630,632	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,350	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,350	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,747,930	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,888,547	31
32	Health Care	3,428,618	32
33	General Administration	1,949,617	33
<b>B. Capital Expense</b>			
34	Ownership	1,367,693	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	283,640	35
36	Provider Participation Fee	127,368	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,045,483	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,702,447	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,702,447	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: 01/01/08

Ending:

12/31/08

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	1,811	2,104	\$ 88,257	\$ 41.95	1
2	Assistant Director of Nursing	1,080	1,340	46,463	34.67	2
3	Registered Nurses	17,965	19,851	619,526	31.21	3
4	Licensed Practical Nurses	30,168	32,336	844,912	26.13	4
5	CNAs & Orderlies	75,807	81,514	940,904	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,582	10,557	171,629	16.26	8
9	Activity Director	1,944	2,133	27,649	12.96	9
10	Activity Assistants	10,790	11,726	102,666	8.76	10
11	Social Service Workers	21,561	23,411	341,551	14.59	11
12	Dietician	1,728	1,969	31,939	16.22	12
13	Food Service Supervisor	1,693	1,982	39,829	20.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,263	7,091	99,955	14.10	15
16	Dishwashers	20,188	21,631	189,889	8.78	16
17	Maintenance Workers	16,683	18,464	257,831	13.96	17
18	Housekeepers	22,611	24,292	214,890	8.85	18
19	Laundry	10,677	11,686	113,253	9.69	19
20	Administrator	1,995	2,087	89,121	42.70	20
21	Assistant Administrator	2,480	2,939	59,540	20.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,107	6,640	94,498	14.23	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	1,855	2,113	34,783	16.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	262,988	285,866	\$ 4,409,085 *	\$ 15.42	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	323	\$ 14,537	01-03	35
36	Medical Director	Monthly	15,208	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,315	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	4	200	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatrist	113	5,351	12-03	47
48	See Attached - Care Centers Allocation		11,181		48
49	TOTAL (lines 35 - 48)	440	\$ 49,792		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: 01/01/08 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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. ILCLTC - \$16,101
- (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. \$ 14,559 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. \$ 127,368  
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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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