

		FOR OHF USE				

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0038232</u></p> <p><b>Facility Name:</b> <u>BRIARBROOK PLACE</u></p> <p><b>Address:</b> <u>228 BRIARBROOK DR.</u> <u>EAST PEORIA</u> <u>61611</u>  Number City Zip Code</p> <p><b>County:</b> <u>TAZEWELL</u></p> <p><b>Telephone Number:</b> <u>(309)698-9200</u> <b>Fax #</b> <u>(309)698-9213</u></p> <p><b>IDPA ID Number:</b> <u>371238076005</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/92</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>ROB KEIME</u> <b>Telephone Number:</b> <u>(309)685/0595 EXT. 304</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>06/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) (_____) _____ Fax # (____) _____</td> </tr> </table> <p align="right"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
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	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (____) _____																												

Facility Name & ID Number BRIARBROOK PLACE

# 0038232 Report Period Beginning: 07/01/02 Ending: 06/30/03

**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 \_\_\_\_\_

	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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,670			5,670	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,670			5,670	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.09%

D. How many bed-hold days during this year were paid by Public Aid? 170 (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 03/08/99

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/08/99 NO

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 N/A

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/03 Fiscal Year: 06/30/03

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

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

BRIARBROOK PLACE

# 0038232

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	20,898	1,579	2,141	24,618		24,618	24,618			1
2	Food Purchase		18,698		18,698		18,698	18,698			2
3	Housekeeping			1,559	1,559		1,559	1,559			3
4	Laundry			1,622	1,622		1,622	1,622			4
5	Heat and Other Utilities			9,701	9,701		9,701	9,701			5
6	Maintenance	8,082		6,892	14,974		14,974	14,974			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	28,980	20,277	21,915	71,172		71,172	71,172			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			660	660		660	660			9
10	Nursing and Medical Records	164,681	2,768	2,537	169,986		169,986	169,986			10
10a	Therapy			260	260		260	260			10a
11	Activities		1,508		1,508		1,508	1,508			11
12	Social Services			1,213	1,213		1,213	1,213			12
13	Nurse Aide Training	7,482	301		7,783		7,783	7,783			13
14	Program Transportation			1,918	1,918		1,918	1,918			14
15	Other (specify):* <b>ROUTINE DENTAL</b>			1,834	1,834		1,834	1,834			15
16	<b>TOTAL Health Care and Programs</b>	172,163	4,577	8,422	185,162		185,162	185,162			16
	<b>C. General Administration</b>										
17	Administrative	14,715		33,565	48,280		48,280	48,280			17
18	Directors Fees			3,646	3,646		3,646	3,646			18
19	Professional Services			11,933	11,933		11,933	15,701	3,768		19
20	Dues, Fees, Subscriptions & Promotions			1,796	1,796		1,796	1,796			20
21	Clerical & General Office Expenses		1,673	20,730	22,403		22,403	22,403			21
22	Employee Benefits & Payroll Taxes			47,748	47,748		47,748	47,748			22
23	Inservice Training & Education			127	127		127	127			23
24	Travel and Seminar			6,136	6,136		6,136	6,136			24
25	Other Admin. Staff Transportation			173	173		173	173			25
26	Insurance-Prop.Liab.Malpractice			6,260	6,260		6,260	6,260			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	14,715	1,673	132,114	148,502		148,502	152,270	3,768		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	215,858	26,527	162,451	404,836		404,836	408,604	3,768		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.

Facility Name & ID Number **BRIARBROOK PLACE**

#0038232

Report Period Beginning:

07/01/02

Ending:

06/30/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,422	9,422		9,422	18,250	27,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,080	6,080		6,080	45,897	51,977			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			66,872	66,872		66,872	(66,872)				34
35	Rent-Equipment & Vehicles			944	944		944		944			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			83,318	83,318		83,318	(2,725)	80,593			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,564	41,564		41,564		41,564			42
43	Other (specify):* <b>NONALLOWABLE</b>			177,066	177,066		177,066	(177,066)				43
44	<b>TOTAL Special Cost Centers</b>			218,630	218,630		218,630	(177,066)	41,564			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	215,858	26,527	464,399	706,784		706,784	(176,023)	530,761			45

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

Facility Name & ID Number BRIARBROOK PLACE

# 0038232

Report Period Beginning: 07/01/02

Ending: 06/30/03

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(175,736)	43		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(531)	43		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	(212)	32		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	(339)	32		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	(718)	43		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	(81)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (177,617)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (177,617)</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	Exceptional Care Program					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>

