

Facility Name & ID Number BRIARBROOK PLACE# 0038232 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>4,501</u>			<u>4,501</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>4,501</u>			<u>4,501</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.86%

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

95 (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)

NONEF. 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

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 03/08/1999 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/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number **BRIARBROOK PLACE** # **0038232** Report Period Beginning: **07/01/2007** Ending: **06/30/2008**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	21,694	1,937	2,083	25,714		25,714		25,714		1
2	Food Purchase		21,296		21,296		21,296		21,296		2
3	Housekeeping		2,481	323	2,804		2,804	240	3,044		3
4	Laundry		320	1,267	1,587		1,587		1,587		4
5	Heat and Other Utilities			9,802	9,802		9,802	924	10,726		5
6	Maintenance	13,829		9,178	23,007		23,007	412	23,419		6
7	Other (specify):*										7
8	TOTAL General Services	35,523	26,034	22,653	84,210		84,210	1,576	85,786		8
	B. Health Care and Programs										
9	Medical Director			660	660		660		660		9
10	Nursing and Medical Records	186,435	4,542	7,102	198,079		198,079	(507)	197,572		10
10a	Therapy			470	470		470		470		10a
11	Activities			652	652		652		652		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation			2,880	2,880		2,880		2,880		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	186,435	4,542	11,764	202,741		202,741	(507)	202,234		16
	C. General Administration										
17	Administrative	12,687			12,687		12,687	38,455	51,142		17
18	Directors Fees			2,575	2,575		2,575	(116)	2,459		18
19	Professional Services			7,250	7,250		7,250	330	7,580		19
20	Dues, Fees, Subscriptions & Promotions			2,769	2,769		2,769	380	3,149		20
21	Clerical & General Office Expenses		3,507	6,544	10,051		10,051	1,445	11,496		21
22	Employee Benefits & Payroll Taxes			47,907	47,907		47,907	6,871	54,778		22
23	Inservice Training & Education			5,114	5,114		5,114	1,985	7,099		23
24	Travel and Seminar			740	740		740	238	978		24
25	Other Admin. Staff Transportation			924	924		924		924		25
26	Insurance-Prop.Liab.Malpractice			4,208	4,208		4,208	1,146	5,354		26
27	Other (specify):*										27
28	TOTAL General Administration	12,687	3,507	78,031	94,225		94,225	50,734	144,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	234,645	34,083	112,448	381,176		381,176	51,803	432,979		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: 07/01/2007 Ending: 06/30/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			26,182	26,182	26,182	1,931	28,113			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			47,395	47,395	47,395	(8,761)	38,634			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds						1,507	1,507			34
35	Rent-Equipment & Vehicles			360	360	360	79	439			35
36	Other (specify):*										36
37	TOTAL Ownership			73,937	73,937	73,937	(5,244)	68,693			37
	Ancillary Expense										
	E. Special Cost Centers										
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			39,216	39,216	39,216		39,216			42
43	Other (specify):* NONALLOW			154,372	154,372	154,372	(154,372)				43
44	TOTAL Special Cost Centers			193,588	193,588	193,588	(154,372)	39,216			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	234,645	34,083	379,973	648,701	648,701	(107,813)	540,888			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: **07/01/2007**

Ending: **06/30/2008**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (152,124)	43	\$	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	(8,539)	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	(157)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,410)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(284)	32		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,248)	43		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (165,762)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (165,762)		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.

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

BHF USE ONLY						
48		49		50		51
						52

BRIARBROOK PLACE

ID# 0038232

Report Period Beginning: 07/01/2007

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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
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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:

07/01/2007

Ending:

