

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0038232 Facility Name: Briarbrook Place Address: 228 Briarbrook Drive East Peoria 61611 County: Tazewell Telephone Number: (309) 698-9200 Fax # (309) 698-9213 HFS ID Number: Date of Initial License for Current Owners: 08/01/1992 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501 C (3) ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Tracey Peloz

Telephone Number: (708) 283-1530

Email Address:

Facility Name & ID Number Briarbrook Place# 0038232 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 bedsN/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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,540			5,540	13
14	TOTALS	5,540			5,540	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.86%

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

77 (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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

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 08/01/1992

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

YES ☒Date 03/08/1999NO ☐

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

YES ☐NO ☒If YES, enter number
of beds certified 0 and days of care provided 0Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	12,828	4,150	2,024	19,002		19,002		19,002		1
2	Food Purchase		39,731		39,731		39,731	(159)	39,572		2
3	Housekeeping		5,201		5,201		5,201	4	5,205		3
4	Laundry		1,594		1,594		1,594		1,594		4
5	Heat and Other Utilities			13,004	13,004		13,004	803	13,807		5
6	Maintenance	10,525	5,986	4,867	21,378		21,378	882	22,260		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	23,353	56,662	19,895	99,910		99,910	1,530	101,440		8
	B. Health Care and Programs										
9	Medical Director			605	605		605		605		9
10	Nursing and Medical Records	219,775	5,589	3,712	229,076		229,076		229,076		10
10a	Therapy			748	748		748		748		10a
11	Activities		869	481	1,350		1,350		1,350		11
12	Social Services			2,184	2,184		2,184		2,184		12
13	CNA Training										13
14	Program Transportation			7,421	7,421		7,421		7,421		14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	219,775	6,458	15,151	241,384		241,384		241,384		16
	C. General Administration										
17	Administrative	393		116,872	117,265		117,265	(116,872)	393		17
18	Directors Fees							2,781	2,781		18
19	Professional Services			1,281	1,281		1,281	11,808	13,089		19
20	Dues, Fees, Subscriptions & Promotions			2,395	2,395		2,395	1,549	3,944		20
21	Clerical & General Office Expenses	125	7,425	8,796	16,346		16,346	60,431	76,777		21
22	Employee Benefits & Payroll Taxes			50,719	50,719		50,719	8,771	59,490		22
23	Inservice Training & Education			153	153		153		153		23
24	Travel and Seminar			516	516		516	2,271	2,787		24
25	Other Admin. Staff Transportation			67	67		67	1,009	1,076		25
26	Insurance-Prop.Liab.Malpractice			6,372	6,372		6,372	1,175	7,547		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	518	7,425	187,171	195,114		195,114	(27,077)	168,037		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	243,646	70,545	222,217	536,408		536,408	(25,547)	510,861		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			22,196	22,196		22,196	2,534	24,730			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,403	44,403		44,403	15,797	60,200			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							5,182	5,182			34
35	Rent-Equipment & Vehicles							649	649			35
36	Other (specify):*											36
37	TOTAL Ownership			66,599	66,599		66,599	24,162	90,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,234		2,234		2,234		2,234			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,112	42,112		42,112		42,112			42
43	Other (specify):* Non-allowable Costs											43
44	TOTAL Special Cost Centers		2,234	42,112	44,346		44,346		44,346			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	243,646	72,779	330,928	647,353		647,353	(1,385)	645,968			45

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

		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(681)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(704)	43		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				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 See Page 5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,385)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,385)		37

