

Facility Name & ID Number Briarbrook Place

0038232 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,363			5,363	13
14	TOTALS	5,363			5,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.83%

D. How many bed-hold days during this year were paid by the Department? 121 (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 Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES NO

I. On what date did you start providing long term care at this location?
 Date started 08/01/1992

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 03/08/1999 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 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number

Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

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	20,686	2,557	2,545	25,788		25,788		25,788		1
2	Food Purchase		32,180		32,180		32,180		32,180		2
3	Housekeeping		2,743	3	2,746		2,746	393	3,139		3
4	Laundry		812		812		812		812		4
5	Heat and Other Utilities			13,118	13,118		13,118	590	13,708		5
6	Maintenance	9,362		7,569	16,931		16,931	464	17,395		6
7	Other (specify):*										7
8	TOTAL General Services	30,048	38,292	23,235	91,575		91,575	1,447	93,022		8
	B. Health Care and Programs										
9	Medical Director			660	660		660		660		9
10	Nursing and Medical Records	178,477	6,221	8,002	192,700		192,700		192,700		10
10a	Therapy			459	459		459		459		10a
11	Activities		1,323		1,323		1,323	513	1,836		11
12	Social Services			2,045	2,045		2,045		2,045		12
13	CNA Training										13
14	Program Transportation			4,248	4,248		4,248		4,248		14
15	Other (specify):*			357	357		357		357		15
16	TOTAL Health Care and Programs	178,477	7,544	15,771	201,792		201,792	513	202,305		16
	C. General Administration										
17	Administrative	625			625		625		625		17
18	Directors Fees			2,267	2,267		2,267		2,267		18
19	Professional Services			11,391	11,391		11,391	4,402	15,793		19
20	Dues, Fees, Subscriptions & Promotions			2,805	2,805		2,805	480	3,285		20
21	Clerical & General Office Expenses		2,708	8,173	10,881		10,881	52,705	63,586		21
22	Employee Benefits & Payroll Taxes			36,041	36,041		36,041	11,189	47,230		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,459	3,459		3,459	596	4,055		24
25	Other Admin. Staff Transportation			2,548	2,548		2,548	278	2,826		25
26	Insurance-Prop.Liab.Malpractice			3,224	3,224		3,224	673	3,897		26
27	Other (specify):*										27
28	TOTAL General Administration	625	2,708	69,908	73,241		73,241	70,323	143,564		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	209,150	48,544	108,914	366,608		366,608	72,283	438,891		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:

7/1/2010

Ending:

6/30/2011

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			22,456	22,456		22,456	2,366	24,822			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,772	44,772		44,772	(15,789)	28,983			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							151	151			35
36	Other (specify):*											36
37	TOTAL Ownership			67,228	67,228		67,228	(13,272)	53,956			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			37,268	37,268		37,268		37,268			42
43	Other (specify):* <i>Non-allowable Costs</i>			199,975	199,975		199,975	(199,975)				43
44	TOTAL Special Cost Centers			237,243	237,243		237,243	(199,975)	37,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	209,150	48,544	413,385	671,079		671,079	(140,964)	530,115			45

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

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	\$ (199,490)	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	(16,176)	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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(485)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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)	\$ (216,151)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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)	75,187		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 75,187		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (140,964)		37

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

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

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

Briarbrook Place

ID# 0038232

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

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	393	0	0	0	0	0	0	0	0	393	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	590	0	0	0	0	0	0	0	0	590	5
6	Maintenance	0	0	464	0	0	0	0	0	0	0	0	464	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	1,447	0	1,447	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	513	0	0	0	0	0	0	0	0	513	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	513	0	513	16							
	C. General Administration													
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	4,402	0	0	0	0	0	0	0	0	4,402	19
20	Fees, Subscriptions & Promotions	0	0	480	0	0	0	0	0	0	0	0	480	20
21	Clerical & General Office Expenses	0	0	52,705	0	0	0	0	0	0	0	0	52,705	21
22	Employee Benefits & Payroll Taxes	0	0	11,189	0	0	0	0	0	0	0	0	11,189	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	596	0	0	0	0	0	0	0	0	596	24
25	Other Admin. Staff Transportation	0	0	278	0	0	0	0	0	0	0	0	278	25
26	Insurance-Prop.Liab.Malpractice	0	0	673	0	0	0	0	0	0	0	0	673	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	70,323	0	70,323	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	72,283	0	72,283	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Briarbrook Place# 0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