06/30/2008

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	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	42	19	60	70	49	240	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	144	68	202	401	109	924	5
6	Maintenance	0	0	0	0	0	0	42	39	115	127	89	412	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	228	126	377	598	247	1,576	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	(362)	4	(38)	157	(268)	(507)	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	(362)	4	(38)	157	(268)	(507)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	6,546	3,104	9,676	13,469	5,660	38,455	17
18	Directors Fees	0	(5)	(5)	(20)	(44)	(42)	0	0	0	0	0	(116)	18
19	Professional Services	0	55	219	(4)	40	20	0	0	0	0	0	330	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	4	16	280	76	4	380	20
21	Clerical & General Office Expenses	0	7	18	3	13	10	259	101	384	405	245	1,445	21
22	Employee Benefits & Payroll Taxes	0	0	0	6	1	1	901	619	1,852	2,386	1,105	6,871	22
23	Inservice Training & Education	0	3	0	2	2	2	392	142	515	540	387	1,985	23
24	Travel and Seminar	0	0	0	0	0	0	0	56	153	0	29	238	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	196	95	285	372	198	1,146	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	60	232	(13)	12	(9)	8,298	4,133	13,145	17,248	7,628	50,734	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	60	232	(13)	12	(9)	8,164	4,263	13,484	18,003	7,607	51,803	29

STATE OF ILLINOIS

Facility Name & ID Number BRIARBROOK PLACE

0038232

Report Period Beginning:

07/01/2007 Ending:

Summary B

06/30/2008

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	0	0	0	0	341	173	512	702	203	1,931	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,980)	0	0	0	2	(58)	48	23	68	8	128	(8,761)	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	0	0	0	247	121	375	475	289	1,507	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	20	0	20	20	19	79	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,980)	0	0	0	2	(58)	656	317	975	1,205	639	(5,244)	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):*	(156,782)	0	0	0	0	0	116	129	886	862	417	(154,372)	43
44	TOTAL Special Cost Centers	(156,782)	0	0	0	0	0	116	129	886	862	417	(154,372)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(165,762)	60	232	(13)	14	(67)	8,936	4,709	15,345	20,070	8,663	(107,813)	45

Facility Name & ID Number BRIARBROOK PLACE

0038232

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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
<u>PROGRESSIVE HOUSING, INC.</u>	<u>100</u>	<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		
<u>SEE ATTACHED SCHEDULE 7A</u>						

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	<u>18 BOARD FEES</u>	\$ <u>446</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	\$ <u>441</u>	\$ <u>(5)</u>	1
2	V	<u>19 PROFESSIONAL FEES</u>	<u>431</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>486</u>	<u>55</u>	2
3	V	<u>20 LICENSE, DUES</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			3
4	V	<u>21 GENERAL OFFICE</u>	<u>224</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>231</u>	<u>7</u>	4
5	V	<u>23 INSERVICE TRAVEL</u>	<u>46</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>49</u>	<u>3</u>	5
6	V	<u>32 INTEREST</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			6
7	V	<u>32 INTEREST INCOME</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			7
8	V	<u>22 EMPLOYEE BENEFITS</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>1,147</u>			\$ <u>1,207</u>	\$ * <u>60</u>	14

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7		8 Difference: Adjustments for Related Organization Costs (7 minus 4)
		Item	4 Amount	Name of Related Organization	Operating Cost of Related Organization				
15	V	18	BOARD FEES	\$ 178	PROGRESSIVE HOUSING, INC.	100.00%	\$ 173	\$ (5)	15
16	V	19	PROFESSIONAL FEES	2,086	PROGRESSIVE HOUSING, INC.	100.00%	2,305	219	16
17	V	20	LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21	GENERAL OFFICE	178	PROGRESSIVE HOUSING, INC.	100.00%	196	18	18
19	V	23	INSERVICE TRAVEL	14	PROGRESSIVE HOUSING, INC.	100.00%	14		19
20	V	32	INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20
21	V	32	INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21
22	V	22	EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%			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			\$ 2,456			\$ 2,688	\$ * 232	39

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****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	18 BOARD FEES	\$ 401	PROGRESSIVE HOUSING, INC.	100.00%	\$ 381	\$ (20)	15	
16	V	19 PROFESSIONAL FEES	1,588	PROGRESSIVE HOUSING, INC.	100.00%	1,584	(4)	16	
17	V	20 LICENSE, DUES	1	PROGRESSIVE HOUSING, INC.	100.00%	1		17	
18	V	21 GENERAL OFFICE	370	PROGRESSIVE HOUSING, INC.	100.00%	373	3	18	
19	V	23 INSERVICE TRAVEL	165	PROGRESSIVE HOUSING, INC.	100.00%	167	2	19	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20	
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21	
22	V	22 EMPLOYEE BENEFITS	259	PROGRESSIVE HOUSING, INC.	100.00%	265	6	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		\$ 2,784			\$ 2,771	\$ *	(13)	39

