



Facility Name & ID Number Briar Place

# 0031765 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	27,582	358	3,939	31,879	8
9	SNF/PED					9
10	ICF	45,132	586	2,549	48,267	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,714	944	6,488	80,146	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.65%

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

None (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 3,213

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	437,416	57,733	13,845	508,994		508,994	12,681	521,675		1
2	Food Purchase		487,901		487,901		487,901	866	488,767		2
3	Housekeeping	250,320	68,860		319,180		319,180	1,114	320,294		3
4	Laundry	87,073	27,165		114,238		114,238		114,238		4
5	Heat and Other Utilities			173,608	173,608		173,608	1,471	175,079		5
6	Maintenance	296,095		195,214	491,309		491,309	23,256	514,565		6
7	Other (specify):*							3,672	3,672		7
8	<b>TOTAL General Services</b>	<b>1,070,904</b>	<b>641,659</b>	<b>382,667</b>	<b>2,095,230</b>		<b>2,095,230</b>	<b>43,060</b>	<b>2,138,290</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,927	18,927		18,927		18,927		9
10	Nursing and Medical Records	2,668,576	200,207	15,126	2,883,909		2,883,909	(13,109)	2,870,800		10
10a	Therapy	191,750		1,158	192,908		192,908		192,908		10a
11	Activities	132,619	13,107		145,726		145,726		145,726		11
12	Social Services	406,132	8,996		415,128		415,128	39,339	454,467		12
13	CNA Training										13
14	Program Transportation			654	654		654		654		14
15	Other (specify):*							19,795	19,795		15
16	<b>TOTAL Health Care and Programs</b>	<b>3,399,077</b>	<b>222,310</b>	<b>35,865</b>	<b>3,657,252</b>		<b>3,657,252</b>	<b>46,025</b>	<b>3,703,277</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	159,084			159,084		159,084	160,437	319,521		17
18	Directors Fees										18
19	Professional Services			657,998	657,998	(22,140)	635,858	(490,036)	145,822		19
20	Dues, Fees, Subscriptions & Promotions			51,415	51,415		51,415	(6,723)	44,692		20
21	Clerical & General Office Expenses	94,391	34,323	96,284	224,998		224,998	245,220	470,218		21
22	Employee Benefits & Payroll Taxes			791,827	791,827		791,827	(6,180)	785,647		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,093	9,093		9,093	2,441	11,534		24
25	Other Admin. Staff Transportation			3,879	3,879		3,879	1,856	5,735		25
26	Insurance-Prop.Liab.Malpractice			237,357	237,357		237,357	3,618	240,975		26
27	Other (specify):*							70,948	70,948		27
28	<b>TOTAL General Administration</b>	<b>253,475</b>	<b>34,323</b>	<b>1,847,853</b>	<b>2,135,651</b>	<b>(22,140)</b>	<b>2,113,511</b>	<b>(18,419)</b>	<b>2,095,091</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,723,456</b>	<b>898,292</b>	<b>2,266,385</b>	<b>7,888,133</b>	<b>(22,140)</b>	<b>7,865,993</b>	<b>70,665</b>	<b>7,936,658</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Briar Place

#0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			79,241	79,241		79,241	223,219	302,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,349	2,349		2,349	603,852	606,201			32
33	Real Estate Taxes			366,362	366,362	22,140	388,502	5,768	394,270			33
34	Rent-Facility & Grounds			954,595	954,595		954,595	(954,000)	595			34
35	Rent-Equipment & Vehicles			9,974	9,974		9,974	1,754	11,728			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,412,521	1,412,521	22,140	1,434,661	(119,407)	1,315,254			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		265,140	277,974	543,114		543,114	(7,888)	535,226			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			597,247	597,247		597,247		597,247			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		265,140	875,221	1,140,361		1,140,361	(7,888)	1,132,473			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,723,456	1,163,432	4,554,127	10,441,015		10,441,015	(56,631)	10,384,384			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