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

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

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

Briarbrook Place

ID#

0038232

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briarbrook Place# 0038232

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	(159)	0	0	0	0	0	0	0	0	0	(159)	2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	803	0	0	0	0	0	0	0	0	0	803	5
6	Maintenance	0	882	0	0	0	0	0	0	0	0	0	882	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,530	0	0	0	0	0	0	0	0	0	1,530	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(116,872)	0	0	0	0	0	0	0	0	0	(116,872)	17
18	Directors Fees	0	2,781	0	0	0	0	0	0	0	0	0	2,781	18
19	Professional Services	0	11,808	0	0	0	0	0	0	0	0	0	11,808	19
20	Fees, Subscriptions & Promotions	0	1,549	0	0	0	0	0	0	0	0	0	1,549	20
21	Clerical & General Office Expenses	0	60,431	0	0	0	0	0	0	0	0	0	60,431	21
22	Employee Benefits & Payroll Taxes	0	8,771	0	0	0	0	0	0	0	0	0	8,771	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,271	0	0	0	0	0	0	0	0	0	2,271	24
25	Other Admin. Staff Transportation	0	1,009	0	0	0	0	0	0	0	0	0	1,009	25
26	Insurance-Prop.Liab.Malpractice	0	1,175	0	0	0	0	0	0	0	0	0	1,175	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(27,077)	0	0	0	0	0	0	0	0	0	(27,077)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	(25,547)	0	0	0	0	0	0	0	0	0	(25,547)	29

STATE OF ILLINOIS

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

07/01/2011 Ending:

Summary B
06/30/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	2,534	0	0	0	0	0	0	0	0	2,534	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	15,797	0	0	0	0	0	0	0	0	15,797	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,182	0	0	0	0	0	0	0	0	5,182	34
35	Rent-Equipment & Vehicles	0	0	649	0	0	0	0	0	0	0	0	649	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	24,162	0	0	0	0	0	0	0	0	24,162	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,385)	0	1,385	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,385)	0	1,385	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,385)	(25,547)	25,547	0	0	0	0	0	0	0	0	(1,385)	45

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
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$ 159	Progressive Housing, Inc.	100.00%	\$	\$ (159)	1
2	V	3	Housekeeping		Progressive Housing, Inc.	100.00%	4	4	2
3	V	5	Utilities		Progressive Housing, Inc.	100.00%	803	803	3
4	V	6	Maintenance		Progressive Housing, Inc.	100.00%	882	882	4
5	V	17	Administrative	116,872	Progressive Housing, Inc.	100.00%		(116,872)	5
6	V	18	Director Fees		Progressive Housing, Inc.	100.00%	2,781	2,781	6
7	V	19	Professional Services		Progressive Housing, Inc.	100.00%	11,808	11,808	7
8	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,549	1,549	8
9	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	60,431	60,431	9
10	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	8,771	8,771	10
11	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	2,271	2,271	11
12	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	1,009	1,009	12
13	V	26	Insurance		Progressive Housing, Inc.	100.00%	1,175	1,175	13
14	Total			\$ 117,031			\$ 91,484	\$ * (25,547)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Progressive Housing, Inc.	100.00%	\$ 2,534	\$ 2,534	15
16	V	32	Interest	4,189	Progressive Housing, Inc.	100.00%	19,986	15,797	16
17	V	34	Rent		Progressive Housing, Inc.	100.00%	5,182	5,182	17
18	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	649	649	18
19	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,385	1,385	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			\$ 4,189			\$ 29,736	\$ * 25,547	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

Facility Name & ID Number

Briarbrook Place

0038232

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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			Sparta Terrace	Sparta				1
2			Taylorville Terrace	Taylorville				2
3			Aviston Terrace	Aviston	Progressive			3
4			Ellner Terrace	Evansville	Housing, Inc.	Olympia Fields	ICF/DD Provider	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Steger	Workshop	6
7			Terra Estates	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Waltonville	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	Edward Childers	Chairman	Board Member	None	8,993	3Hrs/MTG	1.00	Dir. Fees	\$ 607	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,993	3Hrs/MTG	1.00	Dir. Fees	607	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,993	3Hrs/MTG	1.00	Dir. Fees	607	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,993	3Hrs/MTG	1.00	Dir. Fees	607	L18,C8	4
5	Cora Flota	Director	Board Member	None	750	3Hrs/MTG	1.00	Dir. Fees	50	L18,C8	5
6	Edward Copeland	Director	Board Member	None	4,497	3Hrs/MTG	1.00	Dir. Fees	303	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	140,512	1.18	2.95	Salary	9,483	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,264		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

SCHEDULE 7A

Progressive Housing, Inc.