BRIARBROOK PLACE

ID# 0038232

Report Period Beginning: 07/01/02

Ending: 06/30/03

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number BRIARBROOK PLACE

# 0038232 Report Period Beginning:

07/01/02

Ending:

06/30/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	3,768	0	0	0	0	0	0	0	3,768	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	3,768	0	0	0	0	0	0	0	3,768	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	0	0	0	3,768	0	0	0	0	0	0	0	3,768	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232** Report Period Beginning:

07/01/02 Ending:

06/30/03

## 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	0	0	0	18,250	0	0	0	0	0	0	0	18,250 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(551)	0	(22)	46,470	0	0	0	0	0	0	0	45,897 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	(66,872)	0	0	0	0	0	0	0	(66,872) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(551)</b>	<b>0</b>	<b>(22)</b>	<b>(2,152)</b>	<b>0</b>	<b>(2,725) 37</b>						
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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):*	(177,066)	0	0	0	0	0	0	0	0	0	0	(177,066) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(177,066)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(177,066) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(177,617)</b>	<b>0</b>	<b>(22)</b>	<b>1,616</b>	<b>0</b>	<b>(176,023) 45</b>						

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**

Report Period Beginning:

**07/01/02**

Ending:

**06/30/03**

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PROGRESSIVE HOUSING, INC.	100	SEE ATTACHED RELATED PARTY SCHEDULE				
SEE ATTACHED SCHEDULE 7A						

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	24 TRAVEL	\$ 153	PROGRESSIVE HOUSING, INC.	100.00%	\$ 153	\$	1
2	V	18 BOARD FEES	2,457	PROGRESSIVE HOUSING, INC.	100.00%	2,457		2
3	V	21 OFFICE AND COMPUTER	2,548	PROGRESSIVE HOUSING, INC.	100.00%	2,548		3
4	V	22 EMPLOYEE BENEFITS	(16)	PROGRESSIVE HOUSING, INC.	100.00%	(16)		4
5	V	32 INTEREST	3,271	PROGRESSIVE HOUSING, INC.	100.00%	3,271		5
6	V	19 LEGAL & ACCOUNTING	7,334	PROGRESSIVE HOUSING, INC.	100.00%	7,334		6
7	V	20 LICENSE, DUES & SUBS	3	PROGRESSIVE HOUSING, INC.	100.00%	3		7
8	V	43 NONALLOWABLE	17	PROGRESSIVE HOUSING, INC.	100.00%	17		8
9	V	25 OTHER STAFF TRANS	7	PROGRESSIVE HOUSING, INC.	100.00%	7		9
10	V	10 NURSING	2	PROGRESSIVE HOUSING, INC.	100.00%	2		10
11	V							11
12	V							12
13	V							13
14	Total		\$ 15,776			\$ 15,776	\$ *	14

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

Facility Name & ID Number **BRIARBROOK PLACE**

# **0038232**

Report Period Beginning: **07/01/02**

Ending: **06/30/03**

**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	21 OFFICE SUPP, TELEPHONE	\$ 15,045	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO	\$ 15,045	\$
16	V	22 EMPLOYEE BENEFITS	14,602	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	14,602	
17	V	24 TRAVEL, SEMINAR	954	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	954	
18	V	9 LICENSE , DUES & SUBS	114	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	114	
19	V	25 VEHICLE EXPENSE	1	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	1	
20	V	43 NONALLOWABLE	6	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	6	
21	V	18 BOARD FEES	1,189	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	1,189	
22	V	19 LEGAL & ACCOUNTING	4,474	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	4,474	
23	V	35 RENT	809	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	809	
24	V	32 INTEREST	264	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	242	(22)
25	V	30 DEPRECIATION	323	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	323	
26	V	26 INSURANCE	91	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	91	
27	V	9 UTILITIES/REPAIRS	77	CENTER FOR RESIDENTIAL MANAGEMENT, INC.	PARENT CO.	77	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 37,949			\$ 37,927	\$ * (22)