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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	44,859	30		9
10	Interest and Other Investment Income	(55,356)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	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	(185)	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				24
25	Fund Raising, Advertising and Promotional	(6,914)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(128,561)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (146,214)</b>		<b>\$</b>	<b>30</b>

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)	89,584		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 89,584</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (56,631)</b>		<b>37</b>

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY					
48		49		50	
				51	
				52	

Briar Place

ID# 0031765

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (106)	21	1
2	Patient Clothing	(19)	10	2
3	Cook County Sales Tax	(1,482)	21	3
4	Collection Expense	(5,868)	21	4
5	Veterans Expenses	(103,996)	10	5
6	Bldg Co. - Misc Admin Expense	(275)	21	6
7	COPE Dues	(5,640)	20	7
8	Out of Period Professional Fees	(537)	21	8
9	Non Allowable Seminar	(2,000)	24	9
10	Non Allowable Legal	(8,637)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(128,561)	49

Briar Place

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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			523		13,392	(1,234)						12,681	1
2	Food Purchase	(57)		923									866	2
3	Housekeeping			924		190							1,114	3
4	Laundry													4
5	Heat and Other Utilities			1,220		251							1,471	5
6	Maintenance			7,970	15,194	92							23,256	6
7	Other (specify):*				1,637	2,035							3,672	7
8	<b>TOTAL General Services</b>	(57)		11,560	16,831	15,960	(1,234)						43,060	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(104,015)				90,906							(13,109)	10
10a	Therapy													10a
11	Activities													11
12	Social Services					39,339							39,339	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					19,795							19,795	15
16	<b>TOTAL Health Care and Programs</b>	(104,015)				150,040							46,025	16
	<b>C. General Administration</b>													
17	Administrative			6,110	33,731	120,596							160,437	17
18	Directors Fees													18
19	Professional Services	(8,637)		(319,356)		(162,043)							(490,036)	19
20	Fees, Subscriptions & Promotions	(12,554)		5,457		374							(6,723)	20
21	Clerical & General Office Expenses	(8,453)	275	25,791	212,348	15,259							245,220	21
22	Employee Benefits & Payroll Taxes				(6,180)								(6,180)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,000)		699		3,742							2,441	24
25	Other Admin. Staff Transportation			1,856									1,856	25
26	Insurance-Prop.Liab.Malpractice			2,498		1,120							3,618	26
27	Other (specify):*				50,889	20,059							70,948	27
28	<b>TOTAL General Administration</b>	(31,644)	275	(276,945)	290,788	(893)							(18,419)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(135,717)	275	(265,385)	307,619	165,107	(1,234)						70,665	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

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Ending:

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	44,859	164,470	11,231		2,659							223,219	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(55,356)	599,026	3,074		57,108							603,852	32
33	Real Estate Taxes			4,783		985							5,768	33
34	Rent-Facility & Grounds		(954,000)										(954,000)	34
35	Rent-Equipment & Vehicles			1,754									1,754	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(10,497)</b>	<b>(190,504)</b>	<b>20,842</b>		<b>60,752</b>							<b>(119,407)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(391)	(2,346)	(5,151)				(7,888)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>						<b>(391)</b>	<b>(2,346)</b>	<b>(5,151)</b>				<b>(7,888)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(146,214)</b>	<b>(190,229)</b>	<b>(244,543)</b>	<b>307,619</b>	<b>225,859</b>	<b>(1,625)</b>	<b>(2,346)</b>	<b>(5,151)</b>				<b>(56,631)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	\$ 954,000	G W H Limited Partnership	100.00%	\$	\$ (954,000)	1
2	V	21 Miscellaneous Admin Expense		G W H Limited Partnership	100.00%	275	275	2
3	V	30 Depreciation		G W H Limited Partnership	100.00%	164,470	164,470	3
4	V	32 Interest		G W H Limited Partnership	100.00%	599,026	599,026	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 954,000			\$ 763,771	\$ * (190,229)	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%	\$ 523	\$	523	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	923		923	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	924		924	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,220		1,220	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	7,970		7,970	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	6,110		6,110	20
21	V	19 Professional Fees	334,860	Extended Care Consulting, LLC	100.00%	15,504		(319,356)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	5,457		5,457	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	25,791		25,791	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	699		699	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,856		1,856	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	2,498		2,498	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	11,231		11,231	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	3,074		3,074	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,783		4,783	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,754		1,754	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		\$ 334,860			\$ 90,317	\$ *	(244,543)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	15,194	\$	15,194	15
16	V	06 Maintenance (Direct)	586	Extended Care Consulting, LLC	100.00%	586			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,557		1,557	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	80		80	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	33,731		33,731	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	212,348		212,348	22
23	V	21 Office and Clerical (Direct)	20,014	Extended Care Consulting, LLC	100.00%	20,014			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	45,962		45,962	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,927		4,927	25
26	V	22 Employee Benefits	6,180	Extended Care Consulting, LLC	100.00%			(6,180)	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		\$ 26,780			\$ 334,399	\$ *	307,619	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 190	\$	190	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	251		251	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	92		92	17
18	V	19 Professional Fees	164,928	Extended Care Clinical, LLC	100.00%	2,885		(162,043)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	374		374	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	3,872		3,872	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	3,742		3,742	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	1,120		1,120	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	2,659		2,659	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	57,108		57,108	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	985		985	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	13,392		13,392	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	2,035		2,035	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	90,906		90,906	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	39,339		39,339	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	19,795		19,795	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	120,596		120,596	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	11,387		11,387	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	20,059		20,059	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 164,928			\$ 390,787	\$ *	225,859	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Supplies, Supplements	\$ 4,409	Care Centers Health Systems, Inc.	100.00%	\$ 3,174	\$ (1,234)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	1,396	Care Centers Health Systems, Inc.	100.00%	1,005	(391)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 5,805			\$ 4,179	\$ * (1,625)

\* 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	39 Ventilator Equipment	10,385	Vent Lease LLC	100.00%	8,231	\$ (2,154)
16	V	39 Other Ancillary	925	Vent Lease LLC	100.00%	733	(192)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,310			\$ 8,964	\$ * (2,346)

\* 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	39 Therapy	\$ 266,252	Tri Care Rehab	100.00%	\$ 261,101	\$ (5,151)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 266,252			\$ 261,101	\$ * (5,151)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 221,309	\$ 221,309	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	221,309	CCS Employee Benefits Group	100.00%		(221,309)	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		\$ 221,309			\$ 221,309	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ARI WOLFF	2.857%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	G W H LIMITED PARTNERSHIP		BUILDING CO.	1
2	CELESTE GIANNINI TRUST DTD 3/13/00	1.020%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	CHERYL MAGENCE	3.469%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	ERIC ROTHNER	31.429%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPL	4
5	LAURI WOLFF POLEN	2.857%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	LORRAINE SUISSA	10.204%	DYER NURSING & REHAB	DYER, IN	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7	MARILYN WOLFF REVOCABLE TR DTD 1/89	11.837%	GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSIDE	THERAPY	7
8	MARK STEINBERG	2.041%	LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN	HARBOR LIGHT	GLEN ELLYN	HOSPICE	8
9	MARK SUISSA	10.204%	LAKWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	9
10	MEYER MAGENCE	3.469%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	RELIABLE MEDICAL	DES PLAINES	MEDICAL SUPPLIES	10
11	MICHAEL R. GIANNINI TRUST DTD	1.020%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				11
12	NOAH WOLFF REVOCABLE TR DTD 1/89	11.837%	OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				12
13	RANAN WOLFF	2.857%	PARC AT JOLIET LLC	JOLIET				13
14	SHIRLEY DRELICH	2.041%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15	TZIONA ZEFFREN	2.857%	PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SEBOS NURSING & REHAB	HOLBART, IN				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			WHEATON CARE CENTER	WHEATON				24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	Adam Vales	Relative	Clerical	0.00%	See Attached	2.06	5.15%	Alloc. Salary	\$ 3,603	22-7	1
2	Mark Steinberg	Owner	Administrative	2.04%	See Attached	5.30	9.41%	Al Sal/Al Fees	18,507	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 22,110		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:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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

