

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0031765</u></p> <p>Facility Name: <u>Briar Place</u></p> <p>Address: <u>6800 West Joliet</u> <u>Indian Head Park</u> <u>60525</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 246-8500</u> Fax # <u>(708) 246-0086</u></p> <p>HFS ID Number: <u>363472799001</u></p> <p>Date of Initial License for Current Owners: <u>11/1/1986</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> Officer or Administrator of Provider </td> <td style="border: none;"> (Signed) _____ (Type or Print Name) _____ (Title) _____ </td> </tr> <tr> <td style="border: none; vertical-align: top;"> Paid Preparer </td> <td style="border: none;"> (Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u> </td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,560	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	26,847	521	2,683	30,051	8	
9	SNF/PED					9	
10	ICF	43,928	852	1,848	46,628	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	70,775	1,373	4,531	76,679	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.55%

D. How many bed-hold days during this year were paid by the Department? 2,316 (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 11/01/1986

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/1986 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 88 and days of care provided 2,157

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	397,485	48,981	14,494	460,960		460,960	6,092	467,052		1
2	Food Purchase		375,662		375,662		375,662	772	376,434		2
3	Housekeeping	213,452	56,298		269,750		269,750	(3,768)	265,982		3
4	Laundry	140,578	30,525		171,103		171,103	(1,162)	169,941		4
5	Heat and Other Utilities			195,989	195,989		195,989	3,461	199,450		5
6	Maintenance	245,414		181,970	427,384		427,384	19,222	446,606		6
7	Other (specify):*							3,040	3,040		7
8	TOTAL General Services	996,929	511,466	392,453	1,900,848		1,900,848	27,656	1,928,504		8
	B. Health Care and Programs										
9	Medical Director			14,125	14,125		14,125		14,125		9
10	Nursing and Medical Records	2,761,808	169,248	37,487	2,968,543		2,968,543	(39,677)	2,928,866		10
10a	Therapy	152,990		27	153,017		153,017	2,563	155,580		10a
11	Activities	160,617	11,006		171,623		171,623		171,623		11
12	Social Services	391,213	77	18,297	409,587		409,587	13,786	423,373		12
13	CNA Training										13
14	Program Transportation			125	125		125		125		14
15	Other (specify):*							13,607	13,607		15
16	TOTAL Health Care and Programs	3,466,628	180,331	70,061	3,717,020		3,717,020	(9,721)	3,707,299		16
	C. General Administration										
17	Administrative	146,153			146,153		146,153	76,372	222,525		17
18	Directors Fees										18
19	Professional Services			510,439	510,439	(6,500)	503,939	(413,566)	90,373		19
20	Dues, Fees, Subscriptions & Promotions			93,655	93,655		93,655	(4,806)	88,849		20
21	Clerical & General Office Expenses	96,794	35,318	232,363	364,475		364,475	91,856	456,331		21
22	Employee Benefits & Payroll Taxes			672,552	672,552		672,552	(19,154)	653,398		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,177	8,177		8,177	1,608	9,785		24
25	Other Admin. Staff Transportation			5,600	5,600		5,600	613	6,213		25
26	Insurance-Prop.Liab.Malpractice			261,106	261,106		261,106	1,480	262,586		26
27	Other (specify):*							50,287	50,287		27
28	TOTAL General Administration	242,947	35,318	1,783,892	2,062,157	(6,500)	2,055,657	(215,310)	1,840,347		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,706,504	727,115	2,246,406	7,680,025	(6,500)	7,673,525	(197,375)	7,476,150		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Briar Place

#0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			144,958	144,958		144,958	231,197	376,155			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			952	952		952	(952)				32
33	Real Estate Taxes			394,036	394,036	6,500	400,536	3,441	403,977			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(936,747)	5,783			34
35	Rent-Equipment & Vehicles			4,140	4,140		4,140	3,807	7,947			35
36	Other (specify):*											36
37	TOTAL Ownership			1,486,616	1,486,616	6,500	1,493,116	(699,254)	793,862			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,017	116,485	337,502		337,502	63,781	401,283			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		221,017	243,505	464,522		464,522	63,781	528,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,706,504	948,132	3,976,527	9,631,163		9,631,163	(832,848)	8,798,315			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