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****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	18 BOARD FEES	\$ 896	PROGRESSIVE HOUSING, INC.	100.00%	\$ 852	\$ (44)	15
16	V	19 PROFESSIONAL FEES	2,244	PROGRESSIVE HOUSING, INC.	100.00%	2,284	40	16
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21 GENERAL OFFICE	683	PROGRESSIVE HOUSING, INC.	100.00%	696	13	18
19	V	23 INSERVICE TRAVEL	104	PROGRESSIVE HOUSING, INC.	100.00%	106	2	19
20	V	32 INTEREST	77	PROGRESSIVE HOUSING, INC.	100.00%	79	2	20
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21
22	V	22 EMPLOYEE BENEFITS	16	PROGRESSIVE HOUSING, INC.	100.00%	17	1	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		\$ 4,020			\$ 4,034	\$ *	14 39

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****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	18 BOARD FEES	\$ 654	PROGRESSIVE HOUSING, INC.	100.00%	\$ 612	\$ (42)	15	
16	V	19 PROFESSIONAL FEES	661	PROGRESSIVE HOUSING, INC.	100.00%	681	20	16	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17	
18	V	21 GENERAL OFFICE	373	PROGRESSIVE HOUSING, INC.	100.00%	383	10	18	
19	V	23 INSERVICE TRAVEL	88	PROGRESSIVE HOUSING, INC.	100.00%	90	2	19	
20	V	32 INTEREST	37	PROGRESSIVE HOUSING, INC.	100.00%	38	1	20	
21	V	32 INTEREST INCOME	(1,867)	PROGRESSIVE HOUSING, INC.	100.00%	(1,926)	(59)	21	
22	V	22 EMPLOYEE BENEFITS	84	PROGRESSIVE HOUSING, INC.	100.00%	85	1	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		\$ 30			\$ (37)	\$ *	(67)	39

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

Facility Name & ID Number BRIARBROOK PLACE# 0038232Report Period Beginning: 07/01/2007Ending: 06/30/2008

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 6,546	\$	6,546	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4		4	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	901		901	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	392		392	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	196		196	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	341		341	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	51		51	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	247		247	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20		20	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	144		144	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	42		42	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	116		116	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(3)		(3)	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	42		42	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	259		259	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(362)		(362)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 8,936	\$ *	8,936	39

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 3,104	\$ 3,104	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	16	16	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	619	619	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	142	142	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	56	56	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	95	95	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	173	173	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	23	23	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	121	121	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	68	68	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	39	39	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	129	129	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	19	19	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	101	101	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4	4	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 4,709	\$ *	4,709 39

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	9,676	\$	9,676	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	280		280	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,852		1,852	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	515		515	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	153		153	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	285		285	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	512		512	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	68		68	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	375		375	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20		20	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	202		202	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	115		115	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	886		886	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	60		60	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	384		384	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(38)		(38)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			15,345	\$ *	15,345	39

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

Facility Name & ID Number BRIARBROOK PLACE# 0038232Report Period Beginning: 07/01/2007Ending: 06/30/2008

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	17	ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 13,469	\$ 13,469		15
16	V	19	PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20	DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	76	76		17
18	V	22	EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,386	2,386		18
19	V	23	INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	540	540		19
20	V	24	TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				20
21	V	26	INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	372	372		21
22	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	702	702		22
23	V	32	INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	86	86		23
24	V	34	RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	475	475		24
25	V	35	EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20	20		25
26	V	5	UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	401	401		26
27	V	6	MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	127	127		27
28	V	43	NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	862	862		28
29	V	32	MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(78)	(78)		29
30	V	3	HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	70	70		30
31	V	21	OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	405	405		31
32	V	10	NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	157	157		32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 20,070	\$ *	20,070	39

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

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**Ending: **06/30/2008****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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	5,660	\$	5,660	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4		4	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,105		1,105	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	387		387	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	29		29	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	198		198	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	203		203	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	90		90	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	289		289	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	19		19	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	109		109	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	89		89	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	417		417	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	38		38	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	49		49	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	245		245	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(268)		(268)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			8,663	\$	* 8,663	39