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)	
	D. Ownership													
30	Depreciation	0	0	2,366	0	0	0	0	0	0	0	0	2,366	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,176)	0	387	0	0	0	0	0	0	0	0	(15,789)	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	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	151	0	0	0	0	0	0	0	0	151	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,176)	0	2,904	0	(13,272)	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):*	(199,975)	0	0	0	0	0	0	0	0	0	0	(199,975)	43
44	TOTAL Special Cost Centers	(199,975)	0	0	0	0	0	0	0	0	0	0	(199,975)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(216,151)	0	75,187	0	(140,964)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Progressive Housing, Inc</u>	<u>100</u>	<u>See Pg 6-Supp</u>		<u>See Pg 6-Supp</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: 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		
1	V	<u>6 Maintenance</u>	\$ <u>980</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	\$ <u>980</u>	\$	<u>1</u>
2	V	<u>11 Activities</u>	<u>281</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>281</u>		<u>2</u>
3	V	<u>18 Director Fees</u>	<u>2,267</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,267</u>		<u>3</u>
4	V	<u>19 Professional Services</u>	<u>10,179</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>10,179</u>		<u>4</u>
5	V	<u>20 Dues, Fees, Subs and Promotions</u>	<u>686</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>686</u>		<u>5</u>
6	V	<u>21 Clerical and General Office</u>	<u>2,874</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,874</u>		<u>6</u>
7	V	<u>24 Travel and Seminar</u>	<u>496</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>496</u>		<u>7</u>
8	V	<u>32 Interest</u>	<u>149</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>149</u>		<u>8</u>
9	V							<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		\$ <u>17,912</u>			\$ <u>17,912</u>	\$ *	<u>14</u>

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3	Housekeeping	\$	Center For Residential Management	Parent Co.	\$ 393	\$	393	15
16	V	5	Utilities		Center For Residential Management	Parent Co.	590		590	16
17	V	6	Maintenance		Center For Residential Management	Parent Co.	464		464	17
18	V	11	Activities		Center For Residential Management	Parent Co.	513		513	18
19	V	19	Professional Services		Center For Residential Management	Parent Co.	4,402		4,402	19
20	V	20	Dues, Fees, Subs & Promotions		Center For Residential Management	Parent Co.	480		480	20
21	V	21	Clerical and General Office		Center For Residential Management	Parent Co.	52,705		52,705	21
22	V	22	Employee Benefits & Payroll		Center For Residential Management	Parent Co.	11,189		11,189	22
23	V	23	Inservice Training & Education		Center For Residential Management	Parent Co.	0			23
24	V	24	Travel and Seminar		Center For Residential Management	Parent Co.	596		596	24
25	V	25	Other Admin. Staff Transport.		Center For Residential Management	Parent Co.	278		278	25
26	V	26	Insurance-Prop./Liab./Malprac.		Center For Residential Management	Parent Co.	673		673	26
27	V	30	Depreciation		Center For Residential Management	Parent Co.	2,366		2,366	27
28	V	32	Interest		Center For Residential Management	Parent Co.	387		387	28
29	V	35	Rent-Equipment & Vehicles		Center For Residential Management	Parent Co.	151		151	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			\$			\$ 75,187	\$ *	75,187	39

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

Facility Name & ID Number

Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Briarbrook Place

#

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,021	3Hrs/MTG	1.00	Dir. Fees	\$ 579	L18,C3	1
2	Orland Bauer	Treasurer	Board Member	None	9,021	3Hrs/MTG	1.00	Dir. Fees	579	L18,C3	2
3	Robert Bauer	Secretary	Board Member	None	9,022	3Hrs/MTG	1.00	Dir. Fees	578	L18,C3	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,269	3Hrs/MTG	1.00	Dir. Fees	531	L18,C3	4
5	Lawrence Manson	President	Board Memb/CEO	None	150,804	1.18	2.95	Salary	9,284	L21,C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,551		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