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	39,509	30		9
10	Interest and Other Investment Income	(845,743)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	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	(4,700)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,625)	21		24
25	Fund Raising, Advertising and Promotional	(4,289)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(30,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,596)	20		28
29	Other-Attach Schedule	(83,913)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,020,424)		\$	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)	187,576		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 187,576		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (832,848)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Briar Place

ID# 0031765

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Revenue - Jury Duty	\$ (69)	10	1
2	Theft Loss	(157)	21	2
3	Collection Expense	(80)	21	3
4	Pharmacy - Veterans	(77,960)	10	4
5	Prior Period Adjustment - Computer Expense	(5,843)	21	5
6	Annual Report	(100)	20	6
7	Building Co. - Misc. Admin. Expense	(175)	21	7
8	Building Co. - Replacement Tax	(63)	21	8
9	Prior Period and Non-Allowable Legal Fees	(834)	19	9
10	Phone Commissions	(43)	21	10
11	Misc. Income	(39)	21	11
12	Additional Repairs and Maintenance	1,450	06	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
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(83,913)		49

Briar Place

ID# 0031765

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			377		6,548					(833)		6,092	1
2	Food Purchase	(67)		839									772	2
3	Housekeeping			783		86	(4,637)						(3,768)	3
4	Laundry						(1,162)						(1,162)	4
5	Heat and Other Utilities			3,212		206					43		3,461	5
6	Maintenance	1,450		4,985	12,213	27	(453)		967		33		19,222	6
7	Other (specify):*				2,090	950							3,040	7
8	TOTAL General Services	1,383		10,196	14,303	7,817	(6,252)		967		(757)		27,656	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(78,029)				44,573	(4,326)				(1,895)		(39,677)	10
10a	Therapy					2,563							2,563	10a
11	Activities													11
12	Social Services					13,786							13,786	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					13,607							13,607	15
16	TOTAL Health Care and Programs	(78,029)				74,529	(4,326)				(1,895)		(9,721)	16
	C. General Administration													
17	Administrative			3,678	13,335	58,141					1,218		76,372	17
18	Directors Fees													18
19	Professional Services	(834)		(286,550)		(126,280)			53		45		(413,566)	19
20	Fees, Subscriptions & Promotions	(7,985)		3,148		12					19		(4,806)	20
21	Clerical & General Office Expenses	(128,725)	238	25,762	200,562	13,038			(20,494)		1,475		91,856	21
22	Employee Benefits & Payroll Taxes				(10,067)	(8,840)					(247)		(19,154)	22
23	Inservice Training & Education													23
24	Travel and Seminar			99		1,509							1,608	24
25	Other Admin. Staff Transportation			574					4		35		613	25
26	Insurance-Prop.Liab.Malpractice			1,263		75			55		87		1,480	26
27	Other (specify):*				39,654	10,101					532		50,287	27
28	TOTAL General Administration	(137,544)	238	(252,026)	243,484	(52,244)			(20,382)		3,164		(215,310)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(214,190)	238	(241,830)	257,787	30,102	(10,578)		(19,415)		512		(197,375)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place# 0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	39,509	164,470	6,439		1,426			19,264		89		231,197	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(845,743)	729,468	94,646		17,226			3,451				(952)	32
33	Real Estate Taxes			3,104		337							3,441	33
34	Rent-Facility & Grounds		(942,530)	5,385							398		(936,747)	34
35	Rent-Equipment & Vehicles			3,803							4		3,807	35
36	Other (specify):*													36
37	TOTAL Ownership	(806,234)	(48,592)	113,377		18,989			22,715		491		(699,254)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(4,774)		(9,825)	80,356	(1,976)		63,781	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(4,774)		(9,825)	80,356	(1,976)		63,781	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,020,424)	(48,354)	(128,453)	257,787	49,091	(15,353)		(6,525)	80,356	(973)		(832,848)	45