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

Facility Name & ID Number

BRIARBROOK PLACE

#

0038232

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	RONALD SCHROEDER	SECRETARY	BOARD MEMBE	NONE	505	3HRS/MTG	1.00	DIR. FEES	\$ 505	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBE	NONE	463	3HRS/MTG	1.00	DIR. FEES	463	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBE	NONE	505	3HRS/MTG	1.00	DIR. FEES	505	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBE	NONE	272	3HRS/MTG	1.00	DIR. FEES	272	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	230	3HRS/MTG	1.00	DIR. FEES	230	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	484	3HRS/MTG	1.00	DIR. FEES	484	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,459		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: 07/01/2007

Ending: 6/30/2008

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	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	18	BOARD FEES	290	18	\$ 8,000	\$	16	\$ 441	1
2	19	PROFESSIONAL FEES	290	18	8,801		16	486	2
3	20	LICENSE, DUES	290	18	5		16	0	3
4	21	GENERAL OFFICE	290	18	4,178		16	231	4
5	23	INSERVICE TRAVEL	290	18	883		16	49	5
6	32	INTEREST	290	18	0		16	0	6
7	32	INTEREST INCOME	290	18	0		16	0	7
8	22	EMPLOYEE BENEFITS	290	18	0		16	0	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				\$ 21,867	\$		\$ 1,207	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	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	18	BOARD FEES	NUMBER OF BEDS	296	19	\$ 3,200	\$ 16	\$ 173	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	19	42,639	16	2,305	2
3	20	LICENSE, DUES	NUMBER OF BEDS	296	19		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	296	19	3,630	16	196	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	296	19	259	16	14	5
6	32	INTEREST	NUMBER OF BEDS	296	19		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	296	19		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	19		16		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					\$ 49,728	\$	\$ 2,688	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	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	18	BOARD FEES	NUMBER OF BEDS	302	20	\$ 7,200	\$ 16	\$ 381	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	20	29,894	16	1,584	2
3	20	LICENSE, DUES	NUMBER OF BEDS	302	20	15	16	1	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	302	20	7,047	16	373	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	302	20	3,147	16	167	5
6	32	INTEREST	NUMBER OF BEDS	302	20		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	302	20		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	20	5,009	16	265	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					\$ 52,312	\$	\$ 2,771	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	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	18	BOARD FEES	NUMBER OF BEDS	308	21	\$ 16,400	\$ 16	\$ 852	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	21	43,975	16	2,284	2
3	20	LICENSE, DUES	NUMBER OF BEDS	308	21		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	308	21	13,407	16	696	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	308	21	2,031	16	106	5
6	32	INTEREST	NUMBER OF BEDS	308	21	1,521	16	79	6
7	32	INTEREST INCOME	NUMBER OF BEDS	308	21		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	21	320	16	17	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					\$ 77,654	\$	\$ 4,034	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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	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	18	BOARD FEES	NUMBER OF BEDS	314	22	\$ 12,000	\$ 16	\$ 612	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	314	22	13,368	16	681	2
3	20	LICENSE, DUES	NUMBER OF BEDS	314	22		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	314	22	7,508	16	383	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	314	22	1,779	16	90	5
6	32	INTEREST	NUMBER OF BEDS	314	22	747	16	38	6
7	32	INTEREST INCOME	NUMBER OF BEDS	314	22	(37,805)	16	(1,926)	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	314	22	1,680	16	85	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					\$	\$	(37)	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE COST	290	18	\$ 118,649	\$ 105,805	16	\$ 6,546	1
2	19	PROFESSIONAL FEES	290	18			16		2
3	20	DUES, FEES	290	18	78		16	4	3
4	22	EMPLOYEE BENEFITS	290	18	16,327		16	901	4
5	23	INSERVICE EDUCATION	290	18	7,108		16	392	5
6	24	TRAVEL SEMINAR	290	18			16		6
7	26	INSURANCE	290	18	3,549		16	196	7
8	30	DEPRECIATION	290	18	6,182		16	341	8
9	32	INTEREST	290	18	920		16	51	9
10	34	RENT	290	18	4,468		16	247	10
11	35	EQUIPMENT RENTAL	290	18	356		16	20	11
12	5	UTILITIES	290	18	2,613		16	144	12
13	6	MAINTENANCE	290	18	766		16	42	13
14	43	NONALLOWABLE	290	18	2,101		16	116	14
15	32	MISC INCOME	290	18	(50)		16	(3)	15
16	3	HOUSEKEEPING	290	18	760		16	42	16
17	21	OFFICE	290	18	4,703		16	259	17
18	10	NURSING SUPPLIES	290	18	(6,566)		16	(362)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 161,964	\$ 105,805		\$ 8,936	25