Larry
Manson

175th Place	233	19	116	233	233	233	1,066	3,634
Sauganash								
Steger	389	33	194	389	389	389	1,783	6,074
Waltonville	223	19	111	223	223	223	1,022	3,482

Total PHI	9,600	800	4,800	9,600	9,600	9,600	44,000	149,995
-----------	-------	-----	-------	-------	-------	-------	--------	---------

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

Progressive Housing, Inc.

Street Address

3615 Park Drive, Suite 100

City / State / Zip Code

Olympia Fields, IL 60461

Phone Number

(708) 283-1530

Fax Number

(708) 283-2470

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Budgeted Rev/Dir Cost	15,472,003	31	\$ 67	\$	978,177	\$ 4	1
2	5	Utilities	Budgeted Rev/Dir Cost	15,472,003	31	12,706		978,177	803	2
3	6	Maintenance	Budgeted Rev/Dir Cost	15,472,003	31	14,679		978,177	882	3
4	18	Director Fees	Budgeted Rev/Dir Cost	15,472,003	31	44,000		978,177	2,781	4
5	19	Professional Services	Budgeted Rev/Dir Cost	15,472,003	31	182,889		978,177	11,808	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	15,472,003	31	15,420		978,177	1,549	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost	15,472,003	31	951,030	896,943	978,177	60,431	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost	15,472,003	31	138,267		978,177	8,771	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost	15,472,003	31	49,382		978,177	2,271	9
10	25	Auto Expense	Budgeted Rev/Dir Cost	15,472,003	31	14,771		978,177	1,009	10
11	26	Insurance	Budgeted Rev/Dir Cost	15,472,003	31	20,429		978,177	1,175	11
12	30	Depreciation	Budgeted Rev/Dir Cost	15,472,003	31	40,101		978,177	2,534	12
13	32	Interest	Budgeted Rev/Dir Cost	15,472,003	31	316,315		978,177	19,986	13
14	34	Rent	Budgeted Rev/Dir Cost	15,472,003	31	137,366		978,177	5,182	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost	15,472,003	31	12,925		978,177	649	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	15,472,003	31	40,910		978,177	1,385	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,991,257	\$ 896,943		\$ 121,220	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 978,827	\$ 978,827	08/15/26	6.7500	\$ 43,006	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Amortization										1,397	6	
7	Allocation from Home Office-Interest										19,204	7	
8	Allocation from Home Office-Amortization										782	8	
9	TOTAL Facility Related						\$ 978,827	\$ 978,827			\$ 64,389	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income Offset				(4,189)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (4,189)	14	
15	TOTALS (line 9+line14)						\$ 978,827	\$ 978,827			\$ 60,200	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.)		2011	\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007		8
2008		9
2009		10
2010		11
2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Briarbrook Place

COUNTY
Tazewell

FACILITY IDPH LICENSE NUMBER
0038232

CONTACT PERSON REGARDING THIS REPORT
N/A

TELEPHONE ()
FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories One

C. Does the Operating Entity?

X(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?

X(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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X 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: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	47,250	1999	\$ 20,000	1
2	Allocated from Home Office			198	2
3	TOTALS	47,250		\$ 20,198	3