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:	
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)	
1	V	34 Rent	\$ 942,530	G W H Limited Partnership	100.00%	\$	\$ (942,530)	1
2	V	21 Misc. Admin. Expense		G W H Limited Partnership	100.00%	175	175	2
3	V	30 Depreciation		G W H Limited Partnership	100.00%	164,470	164,470	3
4	V	21 Replacement Tax		G W H Limited Partnership	100.00%	63	63	4
5	V	32 Interest		G W H Limited Partnership	100.00%	729,468	729,468	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			\$ 894,176	\$ * (48,354)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 377	\$	377	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	839		839	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	783		783	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	3,212		3,212	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,985		4,985	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,678		3,678	20
21	V	19 Professional Fees	302,458	Extended Care Consulting, LLC	100.00%	15,908		(286,550)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,148		3,148	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	25,762		25,762	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	99		99	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	574		574	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,263		1,263	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	6,439		6,439	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	94,646		94,646	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,104		3,104	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	5,385		5,385	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,803		3,803	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 302,458			\$ 174,005	\$ *	(128,453)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	12,213	\$	12,213	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	2,090		2,090	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	13,335		13,335	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	200,562		200,562	20
21	V	21 Office and Clerical (Direct)	50,335	Extended Care Consulting, LLC	100.00%	50,335			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	34,316		34,316	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,338		5,338	23
24	V	22 Employee Benefits	10,067	Extended Care Consulting, LLC	100.00%			(10,067)	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		\$ 60,402			\$ 318,189	\$ *	257,787	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 86	\$	86	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	206		206	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	27		27	17
18	V	19 Professional Fees	128,069	Extended Care Clinical, LLC	100.00%	1,789		(126,280)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	12		12	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,521		1,521	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,509		1,509	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	75		75	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,426		1,426	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	17,226		17,226	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	337		337	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	6,548		6,548	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	950		950	27
28	V	10 Nursing Salary	34,185	Extended Care Clinical, LLC	100.00%	78,758		44,573	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	2,563		2,563	29
30	V	12 Social Service Salary	10,017	Extended Care Clinical, LLC	100.00%	23,803		13,786	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	13,607		13,607	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	58,141		58,141	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	11,517		11,517	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,101		10,101	34
35	V	22 Employee Benefits	8,840	Extended Care Clinical, LLC	100.00%			(8,840)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 181,111			\$ 230,202	\$ *	49,091	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	50,494	Xcel Supply, LLC	100.00%	45,857	(4,637)	16
17	V	4 Laundry	12,654	Xcel Supply, LLC	100.00%	11,492	(1,162)	17
18	V	6 Repairs & Maintenance	4,936	Xcel Supply, LLC	100.00%	4,483	(453)	18
19	V	10 Nursing	47,111	Xcel Supply, LLC	100.00%	42,784	(4,326)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	51,988	Xcel Supply, LLC	100.00%	47,214	(4,774)	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		\$ 167,182			\$ 151,830	\$ * (15,353)	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%	\$ 88,495	\$ 88,495	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	88,495	CCS Employee Benefits Group	100.00%		(88,495)	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		\$ 88,495			\$ 88,495	\$ *	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%	\$ 967	\$	967	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	53		53	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	82		82	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	4		4	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	55		55	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	2,516		2,516	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	424		424	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	16,748		16,748	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	3,027		3,027	23
24	V	21 Office and Clerical	20,576	Vent Lease, LLC.	100.00%			(20,576)	24
25	V	39 Ancillary	9,825	Vent Lease, LLC.	100.00%			(9,825)	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		\$ 30,401			\$ 23,876	\$ *	(6,525)	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	39 THERAPY	\$ 98,296	TRICARE REHAB		\$ 178,652	\$ 80,356	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		\$ 98,296			\$ 178,652	\$ *	80,356 39