Facility Name & ID Number BRIARBROOK PLACE# 0038232 Report Period Beginning: 07/01/2007Ending: 6/30/2008

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. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	296	19	\$ 57,424	\$ 53,061	16	\$ 3,104	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	19			16		2
3	20	DUES, FEES	NUMBER OF BEDS	296	19	300		16	16	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	19	11,446		16	619	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	296	19	2,621		16	142	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	296	19	1,037		16	56	6
7	26	INSURANCE	NUMBER OF BEDS	296	19	1,765		16	95	7
8	30	DEPRECIATION	NUMBER OF BEDS	296	19	3,192		16	173	8
9	32	INTEREST	NUMBER OF BEDS	296	19	431		16	23	9
10	34	RENT	NUMBER OF BEDS	296	19	2,234		16	121	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	296	19			16		11
12	5	UTILITIES	NUMBER OF BEDS	296	19	1,263		16	68	12
13	6	MAINTENANCE	NUMBER OF BEDS	296	19	718		16	39	13
14	43	NONALLOWABLE	NUMBER OF BEDS	296	19	2,391		16	129	14
15	32	MISC INCOME	NUMBER OF BEDS	296	19			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	296	19	360		16	19	16
17	21	OFFICE	NUMBER OF BEDS	296	19	1,863		16	101	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	296	19	81		16	4	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 87,126	\$ 53,061		\$ 4,709	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	302	20	\$ 182,638	\$ 165,736	16	\$ 9,676	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	20			16		2
3	20	DUES, FEES	NUMBER OF BEDS	302	20	5,285		16	280	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	20	34,950		16	1,852	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	302	20	9,715		16	515	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	302	20	2,896		16	153	6
7	26	INSURANCE	NUMBER OF BEDS	302	20	5,377		16	285	7
8	30	DEPRECIATION	NUMBER OF BEDS	302	20	9,661		16	512	8
9	32	INTEREST	NUMBER OF BEDS	302	20	1,282		16	68	9
10	34	RENT	NUMBER OF BEDS	302	20	7,074		16	375	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	302	20	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	302	20	3,822		16	202	12
13	6	MAINTENANCE	NUMBER OF BEDS	302	20	2,176		16	115	13
14	43	NONALLOWABLE	NUMBER OF BEDS	302	20	16,724		16	886	14
15	32	MISC INCOME	NUMBER OF BEDS	302	20			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	302	20	1,122		16	60	16
17	21	OFFICE	NUMBER OF BEDS	302	20	7,256		16	384	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	302	20	(719)		16	(38)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 289,635	\$ 165,736		\$ 15,345	25

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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
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 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	308	21	\$ 259,282	\$ 236,515	16	\$ 13,469	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	21			16		2
3	20	DUES, FEES	NUMBER OF BEDS	308	21	1,456		16	76	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	21	45,935		16	2,386	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	308	21	10,397		16	540	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	308	21			16		6
7	26	INSURANCE	NUMBER OF BEDS	308	21	7,169		16	372	7
8	30	DEPRECIATION	NUMBER OF BEDS	308	21	13,522		16	702	8
9	32	INTEREST	NUMBER OF BEDS	308	21	1,639		16	86	9
10	34	RENT	NUMBER OF BEDS	308	21	9,148		16	475	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	308	21	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	308	21	7,720		16	401	12
13	6	MAINTENANCE	NUMBER OF BEDS	308	21	2,446		16	127	13
14	43	NONALLOWABLE	NUMBER OF BEDS	308	21	16,600		16	862	14
15	32	MISC INCOME	NUMBER OF BEDS	308	21	(1,502)		16	(78)	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	308	21	1,352		16	70	16
17	21	OFFICE	NUMBER OF BEDS	308	21	7,788		16	405	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	308	21	3,022		16	157	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 386,350	\$ 236,515		\$ 20,070	25