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	1,101,784	30	\$ 7,195	\$ 80,146	\$ 523	1
2	02	Food	Patient Days	1,101,784	30	12,684	80,146	923	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707	80,146	924	3
4	05	Utilities	Patient Days	1,101,784	30	16,778	80,146	1,220	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559	80,146	7,970	5
6	17	Administrative	Patient Days	1,101,784	30	84,000	80,146	6,110	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139	80,146	15,504	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016	80,146	5,457	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548	80,146	25,791	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615	80,146	699	10
11	25	Other Staff Admin. Trans.	Patient Days	1,101,784	30	25,510	80,146	1,856	11
12	26	Insurance	Patient Days	1,101,784	30	34,345	80,146	2,498	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393	80,146	11,231	13
14	32	Interest	Patient Days	1,101,784	30	42,261	80,146	3,074	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749	80,146	4,783	15
16	35	Rent - Equipment & Auto	Patient Days	1,101,784	30	24,117	80,146	1,754	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,241,615	\$	\$ 90,317	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,101,784	30	208,870	208,870	80,146	15,194	1
2	06	Maintenance (Direct)	Direct		30	331,520	331,520		586	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,101,784	30	21,409		80,146	1,557	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	37,937			80	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,101,784	30	463,710	463,710	80,146	33,731	7
8	21	Office and Clerical (Pooled)	Patient Days	1,101,784	30	2,919,199	2,919,199	80,146	212,348	8
9	21	Office and Clerical (Direct)	Direct		30	328,534	328,534		20,014	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,101,784	30	631,850		80,146	45,962	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	55,508			4,927	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,998,538	\$ 4,251,833	\$	334,399	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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	03	Housekeeping	Patient Days	610,520	17	\$ 1,450	\$ 80,146	\$ 190	1
2	05	Utilities	Patient Days	610,520	17	1,914	80,146	251	2
3	06	Maintenance	Patient Days	610,520	17	698	80,146	92	3
4	19	Professional Fees	Patient Days	610,520	17	21,974	80,146	2,885	4
5	20	Dues and Subscriptions	Patient Days	610,520	17	2,847	80,146	374	5
6	21	Office & Clerical	Patient Days	610,520	17	29,496	80,146	3,872	6
7	24	Travel and Seminar	Patient Days	610,520	17	28,507	80,146	3,742	7
8	26	Insurance	Patient Days	610,520	17	8,533	80,146	1,120	8
9	30	Depreciation	Patient Days	610,520	17	20,257	80,146	2,659	9
10	32	Interest	Patient Days	610,520	17	435,028	80,146	57,108	10
11	33	Real Estate Taxes	Patient Days	610,520	17	7,502	80,146	985	11
12	01	Dietary Salary	Patient Days	610,520	17	102,014	102,014	13,392	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	610,520	17	15,504	80,146	2,035	13
14	10	Nursing Salary	Patient Days	610,520	17	692,482	692,482	90,906	14
15	12	Social Service Salary	Patient Days	610,520	17	299,672	299,672	39,339	15
16	15	Emp. Ben. - Healthcare	Patient Days	610,520	17	150,791	80,146	19,795	16
17	17	Administration Salary	Patient Days	610,520	17	918,652	918,652	120,596	17
18	21	Office Salary	Patient Days	610,520	17	86,739	86,739	11,387	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	610,520	17	152,803	80,146	20,059	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,976,862	\$ 2,099,559	\$ 390,787	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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	1	Dietary Supplies, Supplements	Direct Allocation					\$ 3,174	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					1,005	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				\$	\$		\$ 4,179	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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	39	Ventilator Equipment		Direct Allocation				8,231	1
2	39	Other Ancillary		Direct Allocation				733	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				\$	\$		\$ 8,964	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 TriCare Rehab  
 Street Address 240 Fencil Lane  
 City / State / Zip Code Hillside, IL 60162  
 Phone Number ( 773) 449-9400  
 Fax Number ( 773) 449-9700