Briarbrook Place
0038232
6/30/2011

SCHEDULE 7A

	BOARD OF DIRECTOR FEES					SALARY
	Edward Childers	Orland Bauer	Robert Bauer	Shawn Jeffers	Total	Larry Manson
	Progressive Housing, Inc.					Center for Residential Management
Lakeview Living Center						4,603
Sparta Terrace	555	555	555	509	2,174	8,156
Ellner Terrace	564	564	563	517	2,208	7,950
Taylorville Terrace	525	525	526	482	2,058	8,624
Aviston Terrace	611	611	611	560	2,393	8,734
Briarbrook Place	579	579	578	531	2,267	9,284
Harris Place	554	554	555	509	2,172	7,972
Joshua Manor	606	606	606	557	2,375	8,283
Terra Estates	646	646	645	592	2,529	8,910
Park Place	471	471	472	433	1,847	7,269
Western Gardens	229	229	229	211	898	3,263
Galaxy	232	232	232	212	908	4,557
Cardinal	204	204	204	187	799	3,545
Bill Goat Hill	234	234	234	215	917	4,328
Country Club Hill	181	181	182	167	711	3,482
Lee Street	199	199	198	182	778	3,576
Baker Street	193	193	192	177	755	3,644
182nd Street	202	202	202	186	792	3,684
Osage	212	212	213	195	832	3,683
Oakwood	206	206	205	189	806	3,779
Blair	210	210	211	193	824	3,847
Lowell	251	251	252	231	985	3,904
Marquette	208	208	207	191	814	4,037
Cherry	223	223	222	204	872	4,170
Luella	238	238	238	219	933	4,125
Olivia	240	240	241	222	943	4,464
Huron	217	217	217	199	850	4,039
Wilshire	213	213	213	195	834	4,239
Constance	166	166	166	145	643	1,417
175th Place	211	211	212	189	823	3,094
Sauganash						177
Steger						1,913
Waltonville	220	220	219	201	860	3,174
Perfection Cleaning						162
Total PHI	9,600	9,600	9,600	8,800	37,600	160,088

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending: 5/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Progressive Housing, Inc.
 Street Address PO Box 10528
 City / State / Zip Code Peoria, IL. 61612
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

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	6	Maintenance	Budgeted Revenue	14,012,681	30	\$ 16,403	\$ 830,893	\$ 980	1
2	11	Activities	Budgeted Revenue	14,012,681	30	4,740	830,893	281	2
3	18	Director Fees	Budgeted Revenue	14,012,681	30	37,600	830,893	2,267	3
4	19	Professional Services	Budgeted Revenue	14,012,681	30	170,531	830,893	10,179	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Revenue	14,012,681	30	11,434	830,893	686	5
6	21	Clerical and General Office	Budgeted Revenue	14,012,681	30	48,267	830,893	2,874	6
7	24	Travel and Seminar	Budgeted Revenue	14,012,681	30	8,382	830,893	496	7
8	32	Interest	Budgeted Revenue	14,012,681	30	2,492	830,893	149	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					\$ 299,849	\$	\$ 17,912	25

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending: 5/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Center For Residential Management
 Street Address PO Box 10528
 City / State / Zip Code Peoria, IL. 61612
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Revenue	12,359,018	34	\$ 6,784		\$ 393	1
2	5	Utilities	Revenue	12,359,018	34	10,175		590	2
3	6	Maintenance	Revenue	12,359,018	34	8,009		464	3
4	11	Activities	Revenue	12,359,018	34	8,842		513	4
5	19	Professional Services	Revenue	12,359,018	34	75,898		4,402	5
6	20	Dues, Fees, Subs & Promotions	Revenue	12,359,018	34	8,284		480	6
7	21	Clerical and General Office	Revenue	12,359,018	34	908,778	829,663	52,705	7
8	22	Employee Benefits & Payroll	Revenue	12,359,018	34	192,921		11,189	8
9	23	Inservice Training & Education	Revenue	12,359,018	34	8			9
10	24	Travel and Seminar	Revenue	12,359,018	34	10,280		596	10
11	25	Other Admin. Staff Transport.	Revenue	12,359,018	34	4,786		278	11
12	26	Insurance-Prop./Liab./Malprac.	Revenue	12,359,018	34	11,606		673	12
13	30	Depreciation	Revenue	12,359,018	34	40,795		2,366	13
14	32	Interest	Revenue	12,359,018	34	6,672		387	14
15	35	Rent-Equipment & Vehicles	Revenue	12,359,018	34	2,604		151	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,296,442	\$ 829,663	\$ 75,187	25