Facility Name & ID Number BRIARBROOK PLACE

0038232

Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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
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 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	314	22	\$ 111,075	\$ 97,120	16	\$ 5,660	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	314	22			16		2
3	20	DUES, FEES	NUMBER OF BEDS	314	22	76		16	4	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	314	22	21,693		16	1,105	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	314	22	7,585		16	387	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	314	22	567		16	29	6
7	26	INSURANCE	NUMBER OF BEDS	314	22	3,894		16	198	7
8	30	DEPRECIATION	NUMBER OF BEDS	314	22	3,988		16	203	8
9	32	INTEREST	NUMBER OF BEDS	314	22	1,756		16	90	9
10	34	RENT	NUMBER OF BEDS	314	22	5,675		16	289	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	314	22	376		16	19	11
12	5	UTILITIES	NUMBER OF BEDS	314	22	2,146		16	109	12
13	6	MAINTENANCE	NUMBER OF BEDS	314	22	1,737		16	89	13
14	43	NONALLOWABLE	NUMBER OF BEDS	314	22	8,175		16	417	14
15	32	MISC INCOME	NUMBER OF BEDS	314	22	750		16	38	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	314	22	957		16	49	16
17	21	OFFICE	NUMBER OF BEDS	314	22	4,811		16	245	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	314	22	(5,261)		16	(268)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 170,000	\$ 97,120		\$ 8,663	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	IL. HEALTH FAC AUTH. BOND	X		FACILITY ACQUISITION	VARIES	03/09/06	\$ 692,503	\$ 676,596	08/15/26	6.7500	\$ 47,245	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(8,980)	6					
7				MISC./PARENT ALLOCATION							369	7					
8												8					
9	TOTAL Facility Related						\$ 692,503	\$ 676,596			\$ 38,634	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 692,503	\$ 676,596			\$ 38,634	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIARBROOK PLACE COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0038232

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	_____	\$ _____	\$ _____
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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number BRIARBROOK PLACE

0038232 Report Period Beginning:

07/01/2007 Ending:

06/30/2008

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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 CARE</u>	<u>47,250</u>	<u>1999</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	47,250		\$ 20,000	3

Facility Name & ID Number **BRIARBROOK PLACE**

0038232

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250	\$	\$ 170,333	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		LANDSCAPING		1994	1,593	106	15	106		1,541	9
10											10
11		ELECTRICAL WIRING		2001	552	37	15	37		249	11
12		CERAMIC TILE,SINK AND STOOL		2006	1,240	82	15	82		179	12
13		CARPET FOR LIVING ROOM		2006	2,036	136	15	136		294	13
14		BATHROOM REMODEL		2007	266	18	15	18		25	14
15		WATER HEATER		2008	776	13	15	13		13	15
16		BATHROOM REMODEL		2008	950	16	15	16		16	16
17		BATHROOM REMODEL		2008	1072	12	15	12		12	17
18		BATHROOM REMODEL		2008	194	2	15	2		2	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	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	TOTAL (lines 4 thru 69)	\$	738,679	\$	18,672	\$	18,672	\$	172,664	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 20,113	\$ 1,622	\$ 1,622	\$	5-10YRS	\$ 12,674	71
72	Current Year Purchases	1,741	94	94		5-10YRS	94	72
73	Fully Depreciated Assets	8,873	1,045	1,045		5-10YRS	8,873	73
74	ALLOCATED FROM PARENT		1,931	1,931				74
75	TOTALS	\$ 30,727	\$ 4,692	\$ 4,692	\$		\$ 21,641	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	2002 FORD E350 VAN	2002	\$ 28,400	\$ 765	\$ 765	\$	5	\$ 28,400	76
77	RESIDENT USE	2004 DODGE VAN	2004	19,918	3,984	3,984		5	17,263	77
78										78
79										79
80	TOTALS			\$ 48,318	\$ 4,749	\$ 4,749	\$		\$ 45,663	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)		\$ 837,724	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 28,113	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 28,113	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 239,968	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.