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	39	Therapy	Direct Allocation		\$	\$		\$ 261,101	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				\$	\$		\$ 261,101	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1 22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 221,309	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				\$	\$		\$ 221,309	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	White Oak Nursing Center		X	Mortgage	\$78,544.00	03/01/97	\$ 7,441,383	\$ 4,802,426	11/01/21	12.0000	\$ 599,026	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Daiwa		X	Line of Credit							2,349	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$78,544.00		\$ 7,441,383	\$ 4,802,426			\$ 601,375	9						
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X								(55,356)	10						
11	Allocated from EC Consulting	X									3,074	11						
12	Allocated from EC Clinical	X									57,108	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 4,826	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 7,441,383	\$ 4,802,426			\$ 606,201	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:

01/01/13

Ending:

12/31/13

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

\* 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.)

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

## B. Real Estate Taxes

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>161,932</u>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>357,963</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>196,031</u>	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>176,099</u>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>22,140</u>	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>64,198</u> For <u>2009</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>394,270</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>342,236</u>	8	<b>FOR BHF USE ONLY</b>	
	2009	<u>308,829</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2010	<u>217,313</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	<u>338,703</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2012	<u>352,195</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>2013 Accrual = \$352,195 x 1.05 = \$369,805 - 193,707; Beginning accrual adjusted \$193,706 for early payment</u>					
<u>Allocated from Extended Care Consulting, LLC = \$4,783</u>					
<u>Allocated from Extended Care Clinical, LLC = \$985</u>					

## NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0031765  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-20-102-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>352,195.24</u>	\$ <u>352,195.24</u>
2. <u>See Attached</u>	<u>2201 Main Allocation</u>	\$ <u>133,178.74</u>	\$ <u>4,547.18</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>485,373.98</u></u>	\$ <u><u>356,742.42</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Briar Place