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

Facility Name & ID Number Briar Place# 0031765Report Period Beginning: 01/01/09 Ending: 12/31/09

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%	\$ 561	\$ 561	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%	43	43	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	33	33	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	45	45	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	19	19	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	231	231	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	35	35	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	87	87	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	89	89	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%			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%	398	398	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	4	4	28
29	V	01 Dietary	2,320	Care Centers Health Systems, Inc.	100.00%	926	(1,394)	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	3,154	Care Centers Health Systems, Inc.	100.00%	1,259	(1,895)	32
33	V	22 Employee Benefits	411	Care Centers Health Systems, Inc.	100.00%	164	(247)	33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	3,290	Care Centers Health Systems, Inc.	100.00%	1,314	(1,976)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	1,218	1,218	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,244	1,244	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	532	532	38
39	Total		\$ 9,175			\$ 8,202	\$ * (973)	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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Briar Place

0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1.67	5.50%		\$		1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	3.06	5.50%	Alloc. Salary	9,280	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.52	1.30%	Alloc. Salary	928	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,208		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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	30	\$ 6,770	\$	76,679	\$ 377	1
2	02	Food	Patient Days	30	15,058		76,679	839	2
3	03	Housekeeping	Patient Days	30	14,059		76,679	783	3
4	05	Utilities	Patient Days	30	57,646		76,679	3,212	4
5	06	Maintenance	Patient Days	30	89,465		76,679	4,985	5
6	17	Administrative	Patient Days	30	66,000		76,679	3,678	6
7	19	Professional Fees	Patient Days	30	285,482		76,679	15,908	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		76,679	3,148	8
9	21	Office and Clerical	Patient Days	30	462,313		76,679	25,762	9
10	24	Seminar and Travel	Patient Days	30	1,768		76,679	99	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		76,679	574	11
12	26	Insurance	Patient Days	30	22,668		76,679	1,263	12
13	30	Depreciation	Patient Days	30	115,549		76,679	6,439	13
14	32	Interest	Patient Days	30	1,698,489		76,679	94,646	14
15	33	Real Estate Taxes	Patient Days	30	55,709		76,679	3,104	15
16	34	Rent - Building	Patient Days	30	96,636		76,679	5,385	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		76,679	3,803	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 174,005	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	1,376,056	30	219,177	219,177	76,679	12,213	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		76,679	2,090	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464			4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	76,679	13,335	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	76,679	200,562	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			50,335	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	76,679	34,316	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	76,679	5,338	9
10	22	Employee Benefits								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					\$ 5,530,203	\$ 4,838,529		\$ 318,189	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Clinical 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	03	Housekeeping	Patient Days	1,376,056	30	\$ 1,549	\$ 76,679	\$ 86	1
2	05	Utilities	Patient Days	1,376,056	30	3,693	76,679	206	2
3	06	Maintenance	Patient Days	1,376,056	30	477	76,679	27	3
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	76,679	1,789	4
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	76,679	12	5
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	76,679	1,521	6
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	76,679	1,509	7
8	26	Insurance	Patient Days	1,376,056	30	1,342	76,679	75	8
9	30	Depreciation	Patient Days	1,376,056	30	25,586	76,679	1,426	9
10	32	Interest	Patient Days	1,376,056	30	309,136	76,679	17,226	10
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	76,679	337	11
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	76,679	6,548	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	76,679	950	13
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	76,679	44,573	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	76,679	2,563	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	76,679	13,786	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	76,679	8,834	17
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	76,679	58,141	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	76,679	11,517	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	76,679	10,101	20
21	10	Nursing Salary	Direct Allocation			494,488	76,679	34,185	21
22	12	Social Service Salary	Direct Allocation			196,033		10,017	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560		4,773	23
24									24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 230,202	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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					45,857	2
3	4	Laundry	Direct Allocation					11,492	3
4	6	Repairs & Maintenance	Direct Allocation					4,483	4
5	10	Nursing	Direct Allocation					42,784	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					47,214	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				\$	\$		\$ 151,830	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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		\$	\$		\$ 88,495	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				\$	\$		\$ 88,495	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	821,185	26	\$ 80,807	\$ 9,825	\$ 967	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	9,825	53	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	9,825	82	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	9,825	4	4
5	26	Insurance	Direct Billing	821,185	26	4,573	9,825	55	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	9,825	2,516	6
7	32	Interest	Direct Billing	821,185	26	35,420	9,825	424	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	76,679	16,748	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	76,679	3,027	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					\$ 706,114	\$	\$ 23,876	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 TriCare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 178,652	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				\$	\$		\$ 178,652	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	3,421,940	26	72,652	26,419	561	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		26,419		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	26,419	43	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	26,419	33	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	26,419	45	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	26,419	19	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	26,419	231	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	26,419	35	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	26,419	87	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	26,419	89	10	
11	32	Interest	Gross Billable Income	3,421,940	26		26,419		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		26,419		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	26,419	398	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	26,419	4	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	2,320	926	15	
16	02	Food	Direct Billable Income	2,784	26	1,111			16	
17	03	Housekeeping	Direct Billable Income		26				17	
18	10	Nursing	Direct Billable Income	5,466	26	2,182	3,154	1,259	18	
19	22	Employee Benefits	Direct Billable Income	411	26	164	411	164	19	
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20	
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	3,290	1,314	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	26,419	1,218	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	26,419	1,244	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	26,419	532	24	
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 8,202	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Briar Place