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	16		1999	1991	\$ 730,000	\$ 18,300	40	\$ 18,300		\$ 243,383
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping		1994		1,593		15			1,593
10	Electrical Wiring		2001		552	37	15	37		396
11	Ceramic Tiles, Sink and Stool		2006		1,240	82	15	82		508
12	Bathroom Remodel		2007		266	18	15	18		97
13	Water Heater		2008		776	52	15	52		220
14	Bathroom Remodel		2008		950	63	15	63		268
15	Bathroom Remodel		2008		1,072	71	15	71		297
16	Bathroom Remodel		2008		194	13	15	13		54
17	Concrete Sidewalk		2008		2,255	150	15	150		488
18	Carpets for Bedrooms, Living Room and Activity Rooms		2010		5,970	398	15	398		870
19	Kitchen and Pantry Remodel		2010		2,214	148	15	148		495
20	Kitchen and Pantry Remodel- Paint and Materials for project		2010		1,049	70	15	70		175
21	Kitchen and Pantry Remodel - Counter Top, Sink, Plumbing		2010		600	40	15	40		97
22	Kitchen and Pantry Remodel - Steel Door		2010		265	18	15	18		42
23	AC Installation		2010		2,927	195	15	195		390
24	Replace water valve		2010		952	64	15	64		112
25	Kitchen fire repair		2011		574	38	15	38		54
26	Replace condensor fan and capacitor		2011		700	47	15	47		51
27	Replace 2 Furnaces		2011		3,470	174	15	174		174
28										
29										
30										
31	Allocated from Home Office				4,113			2,534	2,534	20,210
32										
33										
34										
35										
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

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	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 761,732	\$ 19,978		\$ 22,512	\$ 2,534	\$ 269,974	70

**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	\$ 16,519	\$ 1,795	\$ 1,795		5-10Yrs	\$ 6,400	71
72	Current Year Purchases					5-10Yrs		72
73	Fully Depreciated Assets	19,714	106	106		5-10Yrs	19,714	73
74	Allocated from Home Office	17,058						74
75	TOTALS	\$ 53,291	\$ 1,901	\$ 1,901			\$ 26,114	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	Resident Transportation	2002 Ford E350/2004 Dodge Car	2002/2004	\$ 48,319				5	\$ 48,319	76
77	Resident Transportation	2002 Ford E350	2009	596	119	119		5	287	77
78	Resident Transportation	2004 Dodge Caravan	2011	991	198	198		5	83	78
79	Allocated from Home Office			8,172						79
80	TOTALS			\$ 58,078	\$ 317	\$ 317			\$ 48,689	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)	\$ 893,299	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,730	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,534	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 344,777	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	N/A		93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

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								5
6	Allocated from Home Office				5,182			6
7	TOTAL				\$ 5,182			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- N/A
- N/A

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: \$ 649
- Description: Allocated from Home Office - postage machine, copier
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning N/A

Ending N/A

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$ N/A
13.	/2014	\$ N/A
14.	/2015	\$ N/A

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				2,234		2,234	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 2,234		\$ 2,234	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,267	\$ 3,267	1
2	Cash-Patient Deposits	10,420	10,420	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,329)	213,306	213,306	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,002	2,002	6
7	Other Prepaid Expenses	205	205	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves</u>	162,122	162,122	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 391,322	\$ 391,322	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,198	20,198	13
14	Buildings, at Historical Cost	761,732	761,732	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	111,369	111,369	16
17	Accumulated Depreciation (book methods)	(344,777)	(344,777)	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) <u>Loan Costs</u>	17,584	17,584	22
23	Other(specify): <u>Deposit</u>	715	715	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 566,821	\$ 566,821	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 958,143	\$ 958,143	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,080	\$ 24,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,420	10,420	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,257	5,257	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	33,214	33,214	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	520	520	36
37	<u>Deferred Income</u>	15,121	15,121	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 88,612	\$ 88,612	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	978,827	978,827	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 978,827	\$ 978,827	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,067,439	\$ 1,067,439	46
47	TOTAL EQUITY (page 18, line 24)	\$ (109,296)	\$ (109,296)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 958,143	\$ 958,143	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,592,155	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,592,156	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	93,373	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 93,373	17
	B. Transfers (Itemize):		
18	Allocation of Progressive Housing, Inc. Balance Sheet		18
19	to individual facilities	(2,794,825)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,794,825)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (109,296)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Briarbrook Place# 0038232Report Period Beginning: 07/01/2011Ending: 06/30/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 724,097	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 724,097	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,383	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,383	23
	D. Non-Operating Revenue		
24	Contributions	6	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Prior Period Adjustment</u>	15,240	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,240	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 740,726	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	99,910	31
32	Health Care	241,384	32
33	General Administration	195,114	33
	B. Capital Expense		
34	Ownership	66,599	34
	C. Ancillary Expense		
35	Special Cost Centers	2,234	35
36	Provider Participation Fee	42,112	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 647,353	40
41	Income before Income Taxes (line 30 minus line 40)**	93,373	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 93,373	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 724,097	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 724,097	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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.