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

Facility Name & ID Number **BRIARBROOK PLACE**

# **0038232**

Report Period Beginning: **07/01/02**

Ending: **06/30/03**

**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	34 RENT	\$ 66,872	RESIDENTIAL CENTERS, INC.	**	\$	\$ (66,872) 15
16	V	32 INTEREST		RESIDENTIAL CENTERS, INC.	**	46,470	46,470 16
17	V	19 BOND TRUSTEE FEES		RESIDENTIAL CENTERS, INC.	**	3,768	3,768 17
18	V	30 DEPRECIATION BUILDING		RESIDENTIAL CENTERS, INC.	**	18,250	18,250 18
19	V						19
20	V						20
21	V						21
22	V						22
23	V						23
24	V						24
25	V			** RESIDENTIAL CENTERS, INC. IS A SISTER COMPANY			25
26	V			TO PROGRESSIVE HOUSING, INC.			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		\$ 66,872			\$ 68,488	\$ * 1,616 39

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

Facility Name & ID Number **BRIARBROOK PLACE** # **0038232** Report Period Beginning: **07/01/02** Ending: **06/30/03**

## 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	DARRELL BOEHNE	PRESIDENT	BOARD MEMBE	NONE	9,084	3HRS/ MTG		DIR. FEES	\$ 516	L18, C8	1
2	EDWARD CHILDERS	VICE PRESIDENT	BOARD MEMBE	NONE	11,351	3HRS/ MTG		DIR. FEES	649	L18, C8	2
3	RONALD SCHROEDER	SECRETARY	BOARD MEMBE	NONE	11,351	3HRS/ MTG		DIR. FEES	649	L18, C8	3
4	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	7,353	3HRS/ MTG		DIR. FEES	647	L18, C8	4
5	CORA FLOTA	BOARD MEMBER	BOARD MEMBE	NONE	4,360	3HRS/ MTG		DIR. FEES	440	L18, C8	5
6	KAY SCHUMAN JOHNSON	BOARD MEMBER	BOARD MEMBE	NONE	0	3HRS/ MTG		DIR. FEES	0	L18, C8	6
7	ROBERT BAUER	BOARD MEMBER	BOARD MEMBE	NONE	4,762	3HRS/ MTG		DIR. FEES	38	L18, C8	7
8	SHAWN JEFFERS	BOARD MEMBER	BOARD MEMBE	NONE	5,409	3HRS/ MTG		DIR. FEES	191	L18, C8	8
9	MERLA MCCLLOUD	RECORDER	ADMINISTRATI	NONE	9,084	3HRS/ MTG		DIR. FEES	516	L18, C8	9
10											10
11											11
12											12
13								TOTAL	\$ 3,646		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

Facility Name & ID Number BRIARBROOK PLACE # 0038232 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 PROGRESSIVE HOUSING, INC.  
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103  
 City / State / Zip Code PEORIA, IL. 61614  
 Phone Number (309)685-0595  
 Fax Number (309)685-8463

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	24 TRAVEL	NUMBER OF BEDS	142	14	\$ 828	\$	16	\$ 93	1
2	18 BOARD FEES	NUMBER OF BEDS	142	14	14,400		16	1,623	2
3	21 OFFICE AND COMPUTER	NUMBER OF BEDS	142	14	2,418		16	272	3
4	32 INTEREST	NUMBER OF BEDS	142	14	8,639		16	973	4
5	19 LEGAL AND ACCOUNTING	NUMBER OF BEDS	142	14	33,140		16	3,734	5
6	20 LICENSE DUES	NUMBER OF BEDS	142	14	8		16	1	6
7	43 NONALLOWABLE	NUMBER OF BEDS	142	14	100		16	11	7
8	25 VEHICLE EXP	NUMBER OF BEDS	142	14	41		16	5	8
9	10 NURSING SUPPLIES	NUMBER OF BEDS	142	14	21		16	2	9
10									10
11	22 EMPLOYEE BEN/PAY TAXES	DIRECT METHOD		DIRECT METHOD				(16)	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				\$ 59,595	\$		\$ 6,698	25

Facility Name & ID Number BRIARBROOK PLACE # 0038232 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 PROGRESSIVE HOUSING, INC.  
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103  
 City / State / Zip Code PEORIA, IL. 61614  
 Phone Number (309)685-0595  
 Fax Number (309)685-8463