# 0031765 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		1997	\$ 402,869	1
2	Allocated from EC Consulting / EC Clinical 2201 Main			27,997	2
3	TOTALS			\$ 430,866	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	232		1976	\$ 6,414,314	\$ 164,470	39	\$ 164,470	\$	\$ 2,874,500	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1986	5,000		20			4,987	9
10	Various		1987	138,915		20			138,076	10
11	Various		1988	9,885		20			9,822	11
12	Various		1989	5,410		20			5,410	12
13	Various		1990	42,578		20			42,575	13
14	Various		1991	11,813		20			11,811	14
15	Various		1992	11,426		20			11,423	15
16	Various		1993	8,851		20			8,851	16
17	Various		1994	25,632		20	1,282	1,282	24,694	17
18	Various		1995	50,028		20	2,501	2,501	46,398	18
19	Various		1996	161,111		20	8,056	8,056	136,261	19
20	Various		1997	165,320		20	8,266	8,266	139,091	20
21	Various		1998	189,177		20	9,459	9,459	147,559	21
22	Various		1999	21,736		20	1,070	1,070	15,501	22
23	Various		2000	122,845		20	6,114	6,114	82,481	23
24	Various		2001	51,096		20	2,555	2,555	32,163	24
25	Various		2002	68,816		20	608	608	67,773	25
26	Various		2003	117,820		20	2,903	2,903	102,633	26
27	Various		2004	41,864		20	2,642	2,642	34,291	27
28	Various		2005	50,621		20	3,062	3,062	43,834	28
29	Various		2006	89,874		20	6,688	6,688	72,458	29
30	Various		2007	96,414		20	6,382	6,382	75,195	30
31	Various		2008	49,099		20	2,890	2,890	31,873	31
32	Various		2009	62,307		20	6,879	6,879	30,393	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			113,651	7,720	7,720		76,923	68
69				79,241		(79,241)		69
70		\$	8,125,603	\$ 251,431		\$ 243,546	\$ (7,885)	\$ 4,266,976 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 8,125,603	\$ 251,431		\$ 243,546	\$ (7,885)	\$ 4,266,976	1
2	Communication System - New Ceiling Assembly, Cables And Spea	2010	3,823		20	382	382	1,529	2
3	Communication System - Wiring For Matrix	2010	4,630		20	463	463	1,775	3
4	Communication System - Nurse Call Station Installation	2010	8,305		20	1,661	1,661	6,367	4
5	Multistack 150 Ton Chiller	2010	174,658		20	17,466	17,466	58,219	5
6	Hvac Repairs	2010	2,519		20	252	252	924	6
7	Painting (Transfer From Home Office)	2010	2,667		20	267	267	1,000	7
8	Painting (Transfer From Home Office)	2010	3,506		20	351	351	1,286	8
9	Hvac Repairs	2010	8,765		20	877	877	3,287	9
10	Repair Chiller Compressor	2010	4,435		20	444	444	1,626	10
11	Installation Of Smoke Dampers	2010	2,800		20	280	280	980	11
12	Repair Circulating Pump	2010	3,350		20	335	335	1,061	12
13	Water Heater	2011	6,710		20	671	671	2,013	13
14	Rebuild Air Handler	2011	3,500		20	700	700	1,983	14
15	Install Filter Housing On Recirculating Pumps	2011	4,700		20	940	940	2,507	15
16	Elevator Repairs	2011	2,776		20	278	278	671	16
17	Valve & Pump Repair	2011	4,435		20	444	444	1,072	17
18	Walk In Freezer Door	2011	3,600		20	360	360	780	18
19	Boiler Valve Repair	2011	2,617		20	131	131	283	19
20	Piping & Valves	2012	16,928		20	1,693	1,693	3,386	20
21	Boiler Repair	2012	4,500		20	225	225	375	21
22	Install Surplus Ats	2012	5,635		20	564	564	939	22
23	Concrete Patio-Walkway & Drainage Pipe	2012	12,500		20	834	834	1,250	23
24	Add'L Concrete Work & Soding	2012	5,600		20	374	374	560	24
25	Replacement Of 2 Boilers	2012	126,500		20	12,650	12,650	16,867	25
26	Piping Insulation	2012	4,015		20	402	402	435	26
27	Cubicle Curtains	2013	11,033		20	1,287	1,287	1,287	27
28	New Ramp	2013	19,800		20	660	660	660	28
29	Cooling Tower Repairs	2013	6,646		20	166	166	166	29
30	Sealcoating	2013	6,200		20	155	155	155	30
31	Water Heater	2013	7,722		20	129	129	129	31
32	Railings For New Ramp	2013	10,800		20	180	180	180	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727	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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727		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	<b>TOTAL (lines 1 thru 33)</b>	\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727		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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727	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)		\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727	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 and Improvement Costs-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 12D, Carried Forward		\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727	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)		\$ 8,611,277	\$ 251,431		\$ 289,163	\$ 37,732	\$ 4,380,727	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								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 and Improvement Costs-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		\$	\$		\$	\$	\$	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from Extended Care Consulting 2201 Main,LLC	2002	31,993	820	39	820		9,263	3
4	Allocated from Extended Care Clinical 2201 Main,LLC	2002	6,588	169	39	169		1,908	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Allocated from Extended Care Consulting, LLC	2007	335	17	20	17		117	9
10	Allocated from Extended Care Consulting, LLC	2009	200	10	20	10		50	10
11	Allocated from Extended Care Consulting, LLC	2010	1,963	98	20	98		393	11
12	Allocated from Extended Care Consulting, LLC	2011	706	35	20	35		106	12
13	Allocated from Extended Care Consulting, LLC	2012	233	12	20	12		23	13
14									14
15	Allocated from Extended Care Consulting 2201 Main,LLC	2002	26,429	2,415	20	2,415		24,176	15
16	Allocated from Extended Care Consulting 2201 Main,LLC	2003	31,146	2,846	20	2,846		28,491	16
17	Allocated from Extended Care Consulting 2201 Main,LLC	2005	1,547	164	20	164		1,216	17
18	Allocated from Extended Care Consulting 2201 Main,LLC	2009	279	14	20	14		70	18
19									19
20	Allocated from Extended Care Clinical 2201 Main,LLC	2002	5,442	497	20	497		4,979	20
21	Allocated from Extended Care Clinical 2201 Main,LLC	2003	6,414	586	20	586		5,867	21
22	Allocated from Extended Care Clinical 2201 Main,LLC	2005	319	34	20	34		250	22
23	Allocated from Extended Care Clinical 2201 Main,LLC	2009	57	3	20	3		14	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