Facility Name & ID Number BRIARBROOK PLACE

0038232

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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 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	SEE SCH 6E-I				1,507			6
7	TOTAL				\$ 1,507			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 439 Description: WATER SOFTNET, SEE SCH 6E-I

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

Facility Name & ID Number **BRIARBROOK PLACE**# **0038232**Report Period Beginning: **07/01/2007**

Ending:

06/30/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2008**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	14,388		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 6,937)	227,214		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68		6
7	Other Prepaid Expenses	434		7
8	Accounts Receivable (owners or related parties)	1,841,049		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,083,553	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	730,000		14
15	Leasehold Improvements, at Historical Cost	8,679		15
16	Equipment, at Historical Cost	79,045		16
17	Accumulated Depreciation (book methods)	(239,968)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	111,434		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	16,681		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 725,871	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,809,424	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 104,068	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,388		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,173		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,064		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 148,693	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	676,596		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME BONDS	25,269		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 701,865	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 850,558	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,958,866	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,809,424	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,851,744	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,851,744	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	107,122	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)	\$ 107,122	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,958,866	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BRIARBROOK PLACE

0038232

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 594,876	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 594,876	3
B. Ancillary Revenue			
4	Day Care	152,124	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 152,124	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	284	24
25	Interest and Other Investment Income***	8,539	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,823	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 755,823	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	84,210	31
32	Health Care	202,741	32
33	General Administration	94,225	33
B. Capital Expense			
34	Ownership	73,937	34
C. Ancillary Expense			
35	Special Cost Centers	154,372	35
36	Provider Participation Fee	39,216	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 648,701	40
41	Income before Income Taxes (line 30 minus line 40)**	107,122	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 107,122	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: **07/01/2007**

Ending:

06/30/2008

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	471	473	9,699	20.51	3
4	Licensed Practical Nurses	94	94	1,526	16.23	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	2,015	2,129	21,694	10.19	15
16	Dishwashers					16
17	Maintenance Workers	1,033	1,080	13,829	12.80	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	299	316	12,687	40.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,783	1,827	27,495	15.05	29
30	Habilitation Aides (DD Homes)	15,688	16,420	147,715	9.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,383	22,339	\$ 234,645 *	\$ 10.50	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	24	\$ 1,860	L1, C3	35
36	Medical Director	MONTHLY	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	89	2,225	L10, C3	38
39	Pharmacist Consultant	MONTHLY	343	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	470	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant			L12, C3	45
46	Other(specify) <u>PSYCHOLOGICAL</u>	46	3,680	L10, C3	46
47				L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	171	\$ 9,238		49

C. CONTRACT NURSES

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

Facility Name & ID Number **BRIARBROOK PLACE**

0038232

Report Period Beginning: **07/01/2007**

Ending: **06/30/2008**

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			
JOHN MIRECKI	ADMINISTRATOR	0	\$ 12,687	Workers' Compensation Insurance	\$ 3,518	IDPH License Fee	\$			
				Unemployment Compensation Insurance	6,349	Advertising: Employee Recruitment	1,644			
				FICA Taxes	20,405	Health Care Worker Background Check				
				Employee Health Insurance	18,252	(Indicate # of checks performed <u>17</u>)	170			
				Employee Meals	4,578	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		VEHICLE LICENSE	169			
				EMPLOYEE PHYSICALS	175	MISCELLANEOUS DUES & FEES	482			
				EMPLOYEE MORAL	2,501	IHCA DUES	684			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 12,687	TOTAL (agree to Schedule V, line 22, col.8)			\$ 55,778	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,149
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
N/A			\$	N/A		\$	Out-of-State Travel	\$		
							In-State Travel			
							BEST PRACTICES LISLE	25		
							MISC SEMINARS	84		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	Seminar Expense		
(Attach a copy of any management service agreement)								IHCA CONVENTION		104
C. Professional Services								CPI TRAINING		122
Vendor/Payee	Type		Amount					ADMINISTRATOR REVIEW		643
JONES DAY	LEGAL		\$ 110					Entertainment Expense		
WELLS FARGO	BOND TRUSTEE		152					(agree to Sch. V, line 24, col. 8)		
KRIEG, DEVAULT	LEGAL		4,156					TOTAL		\$ 978
PERSONNEL PLANNERS	UNEMP. REVIEW		240							
HEINOLD-BANWART	ACCOUNTING		2,922							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 7,580							
(If total legal fees exceed \$5,000, attach copy of invoices.)										

* Attach copy of IMRF notifications

**See instructions.