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 692,503	\$ 622,019	08/15/26	6.7500	\$ 43,201	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Vendor Finance Charge		X	Working Capital							63	6								
7	Allocation from Parent Co.	X		Working Capital							505	7								
8	Amort of Loan Cost		X	Line of Credit Fee							1,390	8								
9	TOTAL Facility Related						\$ 692,503	\$ 622,019			\$ 45,159	9								
B. Non-Facility Related*																				
10												10								
11	Offset Interest Income										(16,176)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (16,176)	14								
15	TOTALS (line 9+line14)						\$ 692,503	\$ 622,019			\$ 28,983	15								

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

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

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

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

B. Real Estate Taxes

<p style="text-align: center;">Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2010 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.)	2010	N/A	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2006</td><td>_____</td><td style="text-align: center;">8</td></tr> <tr><td>2007</td><td>_____</td><td style="text-align: center;">9</td></tr> <tr><td>2008</td><td>_____</td><td style="text-align: center;">10</td></tr> <tr><td>2009</td><td>_____</td><td style="text-align: center;">11</td></tr> <tr><td>2010</td><td>_____</td><td style="text-align: center;">12</td></tr> </table>	2006	_____	8	2007	_____	9	2008	_____	10	2009	_____	11	2010	_____	12	<table border="1"> <tr><th colspan="2" style="text-align: center;">FOR BHF USE ONLY</th></tr> <tr><td style="text-align: center;">13</td><td>FROM R. E. TAX STATEMENT FOR 2010 \$ _____</td></tr> <tr><td style="text-align: center;">14</td><td>PLUS APPEAL COST FROM LINE 5 \$ _____</td></tr> <tr><td style="text-align: center;">15</td><td>LESS REFUND FROM LINE 6 \$ _____</td></tr> <tr><td style="text-align: center;">16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2010 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
2006	_____	8																									
2007	_____	9																									
2008	_____	10																									
2009	_____	11																									
2010	_____	12																									
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2010 \$ _____																										
14	PLUS APPEAL COST FROM LINE 5 \$ _____																										
15	LESS REFUND FROM LINE 6 \$ _____																										
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____																										

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.

2010 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 2010 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 2010.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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:

7/1/2010 Ending:

6/30/2011

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>47,250</u>	<u>1999</u>	<u>\$ 20,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	47,250		\$ 20,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250	\$	\$ 225,083	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Landscaping		1994	1,593		15			1,593	9
10	Electrical Wiring		2001	552	37	15	37		359	10
11	Ceramic Tiles, Sink and Stool		2006	1,240	82	15	82		426	11
12	Bathroom Remodel		2007	266	18	15	18		79	12
13	Water Heater		2008	776	52	15	52		168	13
14	Bathroom Remodel		2008	950	63	15	63		205	14
15	Bathroom Remodel		2008	1,072	71	15	71		226	15
16	Bathroom Remodel		2008	194	13	15	13		41	16
17	Concrete Sidewalk		2008	2,255	150	15	150		338	17
18	Carpets for Bedrooms, Living Room and Activity Rooms		2010	5,970	398	15	398		472	18
19	Kitchen and Pantry Remodel		2010	2,214	148	15	148		347	19
20	Kitchen and Pantry Remodel- Paint and Materials for project		2010	1,049	70	15	70		105	20
21	Kitchen and Pantry Remodel - Counter Top, Sink, Plumbing		2010	600	40	15	40		57	21
22	Kitchen and Pantry Remodel - Steel Door		2010	265	18	15	18		24	22
23	AC Installation		2010	2,927	195	15	195		195	23
24	Replace water valve		2010	952	48	15	48		48	24
25	Kitchen fire repair		2011	574	16	15	16		16	25
26	Replace condensor fan and capacitor		2011	700	4	15	4		4	26
27										27
28										28
29										29
30										30
31	Allocated from Parent Company						757	757		31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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)	\$	\$		\$	\$	\$	70
			754,149	19,673	20,430	757	229,786	