Facility Name & ID Number Briar Place

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	\$	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	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 113,651	\$ 7,720		\$ 7,720	\$	\$ 76,923	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 330,667	\$ 752	\$ 6,372	\$ 5,620	10	\$ 310,013	71
72	Current Year Purchases	21,517	144	1,586	1,442	10	1,586	72
73	Fully Depreciated Assets	2,094,357	3,924	3,924		10	2,094,357	73
74								74
75	TOTALS	\$ 2,446,541	\$ 4,820	\$ 11,883	\$ 7,063		\$ 2,405,957	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Autos - See Attached	2012	\$ 122,319	\$	\$ 64	\$ 64	5	\$ 121,768	76
77		Allocated from EC Consulting	2013	11,273				5	11,273	77
78		Allocated from EC Clinical	2013	6,745	1,349	1,349		5	1,994	78
79										79
80	TOTALS			\$ 140,337	\$ 1,349	\$ 1,413	\$ 64		\$ 135,035	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,629,022	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 257,600	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 302,459	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,859	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,921,719	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning: 01/01/13

Ending: 12/31/13

**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	Storage Rental				595			5
6								6
7	TOTAL				\$ 595			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 6,487 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Toyota	\$ 655.17	\$ 5,241	17
18					18
19					19
20					20
21	TOTAL		\$ 655.17	\$ 5,241	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	93,202	\$		\$	93,202	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				28,253				28,253	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				146,134				146,134	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					174,623			174,623	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						10,385	90,517			100,902	13
14	TOTAL			\$		\$	277,974	\$	265,140	\$	543,114	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: 01/01/13 Ending: 12/31/13  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 9,634	\$ (159,349)	1
2	Cash-Patient Deposits	49,863	49,863	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,034,809	1,034,809	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	294,794	294,794	6
7	Other Prepaid Expenses	3,554	3,554	7
8	Accounts Receivable (owners or related parties)	846,151	846,151	8
9	Other(specify): <u>See Attached Schedule</u>	1,005,721	1,155,626	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,244,526	\$ 3,225,448	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost	19,800	6,434,114	14
15	Leasehold Improvements, at Historical Cost	1,756,818	1,756,818	15
16	Equipment, at Historical Cost	1,261,608	2,486,608	16
17	Accumulated Depreciation (book methods)	(2,573,471)	(6,560,196)	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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 464,755	\$ 4,519,413	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,709,281	\$ 7,744,861	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 2,308,434	\$ 2,308,433	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,561	49,561	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	380,305	380,305	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,233	17,233	31
32	Accrued Real Estate Taxes(Sch.IX-B)	217,276	176,099	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,972,809	\$ 2,931,631	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,802,426	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43			220,320	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,022,746	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,972,809	\$ 7,954,377	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 736,472	\$ (209,516)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,709,281	\$ 7,744,861	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 639,525	1
2	Restatements (describe):		2
3	Prior year bad debt / allowance adjustment	(128,193)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 511,332	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,025,478	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	(800,338)	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)	\$ 225,140	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 736,472	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,016,772	1
2	Discounts and Allowances for all Levels	(1,348,968)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,667,804</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,043,225	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,043,225</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	296,942	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,743	19
20	Radiology and X-Ray	2,580	20