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	24 TRAVEL	NUMBER OF BEDS	138	13	\$ 514	\$	16	\$ 60	1
2	18 BOARD FEES	NUMBER OF BEDS	138	13	7,200		16	834	2
3	21 OFFICE AND COMPUTER	NUMBER OF BEDS	138	13	19,641		16	2,276	3
4	32 INTEREST	NUMBER OF BEDS	138	13	19,813		16	2,298	4
5	19 LEGAL AND ACCOUNTING	NUMBER OF BEDS	138	13	31,053		16	3,600	5
6	20 LICENSE DUES	NUMBER OF BEDS	138	13	15		16	2	6
7	43 NONALLOWABLE	NUMBER OF BEDS	138	13	50		16	6	7
8	25 VEHICLE EXP	NUMBER OF BEDS	138	13	19		16	2	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				\$ 78,305	\$		\$ 9,078	25

Facility Name & ID Number BRIARBROOK PLACE # 0038232 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 CENTER FOR RESIDENTIAL MANAGEMENT  
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103  
 City / State / Zip Code PEORIA, IL. 61614  
 Phone Number (309)685-0595  
 Fax Number (309)685-8463

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	21	OFF CONST., SUPP & COMPUT	BEDS	335	18	\$ 28,385	\$ 16	\$ 1,356	1
2	19	PROFESSIONAL FEES	BEDS	335	18	38,969	16	1,861	2
3	24	TRAVEL SEMINAR	BEDS	335	18	5,082	16	243	3
4	20	LICENSE, DUES & SUB	BEDS	335	18	675	16	32	4
5	18	BOARD FEES	BEDS	335	18	16,800	16	802	5
6	32	INTEREST	BEDS	335	18	(36)	16	(2)	6
7	30	DEPRECIATION	BEDS	335	18	1,915	16	91	7
8	26	INSURANCE	BEDS	335	18	302	16	14	8
9									9
10	32	INTEREST	DIRECT METHOD					(22)	10
11	22	EMPLOYEE BENEFITS	DIRECT METHOD					14,263	11
12	21	OFFICE SUPP/TELEPHONE	DIRECT METHOD					(72)	12
13	20	LICENSE, DUES & SUB	DIRECT METHOD					63	13
14	24	TRAVEL SEMINAR	DIRECT METHOD					56	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 92,092	\$	\$ 18,685	25

Facility Name & ID Number BRIARBROOK PLACE # 0038232 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 CENTER FOR RESIDENTIAL MANAGEMENT  
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103  
 City / State / Zip Code PEORIA, IL. 61614  
 Phone Number (309)685-0595  
 Fax Number (309)685-8463

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	21	OFF CONST., SUPP & COMPUT	BEDS	331	17	\$ 284,669	\$ 186,143	16	\$ 13,761	1
2	19	PROFESSIONAL FEES	BEDS	331	17	54,060		16	2,613	2
3	24	TRAVEL SEMINAR	BEDS	331	17	13,543		16	655	3
4	20	LICENSE, DUES & SUB	BEDS	331	17	393		16	19	4
5	18	BOARD FEES	BEDS	331	17	8,000		16	387	5
6	32	INTEREST	BEDS	331	17	5,493		16	266	6
7	30	DEPRECIATION	BEDS	331	17	4,795		16	232	7
8	26	INSURANCE	BEDS	331	17	1,586		16	77	8
9	25	VEHICLE EXPENSE	BEDS	331	17	16		16	1	9
10	43	NONALLOWABLE	BEDS	331	17	125		16	6	10
11	35	OFFICE EQUIP LEASE	BEDS	331	17	116		16	6	11
12	22	EMPLOYEE BENEFITS	BEDS	331	17	7,010		16	339	12
13	35	RENT	BEDS	331	17	16,614		16	803	13
14	6	UTILITIES AND REPAIRS	BEDS	331	17	1,598		16	77	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 398,018	\$ 186,143		\$ 19,242	25

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**

Report Period Beginning:

**07/01/02**

Ending:

**06/30/03**

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	LEASE OBLIGATION NCS		X	HARDWARE/ SOFTWARE	\$94.00	10/31/98	\$ 3,756	\$ 686	09/30/03	0.1429	\$	1								
2	BANK ONE/MARINE BANK BOND	X		ACQUISITION OF FACILITY	\$20,271.53	06/25/98	2,584,836	774,178	07/01/19	VARIES		46,470								
3	EFFINGHAM STATE BANK	X		VAN PURCHASE	\$1,318.43	07/23/02	29,400	16,445	07/23/04	0.0716		1,548								
4	GREAT AMERICA LEASING		X	COPIER	\$110.00	02/01/033	2,962		01/31/03	0.1987		57								
5												5								
	<b>Working Capital</b>																			
6	HEALTH CARE BUSINESS CREDIT	X		WORKING CAPITAL		05/12/03	286,000	43,623		0.0750		4,273								
7				OFFSET INTERST INCOME/ NONALLOWABLE INT.								(551)								
8				MISC./PARENT ALLOCATION								180								
9	TOTAL Facility Related				\$21,793.96		\$ 2,906,954	\$ 834,932			\$	51,977								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,906,954	\$ 834,932			\$	51,977								