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

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 22,974	\$ 2,516	\$ 2,516	\$	5-10Yrs	\$ 11,736	71
72	Current Year Purchases	847	65	65		10Yrs	65	72
73	Fully Depreciated Assets	12,412				5-10Yrs	12,412	73
74	Allocated From Parent Co.			1,609	1,609			74
75	TOTALS	\$ 36,233	\$ 2,581	\$ 4,190	\$ 1,609		\$ 24,213	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trans	2002 Ford E350	2002	\$ 28,401	\$		\$	5	\$ 28,401	76
77	Resident Trans	2004 Dodge Caravan	2004	19,918				5	19,918	77
78	Resident Trans	2002 Ford E350	2009	596	119	119		5	287	78
79	Resident Trans	2004 Dodge Caravan	2011	991	83	83		5	83	79
80	TOTALS			\$ 49,906	\$ 202	\$ 202	\$		\$ 48,689	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 860,288	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,456	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,822	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,366	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 302,688	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:							3
4	Additions	<u>N/A</u>						4
5								5
6								6
7	TOTAL				\$			7

**

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A
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: \$ 151 Description: Allocated from Parent Co - postage machine, copier

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2012</u>	\$ <u>N/A</u>
13.	<u>/2013</u>	\$ <u>N/A</u>
14.	<u>/2014</u>	\$ <u>N/A</u>

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
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		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					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	10(3)	visits			19	2,137					19	2,137			6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													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			\$		19	\$ 2,137	\$		\$		19	\$ 2,137			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: 7/1/2010

Ending:

6/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 300	\$ 300	1
2	Cash-Patient Deposits	4,871	4,871	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,162)	252,285	252,285	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67	67	6
7	Other Prepaid Expenses	318	318	7
8	Accounts Receivable (owners or related parties)	2,502,877	2,502,877	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,760,718	\$ 2,760,718	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	754,149	754,149	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	86,139	86,139	16
17	Accumulated Depreciation (book methods)	(302,688)	(302,688)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	102,107	102,107	21
22	Other Long-Term Assets (spe <u>Loan Cost</u>)	12,539	12,539	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 672,246	\$ 672,246	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,432,964	\$ 3,432,964	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 78,885	\$ 78,885	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,871	4,871	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,291	16,291	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,654	16,654	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Workshop</u>	84,431	84,431	36
37	<u>Deferred Income</u>	17,658	17,658	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 218,790	\$ 218,790	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	622,019	622,019	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 622,019	\$ 622,019	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 840,809	\$ 840,809	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,592,155	\$ 2,592,155	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,432,964	\$ 3,432,964	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,325,342	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,325,342	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	266,813	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)	\$ 266,813	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)	\$ 2,592,155	24 *

* This must agree with page 17, line 47.

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	\$ 716,774	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 716,774	3
B. Ancillary Revenue			
4	Day Care	198,393	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 198,393	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 DSP Training	5,134	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,134	23
D. Non-Operating Revenue			
24	Contributions	1,415	24
25	Interest and Other Investment Income***	16,176	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,591	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)	\$ 937,892	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	91,575	31
32	Health Care	201,792	32
33	General Administration	73,241	33
B. Capital Expense			
34	Ownership	67,228	34
C. Ancillary Expense			
35	Special Cost Centers	199,975	35
36	Provider Participation Fee	37,268	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 671,079	40
41	Income before Income Taxes (line 30 minus line 40)**	266,813	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 266,813	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	Briarbrook Place
ID#	0038232
FYE	6/30/2011