0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	White Oak Nursing Center		X	Mortgage	\$78,544.00	03/01/97	\$ 7,441,383	\$ 5,961,388	11/01/21	12.0000	\$ 729,468	1							
2	Auto Loan		X					9,711			952	2							
3												3							
4												4							
5	See Supplemental Schedule											5							
Working Capital																			
6												6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related				\$78,544.00		\$ 7,441,383	\$ 5,971,099			\$ 730,420	9							
B. Non-Facility Related*																			
10	Interest Income										(845,743)	10							
11	Allocated from EC Consulting		X								94,646	11							
12	Allocated from EC Clinical		X								17,226	12							
13	See Supplemental Schedule										3,451	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (730,420)	14							
15	TOTALS (line 9+line14)						\$ 7,441,383	\$ 5,971,099			\$	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:

01/01/09

Ending:

12/31/09

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term											7								
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital											14								
	B. Non-Facility Related*																			
15	Allocated from Vent Lease		X				\$	\$			\$	3,451	15							
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related											3,451	20							

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

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.

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

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

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 402,869, 1997, \$402,869, 1. Row 2: Allocated from EC Consulting/EC Clinical 2201 Main, 20,450, 2. Row 3: TOTALS, 423,319, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1986	5,000		20			4,987	9
10	Various		1987	138,915		20			138,077	10
11	Various		1988	9,885		20			9,822	11
12	Various		1989	5,410		20	264	264	5,367	12
13	Various		1990	42,578		20	2,130	2,130	41,648	13
14	Various		1991	11,813		20	591	591	11,129	14
15	Various		1992	11,426		20	571	571	9,899	15
16	Various		1993	8,851		20	150	150	8,757	16
17	Various		1994	25,632		20	1,282	1,282	19,568	17
18	Various		1995	50,028		20	2,502	2,502	36,392	18
19	Various		1996	161,111		20	8,053	8,053	104,039	19
20	Various		1997	165,320		20	8,266	8,266	106,028	20
21	Various		1998	185,999		20	9,301	9,301	107,962	21
22	Various		1999	23,879		20	1,177	1,177	12,353	22
23	Various		2000	122,845		20	6,171	6,171	57,979	23
24	Various		2001	51,096		20	2,554	2,554	21,943	24
25	Various		2002	69,506		20	6,135	6,135	52,469	25
26	Various		2003	118,393		20	10,180	10,180	69,764	26
27	Various		2004	41,863		20	3,933	3,933	23,563	27
28	Various		2005	62,991		20	8,943	8,943	40,586	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