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232** Report Period Beginning: **07/01/02** Ending: **06/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2002 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.)		\$	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	3
4.	Real Estate Tax accrual used for 2003 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		1998	9,155	8
		1999	10,087	9
		2000	N/A	10
		2001	N/A	11
		2002	N/A	12
		<b>FOR OHF USE ONLY</b>		
		13	FROM R. E. TAX STATEMENT FOR 2002 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 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 2002 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 2002.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

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?  (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, nurse aide 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 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	<u>RESIDENT USE</u>	<u>47,250</u>	<u>1999</u>	<u>\$ 20,000</u>	1
2					2
3	<b>TOTALS</b>	<b>47,250</b>		<b>\$ 20,000</b>	<b>3</b>

Facility Name & ID Number **BRIARBROOK PLACE**

# **0038232**

Report Period Beginning:

**07/01/02**

Ending:

**06/30/03**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1999	1991	\$ 730,000	\$	40	\$ 18,250	\$ 18,250	\$ 79,083	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		LANDSCAPING		1994	1,593	106	15	106		1,011	9
10		CARPETING		1999	1,728	115	15	115		518	10
11		ELECTRICAL WIRING		2001	552	37	15	37		64	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

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 733,873	\$ 258		\$ 18,508	\$ 18,250	\$ 80,676		70

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

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 30,930	\$ 3,038	\$ 3,038	\$	5-10 YRS	\$ 16,657	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 30,930	\$ 3,038	\$ 3,038	\$		\$ 16,657	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT USE	1996 DODGE VAN	2002	\$ 3,500	\$ 408	\$ 408	\$	5 YRS	\$ 525	76
77	RESIDENT USE	2002 FORD E350 VAN	2002	28,400	5,207	5,207		5 YRS	5,207	77
78	RESIDENT USE	1995 CHEVY CORCIA	2002	TRADED IN	188	188				78
79	PARENT CO. ALLOCATIONS				323	323				79
80	TOTALS			\$ 31,900	\$ 6,126	\$ 6,126	\$		\$ 5,732	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)	\$ 816,703	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,422	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,672	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,250	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 103,065	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_  
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	/2004	\$ _____
13.	/2005	\$ _____
14.	/2006	\$ _____

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: N/A \*

**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: \$ 135 Description: COOLER RENTAL

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></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		265		265
3	Classroom Wages (a)		2,403		2,403
4	Clinical Wages (b)		5,079		5,079
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		36		36
9	<b>TOTALS</b>	\$	7,783	\$	7,783
10	SUM OF line 9, col. 1 and 2 (e)	\$	7,783		

**C. CONTRACTUAL INCOME**

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

\$ N/A

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>11</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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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		# of prescrpts										9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	<b>TOTAL</b>			\$		\$	\$		\$		\$		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 nurse aides, who help with the above activities should not be listed on this schedule.**

Facility Name &amp; ID Number BRIARBROOK PLACE

# 0038232

Report Period Beginning: 07/01/02

Ending:

06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/03

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 42,066	\$ 42,066	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (5,839) )	134,186	134,186	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,932	2,932	6
7	Other Prepaid Expenses	(2,809)	(2,809)	7
8	Accounts Receivable (owners or related parties)	1,002,194	1,002,194	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,178,569	\$ 1,178,569	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	730,000	730,000	14
15	Leasehold Improvements, at Historical Cost	3,873	3,873	15
16	Equipment, at Historical Cost	62,830	62,830	16
17	Accumulated Depreciation (book methods)	(103,065)	(103,065)	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): <b>LOAN COSTS</b>	39,443	39,443	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 753,081	\$ 753,081	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,931,650	\$ 1,931,650	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 50,560	\$ 50,560	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,394	2,394	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,770	13,770	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,877	22,877	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>	\$ 89,601	\$ 89,601	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	60,754	60,754	39
40	Mortgage Payable			40
41	Bonds Payable	774,178	774,178	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 834,932	\$ 834,932	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 924,533	\$ 924,533	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,007,117	\$ 1,007,117	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,931,650	\$ 1,931,650	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>927,025</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>PRIOR PERIOD AUDIT ADJ.</b>	<b>(8,312)</b>	<b>3</b>
<b>4</b>	<b>BUILDING ADJ</b>	<b>(93,971)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>824,742</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>182,375</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>182,375</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,007,117</b>	<b>24</b> *