21	Other Medical Services	20,910	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 339,175</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	55,356	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 55,356</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	360,933	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 360,933</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 11,466,493</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,095,230	31
32	Health Care	3,657,252	32
33	General Administration	2,135,651	33
<b>B. Capital Expense</b>			
34	Ownership	1,412,521	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	543,114	35
36	Provider Participation Fee	597,247	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 10,441,015</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,025,478</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,025,478</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 8,732,288	44
45	Private Pay - Net Inpatient Revenue	166,365	45
46	Medicare - Net Inpatient Revenue	211,078	46
47	Other-(specify) Hospice	207,636	47
48	Other-(specify) Veteran, Insurance	350,437	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 9,667,804</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,997	2,158	\$ 106,673	\$ 49.43	1
2	Assistant Director of Nursing	2,203	2,500	90,383	36.15	2
3	Registered Nurses	14,068	15,679	527,898	33.67	3
4	Licensed Practical Nurses	35,494	39,247	968,697	24.68	4
5	CNAs & Orderlies	66,541	73,341	913,123	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,546	11,726	191,750	16.35	8
9	Activity Director	3,298	3,682	59,138	16.06	9
10	Activity Assistants	7,877	8,467	73,481	8.68	10
11	Social Service Workers	20,581	22,716	406,132	17.88	11
12	Dietician	1,938	2,142	41,049	19.16	12
13	Food Service Supervisor	1,894	2,236	52,102	23.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,348	7,180	115,570	16.10	15
16	Dishwashers	20,779	23,259	228,695	9.83	16
17	Maintenance Workers	20,773	22,601	296,095	13.10	17
18	Housekeepers	21,064	23,426	250,320	10.69	18
19	Laundry	6,286	7,269	87,073	11.98	19
20	Administrator	1,933	2,109	112,425	53.31	20
21	Assistant Administrator	1,859	1,867	46,659	24.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,745	5,283	94,391	17.87	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	1,882	2,120	37,852	17.85	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,654	1,892	23,949	12.66	33
34	TOTAL (lines 1 - 33)	253,760	280,900	\$ 4,723,455 *	\$ 16.82	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	284	\$ 13,845	01-03	35
36	Medical Director	Monthly	18,927	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,126	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	23	1,158	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	307	\$ 49,056		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	
Delnaz Vazidfar	Administrator	0.00%	\$ 112,425	Workers' Compensation Insurance	\$ 150,122	IDPH License Fee	\$	
Stephanie Rucker	Asst. Admin	0.00%	46,659	Unemployment Compensation Insurance	84,983	Advertising: Employee Recruitment	245	
				FICA Taxes	355,373	Health Care Worker Background Check (Indicate # of checks performed 208 )	2,090	
				Employee Health Insurance	168,624	Patient Background Checks		
				Employee Meals		Dues & Subscriptions	26,586	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	9,940	
				Employee Physicals	16,313	Allocated from EC Consulting	5,457	
				Holiday Expense	3,061	Allocated from EC Clinical	374	
				Other Employee Welfare	7,171			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 159,084	TOTAL (agree to Schedule V, line 22, col.8)		\$ 44,692		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
			\$				Yellow page advertising ( )	
							TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 44,692	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 25,783			\$	Out-of-State Travel	
Extended Care Consulting	Home Office Expense		334,860					
Extended Care Clinical	Home Office Expense		164,928					
Personnel Planners	Unemployment Consult.		3,100				In-State Travel	
Paycor	Payroll Services		25,499					
E-Health Data Solutions	MDS Software		3,180					
AIS Assessment	MDS Consulting		1,948					
Ability Network	Medicare Billing		161				Seminar Expense	
National Datacare Corporation	Resident Fund Processing		3,856				7,092	
Daiwa	Line of Credit Audit		22,889				Allocated from EC Consulting	
Prospect Resources	Natural Gas Procurement		2,600				699	
See Supplemental Schedule			69,192				Allocated from EC Clinical	
							3,742	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 657,997	TOTAL		\$	Entertainment Expense ( )	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 11,533	

\* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Briar Place

# 0031765

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC: \$25,636
- (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. \$ 15,111 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. \$ 597,247  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ N/A
- (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.