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	Related Building Company (Pages 12F & 12G)	6,414,314	164,470		183,266	18,796	2,197,824	67
68	Related Party Allocations (Pages 12H & 12I)	80,916	5,528		5,528		33,665	68
69	Financial Statement Depreciation		144,958			(144,958)		69
70	TOTAL (lines 4 thru 69)	\$ 7,807,771	\$ 314,956		\$ 260,997	\$ (53,959)	\$ 3,113,821	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,807,771	\$ 314,956		\$ 260,997	\$ (53,959)	\$ 3,113,821	1
2	Patio Roof Repair-Sundek Of Illinois	2006	19,985		20	1,999	1,999	7,328	2
3	Bruno'S Tuckpointing- Tuckpointing Repairs	2006	2,840		20	284	284	1,018	3
4	Tuckpointing Repairs- Brunos'S Tuckpointing	2006	4,439		20	444	444	1,591	4
5	Stainless Steel Cab For 2 Elevators- Valley Elevator	2006	9,975		20	1,995	1,995	7,814	5
6	Emergency Generator Repairs- Lionheart Engineering	2006	5,513		20	551	551	1,975	6
7	Replaced Panel Board For Fire Alarm System- Fox Valley Fire &	2006	2,765		20	553	553	1,936	7
8	Tiling Of Floor And Walls - 1St Floor	2006	5,500		20	550	550	1,742	8
9	Tiling Of Floor And Walls - 2Nd Floor	2006	11,200		20	1,120	1,120	3,547	9
10	Work On New Ventilation System	2006	17,400		20	1,740	1,740	5,510	10
11	Water Heater	2006	6,474		20	1,295	1,295	4,100	11
12	Cubicle Curtains	2006	3,783		20	757	757	2,333	12
13	Cubicle Curtains	2007	18,969		20	3,794	3,794	11,065	13
14	New Vent Sys--First Pymnt In Nov 06	2007	7,495		20	750	750	2,124	14
15	New Bearings In Hvac System	2007	5,725		20	1,145	1,145	3,053	15
16	Repave Parking Lot	2007	53,500		20	5,350	5,350	14,267	16
17	Parking Lot - Additional Work	2007	2,825		20	283	283	683	17
18	Upgrade Walk In Freezer	2007	7,900		20	1,580	1,580	3,687	18
19	New Pumping Unit	2008	15,685		20	1,569	1,569	2,483	19
20	New Flooring	2008	13,167		20	878	878	1,390	20
21	New Alarm Coding	2008	4,435		20	444	444	628	21
22	Painting (Transfer From Home Office)	2008	11,345		20	9,454	9,454	11,345	22
23	Painting (Transfer From Home Office)	2008	4,467		20	4,095	4,095	4,467	23
24	Painting	2009	8,135		20	8,135	8,135	8,135	24
25	Painting	2009	7,418		20	5,880	5,880	5,880	25
26	Painting	2009	12,538		20	10,448	10,448	10,448	26
27	Actuator	2009	3,189		20	27	27	27	27
28	Painting	2009	24,546		20	1,987	1,987	1,987	28
29	Water Heater	2009	6,481		20	108	108	108	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492	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)	\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492	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)	\$ 8,105,465	\$ 314,956		\$ 328,212	\$ 13,256	\$ 3,234,492	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	232 Bed Facility	1976	6,414,314	164,470	39	183,266	18,796	2,197,824	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 6,414,314	\$ 164,470		\$ 183,266	\$ 18,796	\$ 2,197,824