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

Facility Name & ID Number BRIARBROOK PLACE

# 0038232

Report Period Beginning: 07/01/02

Ending:

06/30/03

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 702,256	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 702,256	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	175,736	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	11,065	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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 186,801	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	212	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 212	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS INCOME</b>	(110)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (110)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 889,159	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	71,172	31
32	Health Care	185,162	32
33	General Administration	148,502	33
<b>B. Capital Expense</b>			
34	Ownership	83,318	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	177,066	35
36	Provider Participation Fee	41,564	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 706,784	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	182,375	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 182,375	43

\* 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 & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/02**Ending: **06/30/03**

## 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			\$	\$	1
2					2
3	651	699	14,675	20.99	3
4					4
5					5
6	872	872	7,482	8.58	6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15	1,867	2,026	20,898	10.31	15
16					16
17	866	870	8,082	9.29	17
18					18
19					19
20	647	702	14,715	20.96	20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29	1,664	1,765	29,120	16.50	29
30	13,199	14,096	120,886	8.58	30
31					31
32					32
33					33
34	19,766	21,030	\$ 215,858 *	\$ 10.26	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	35	\$ 1,900	L1, C3	35
36	MONTHLY	660	L9, C3	36
37				37
38				38
39				39
40				40
41				41
42				42
43	7	260	L10A, C3	43
44				44
45	22	1,213	L12, C3	45
46				46
47	MONTHLY	2,537	L10, C3	47
48				48
49	64	\$ 6,570		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		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	
ALAN CARY	ADMINISTRATOR	0	\$ 9,183	Workers' Compensation Insurance	\$ 14,420	IDPH License Fee	\$ 400	
DEBRA MICHAEL	ADMINISTRATOR	0	5,532	Unemployment Compensation Insurance	932	Advertising: Employee Recruitment	233	
				FICA Taxes	16,426	Health Care Worker Background Check (Indicate # of checks performed <u>9</u> )	63	
				Employee Health Insurance	11,642	ILLINOIS HEALTH CARE DUES	890	
				Employee Meals	3,031	VEHICLE LICENSE	156	
				Illinois Municipal Retirement Fund (IMRF)*		MISCELLANEOUS DUES & FEES	54	
				EMPLOYEE MORAL	1,277			
				EMPLOYEE PHYSICALS	20			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 14,715	TOTAL (agree to Schedule V, line 22, col.8)			\$ 47,748	
B. Administrative - Other								
Description			Amount					
DEVELOPMENTAL SERVICES OF ILLINOIS, INC.			\$ 33,565					
ADMINISTRATIVE SERVICE FEES								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 33,565					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Vendor/Payee	Type	Amount		Description	Line #	Amount		
PERSONNEL PLANNERS, INC	U/C CONSULTATION	294		N/A				
LAWRENCE MANSON	LEGAL	942						
AMERICAN EXPRESS T&B	ACCOUNTING	6,073						
HEINOLD-BANWART	ACCOUNTING	150						
PARENT COMPANY	ALLOCATION	4,474						
BOND TRUSTEE FEES	TRUSTEE	3,768						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 15,701	TOTAL			\$	
				G. Schedule of Travel and Seminar**				
				Description	Amount			
				Out-of-State Travel	\$ 0			
				In-State Travel	5,618			
				Seminar Expense	518			
				Entertainment Expense	( )			
				(agree to Sch. V, line 24, col. 8)		\$ 6,136		

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/02**Ending: **06/30/03****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. ILLINOIS HEALTH CARE ASSOC. \$890
- (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? 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? 7.5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,550 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 of Public Aid during this cost report period. \$ 41,564  
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? YES 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 of Public Aid, 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. \$ 3,031 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? 91%
- d. Have vehicle usage logs been maintained? ADEQUATE RECORDS ARE 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? N/A
- 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. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.
- (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 \$2500, 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.