Facility Name	Briarbrook Place
ID#	0038232
FYE	6/30/2012

SCH 19A

Schedule XVII
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)
and is part of a Consolidated Entity Tax Return.
Therefore, the Income or Loss cannot be
traced to the Federal Income Tax Return.

Facility Name & ID Number Briarbrook Place# 0038232Report Period Beginning: 07/01/2011Ending: 06/30/2012

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	1,796	1,829	33,281	18.20	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,373	1,463	12,828	8.77	15
16	Dishwashers					16
17	Maintenance Workers	882	899	10,525	11.71	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	5	23	393	17.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4	6	125	20.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,811	1,879	28,724	15.29	29
30	Habilitation Aides (DD Homes)	16,092	17,107	156,491	9.15	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>QSP</u>	73	73	1,279	17.52	33
34	TOTAL (lines 1 - 33)	22,036	23,279	\$ 243,646 *	\$ 10.47	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	80	\$ 2,024	L1, C3	35
36	Medical Director	Monthly	605	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	86	2,489	L10, C3	38
39	Pharmacist Consultant	Monthly	1,143	L10, C3	39
40	Physical Therapy Consultant	5	374	L10A, C3	40
41	Occupational Therapy Consultant	5	374	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	29	2,184	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	205	\$ 9,193		49

C. CONTRACT NURSES

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

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	
Christina Durbin	Administrator	0	\$ 393	Workers' Compensation Insurance		\$ 7,191	IDPH License Fee	\$	
				Unemployment Compensation Insurance		16,571	Advertising: Employee Recruitment		
				FICA Taxes		18,996	Health Care Worker Background Check		
				Employee Health Insurance		7,793	(Indicate # of checks performed 12)	122	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*					
TOTAL (agree to Schedule V, line 17, col. 1)							Hiring Exepense	1,144	
(List each licensed administrator separately.)							Miscellaneous Dues & Fees	1,129	
				Life Insurance		20			
				Other Employee Benefits		148	Allocated from Home Office	1,549	
							Less: Public Relations Expense	()	
				Allocated from Home Office		8,771	Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 59,490	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,944	
(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**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Allocated from Progressive Housing, Inc.			\$ 116,872	N/A			Out-of-State Travel	\$	
							In-State Travel	507	
							Allocated from Home Office	2,223	
							Seminar Expense	9	
							Allocated from Home Office	48	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)						\$	TOTAL	\$ 2,787	

*** Attach copy of IMRF notifications**

****See instructions.**

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

N/A
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

N/A

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?

5-10 Yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

2,159

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.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

42,112

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

0

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

0
- (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?

99

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

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?

Yes

Firm Name:

Heinold- Banwart, LTD
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	12,828	4,150	2,024	19,002	0	19,002	0	19,002
2. Food Purchase	0	39,731	0	39,731	0	39,731	-159	39,572
3. Housekeeping	0	5,201	0	5,201	0	5,201	4	5,205
4. Laundry	0	1,594	0	1,594	0	1,594	0	1,594
5. Heat and Other Utilities	0	0	13,004	13,004	0	13,004	803	13,807
6. Maintenance	10,525	5,986	4,867	21,378	0	21,378	882	22,260
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	23,353	56,662	19,895	99,910	0	99,910	1,530	101,440
9. Medical Director	0	0	605	605	0	605	0	605
10. Nursing & Medical Records	219,775	5,589	3,712	229,076	0	229,076	0	229,076
10a. Therapy	0	0	748	748	0	748	0	748
11. Activities	0	869	481	1,350	0	1,350	0	1,350
12. Social Services	0	0	2,184	2,184	0	2,184	0	2,184
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	7,421	7,421	0	7,421	0	7,421
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	219,775	6,458	15,151	241,384	0	241,384	0	241,384
17. Administrative	393	0	116,872	117,265	0	117,265	-116,872	393
18. Directors Fees	0	0	0	0	0	0	2,781	2,781
19. Professional Services	0	0	1,281	1,281	0	1,281	11,808	13,089
20. Fees, Subscriptions & Promotion	0	0	2,395	2,395	0	2,395	1,549	3,944
21. Clerical & General Office	125	7,425	8,796	16,346	0	16,346	60,431	76,777
22. Employee Benefits & Payroll	0	0	50,719	50,719	0	50,719	8,771	59,490
23. Inservice Training & Education	0	0	153	153	0	153	0	153
24. Travel and Seminar	0	0	516	516	0	516	2,271	2,787
25. Other Admin. Staff Trans	0	0	67	67	0	67	1,009	1,076
26. Insurance-Prop.Liab.Malpractice	0	0	6,372	6,372	0	6,372	1,175	7,547
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	518	7,425	187,171	195,114	0	195,114	-27,077	168,037
29. Total General Administrative	243,646	70,545	222,217	536,408	0	536,408	-25,547	510,861
30. Depreciation	0	0	22,196	22,196	0	22,196	2,534	24,730
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	44,403	44,403	0	44,403	15,797	60,200
33. Real Estate	0	0	0	0	0	0	0	0

34. Rent - Facility & Grounds	0	0	0	0	0	0	5,182	5,182
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	649	649
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	66,599	66,599	0	66,599	24,162	90,761
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	2,234	0	2,234	0	2,234	0	2,234
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	42,112	42,112	0	42,112	0	42,112
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	2,234	42,112	44,346	0	44,346	0	44,346
45. Grand Total	243,646	72,779	330,928	647,353	0	647,353	-1,385	645,968

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	3,267	3,267
2. Cash - Patient Deposits	10,420	10,420
3. Accounts & Notes Recievable	213,306	213,306
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	2,002	2,002
7. Other Prepaid Expenses	205	205
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	162,122	162,122
10. Total current assets	391,322	391,322
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,198	20,198
14. Buildings, at Historical Cost	761,732	761,732
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	111,369	111,369
17. Accumulated Depreciation (book methods)	-344,777	-344,777
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	17,584	17,584
23. other (specify):	715	715
24. Total Long-Term Assets	566,821	566,821
25. Total Assets	958,143	958,143
CURRENT LIABILITIES		
26. Accounts Payable	24,080	24,080
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	10,420	10,420
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	5,257	5,257
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	33,214	33,214
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	520	520

37. Other Current Liabilities (specify):	15,121	15,121
38. Total Current Liabilities	88,612	88,612
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	978,827	978,827
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	978,827	978,827
46.Total Liabilities	1,067,439	1,067,439
47.Total Equity	-109,296	-109,296
48.Total Liabilities and Equity	958,143	958,143

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	724,097
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	724,097
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	1,383
22. Laundry	0
Subtotal - Other Operating Revenue	1,383
24. Contributions	6
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	6
27. Other Revenue (specify):	0
28. Other Revenue (specify):	15,240
Subtotal - Other Revenue	15,240
30. Total Revenue	740,726
31. General Services	91,575
32. Health Care	201,792
33. General Administration	73,241
34. Ownership	67,228

35. Special Cost Centers	199,975
35. Provider Participation Fee	37,268
37. Other	0
40. Total Expenses	671,079
41. Income Before Income Taxes	69,647
42. Income Taxes	0
43. Net Income or Loss for the Year	69,647