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	25,386	651	39	651		4,746	3
4	Allocated from Extended Care Clinical 2201 Main	2002	2,797	72	39	72		523	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	256	4	20	4		30	9
10	Allocated from Extended Care Consulting	2009	153	8	20	8		8	10
11									11
12	Allocated from Extended Care Consulting 2201 Main	2002	20,970	1,917	20	1,917		11,517	12
13	Allocated from Extended Care Consulting 2201 Main	2003	24,713	2,259	20	2,259		13,573	13
14	Allocated from Extended Care Consulting 2201 Main	2005	1,228	131	20	131		443	14
15	Allocated from Extended Care Consulting 2201 Main	2009	222	11	20	11		11	15
16									16
17	Allocated from Extended Care Clinical 2201 Main	2002	2,310	211	20	211		1,269	17
18	Allocated from Extended Care Clinical 2201 Main	2003	2,722	249	20	249		1,495	18
19	Allocated from Extended Care Clinical 2201 Main	2005	135	14	20	14		49	19
20	Allocated from Extended Care Clinical 2201 Main	2009	24	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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								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 (12H & 12I lines 1 thru 33)	\$ 80,916	\$ 5,528		\$ 5,528	\$	\$ 33,665	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:

01/01/09

Ending:

12/31/09

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	\$ 533,415	\$ 20,547	\$ 36,439	\$ 15,892	10	\$ 486,449	71
72	Current Year Purchases	6,812	17	128	111	10	145	72
73	Fully Depreciated Assets	1,730,447				10	1,730,447	73
74								74
75	TOTALS	\$ 2,270,674	\$ 20,564	\$ 36,567	\$ 16,003		\$ 2,217,041	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	Various	\$ 122,319	\$	\$ 10,250	\$ 10,250	5	\$ 108,796	76
77		Alloc. Extended Care Consult.	2009	17,919	280	280		5	17,079	77
78		Alloc. Extended Care Clinical	2009	4,006	801	801		5	2,359	78
79		Alloc. EC Health Systems	2009	226	45	45		5	68	79
80	TOTALS			\$ 144,470	\$ 1,126	\$ 11,376	\$ 10,250		\$ 128,302	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 10,943,928	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 336,646	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 376,155	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,509	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,579,835	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	<u>Allocated from EC Consulting</u>			<u>5,385</u>			5
6	<u>Allocated from EC Health Systems</u>			<u>398</u>			6
7	TOTAL			\$ <u>5,783</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,946 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 42,488	\$		\$ 42,488	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			18,387			18,387	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			53,467			53,467	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				118,805		118,805	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					2,143	102,212		104,355	13
14	TOTAL			\$		\$ 116,485	\$ 221,017		\$ 337,502	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:

01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of

12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 650	\$ 1,028	1
2	Cash-Patient Deposits	80,590	80,590	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	836,711	836,711	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	305,065	305,065	6
7	Other Prepaid Expenses	3,205	3,205	7
8	Accounts Receivable (owners or related parties)	1,280,820	1,060,500	8
9	Other(specify): <u>See Attached Schedule</u>	11,121,209	11,121,209	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 13,628,250	\$ 13,408,308	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,397,009	1,397,009	15
16	Equipment, at Historical Cost	1,214,269	2,439,269	16
17	Accumulated Depreciation (book methods)	(2,246,765)	(5,575,610)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 364,513	\$ 5,077,051	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,992,763	\$ 18,485,359	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,837,172	\$ 1,837,172	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,842	63,842	28
29	Short-Term Notes Payable	9,711	9,711	29
30	Accrued Salaries Payable	261,601	261,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,326	9,326	31
32	Accrued Real Estate Taxes(Sch.IX-B)	359,300	359,300	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	341,971	341,971	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,882,923	\$ 2,882,923	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,961,388	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,961,388	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,882,923	\$ 8,844,311	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,109,840	\$ 9,641,048	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,992,763	\$ 18,485,359	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,990,392	1
2	Restatements (describe):		2
3	Interest	(1,411)	3
4	Pension Expense	1,153	4
5	Rounding	(4)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,990,130	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,119,710	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)	\$ 1,119,710	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,109,840	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,797,392	1
2	Discounts and Allowances for all Levels	(550,269)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,247,123	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	359,023	6
7	Oxygen	2,956	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 361,979	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	203,581	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,051	19
20	Radiology and X-Ray	2,050	20
21	Other Medical Services	7,417	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 234,099	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	906,621	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 906,621	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,051	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,051	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,750,873	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,900,848	31
32	Health Care	3,717,020	32
33	General Administration	2,062,157	33
B. Capital Expense			
34	Ownership	1,486,616	34
C. Ancillary Expense			
35	Special Cost Centers	337,502	35
36	Provider Participation Fee	127,020	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,631,163	40
41	Income before Income Taxes (line 30 minus line 40)**	1,119,710	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,119,710	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:

01/01/09

Ending:

12/31/09

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	2,023	2,212	\$ 89,125	\$ 40.29	1
2	Assistant Director of Nursing	1,394	1,586	57,049	35.97	2
3	Registered Nurses	17,347	18,780	628,325	33.46	3
4	Licensed Practical Nurses	34,938	37,974	914,722	24.09	4
5	CNAs & Orderlies	82,702	91,185	1,041,127	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,739	10,768	152,990	14.21	8
9	Activity Director	2,335	2,534	36,926	14.57	9
10	Activity Assistants	12,387	13,704	123,691	9.03	10
11	Social Service Workers	22,568	24,313	391,213	16.09	11
12	Dietician	1,949	2,062	36,816	17.85	12
13	Food Service Supervisor	2,028	2,396	48,915	20.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,108	7,036	100,662	14.31	15
16	Dishwashers	21,120	23,766	211,092	8.88	16
17	Maintenance Workers	17,374	19,046	245,414	12.89	17
18	Housekeepers	20,912	23,430	213,452	9.11	18
19	Laundry	11,065	13,165	140,578	10.68	19
20	Administrator	1,932	2,119	99,614	47.01	20
21	Assistant Administrator	1,714	1,983	46,539	23.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,844	6,561	96,794	14.75	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	1,553	1,879	31,354	16.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9	9	106	11.37	33
34	TOTAL (lines 1 - 33)	277,041	306,508	\$ 4,706,504 *	\$ 15.36	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	319	\$ 14,494	01-03	35
36	Medical Director	Monthly	14,125	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,301	10-03	39
40	Physical Therapy Consultant	1	27	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	84	3,780	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	4,500	12-03	47
48	See Attached - Extended Care Allocation		44,203		48
49	TOTAL (lines 35 - 48)	404	\$ 84,430		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Hilda Derzsy (01/09-12/09)	Admininstrator	0	\$ 475	Workers' Compensation Insurance	\$ 101,806	IDPH License Fee	\$ 1,990	
Linda Pyfer (12/09-Current)	Admininstrator	0	99,139	Unemployment Compensation Insurance	50,865	Advertising: Employee Recruitment	48,374	
Keenan Weekley	Assist. Admin.	0	8,757	FICA Taxes	349,151	Health Care Worker Background Check		
Tamara Sugg	Assist. Admin.	0	37,782	Employee Health Insurance	132,867	(Indicate # of checks performed 304)	4,191	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council On LTC	18,359	
				Employee Physicals	8,739	Dues & Subscription	219	
				Other Employee Welfare	6,844	Licenses & Fees	12,537	
				Holiday Expense	3,126	Yellow Page Advertising	3,596	
						See Supplemental Schedule	3,179	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	(3,596)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 146,153			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 88,849	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	8,177
							Allocated from EC Consulting	99
							Allocated from EC Clinical	1,509
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 9,785
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 20,267					
Paycor	Payroll Processing		13,992					
ADP	Payroll Processing		1,278					
Ehealth Data Solutions	MDS Software		3,180					
National Datacare Corporation	Data Processing		3,515					
See Attached	Legal		12,369					
Personnel Planners	Unemployment Tax Cons.		3,750					
Pinnacle Consulting	Customer Satisfaction		3,174					
Extended Care Consulting	Other Professional Fees		800					
Wellspring Partners	Real Estate Tax Appraisal		1,500					
Prospect Resources	Natural Gas Procurement		1,300					
See Supplemental Schedule			445,314					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 510,439					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

0031765

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council On LTC \$17,609
- (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. \$ 12,870 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 127,020
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.