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	127	2,188	17.23	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	2,179	20,686	9.13	15
16	Dishwashers				16
17	Maintenance Workers	758	9,362	11.44	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	40	625	15.63	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)	7	125	17.86	28
29	Resident Services Coordinator	1,634	22,884	13.30	29
30	Habilitation Aides (DD Homes)	16,008	153,280	9.00	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	20,753	\$ 209,150 *	\$ 9.50	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	31	\$ 2,470	L1, C3	35
36	Medical Director	Monthly	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	171	5,040	L10, C3	38
39	Pharmacist Consultant	Monthly	825	L10, C3	39
40	Physical Therapy Consultant	1	109	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	350	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	27	2,045	L12, C3	45
46	Other(specify) <u>Psychiatrist Cons</u>	1	57	L15, C3	46
47	<u>Psychological Consultant</u>	3	300	L15, C3	47
48					48
49	TOTAL (lines 35 - 48)	243	\$ 11,856		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christina Durbin	Administrator	0	\$ 625	Workers' Compensation Insurance	\$ 5,070	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,078	Advertising: Employee Recruitment	986	
				FICA Taxes	15,024	Health Care Worker Background Check (Indicate # of checks performed <u>5</u>)	170	
				Employee Health Insurance	7,560	<u>Patient Background Checks</u>		
				Employee Meals		Therapy License	445	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	368	
				Employee Moral	240	Miscellaneous Licenses and Permits	172	
				Drug Tests	69	Miscellaneous Dues & Subs	664	
						Allocation from Parent Co.	480	
				Allocation from Parent Co.	11,189	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 625		\$ 47,230		\$ 3,285	
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
Allocated from Center For Residential Management			\$	N/A			Out-of-State Travel	\$
							In-State Travel	3,258
							Allocation from Parent Co.	531
							Seminar Expense	201
							Allocation from Parent Co.	65
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
			\$					\$ 4,055
C. Professional Services								
Vendor/Payee	Type		Amount					
Schuyler Roche	Legal		\$ 836					
Wells Fargo	Bond Trustee		275					
Mike Kaplan	Financial Consulting		172					
Personnel Planners	UC Consultant		545					
Heinold-Banwart, LTD	Accounting		5,250					
Barbara Weiner	Legal		59					
Wildman, Harrold, Allen	Legal		2,832					
Dean Group Consulting	HR Consultant		214					
Ice Miller	Legal		148					
Westervelt, Johnson, Nicoll & Keller	Legal		1,060					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 11,391					

* Attach copy of IMRF notifications

**See instructions.

Briarbrook Place
0038232
Period Beginning 7/1/2010
Period End 6/30/2011

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,391

CRM Management Allocation

National Hotline Services	Employee Hotline	104
Mike Kaplan	Finanacial Consultant	3,496
Klancic Architect PC	Architect	79
Title Professionals	Loan Settlement fees	722
Total (agree to Schedule V, line 19, column 8)		<u>15,793</u>

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

(See instructions.)

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

Facility Name & ID Number Briarbrook Place

0038232

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

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. IHCA \$368
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N/A If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,222 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 37,268
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 83
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold- Banwart, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	20,686	2,557	2,545	25,788	0	25,788	0	25,788
2. Food Purchase	0	32,180	0	32,180	0	32,180	0	32,180
3. Housekeeping	0	2,743	3	2,746	0	2,746	393	3,139
4. Laundry	0	812	0	812	0	812	0	812
5. Heat and Other Utilities	0	0	13,118	13,118	0	13,118	590	13,708
6. Maintenance	9,362	0	7,569	16,931	0	16,931	464	17,395
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	30,048	38,292	23,235	91,575	0	91,575	1,447	93,022
9. Medical Director	0	0	660	660	0	660	0	660
10. Nursing & Medical Records	178,477	6,221	8,002	192,700	0	192,700	0	192,700
10a. Therapy	0	0	459	459	0	459	0	459
11. Activities	0	1,323	0	1,323	0	1,323	513	1,836
12. Social Services	0	0	2,045	2,045	0	2,045	0	2,045
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	4,248	4,248	0	4,248	0	4,248
15. Other (specify)*	0	0	357	357	0	357	0	357
16. Total Health Care & Programs	178,477	7,544	15,771	201,792	0	201,792	513	202,305
17. Administrative	625	0	0	625	0	625	0	625
18. Directors Fees	0	0	2,267	2,267	0	2,267	0	2,267
19. Professional Services	0	0	11,391	11,391	0	11,391	4,402	15,793
20. Fees, Subscriptions & Promotion	0	0	2,805	2,805	0	2,805	480	3,285
21. Clerical & General Office	0	2,708	8,173	10,881	0	10,881	52,705	63,586
22. Employee Benefits & Payroll	0	0	36,041	36,041	0	36,041	11,189	47,230
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,459	3,459	0	3,459	596	4,055
25. Other Admin. Staff Trans	0	0	2,548	2,548	0	2,548	278	2,826
26. Insurance-Prop.Liab.Malpractice	0	0	3,224	3,224	0	3,224	673	3,897
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	625	2,708	69,908	73,241	0	73,241	70,323	143,564
29. Total General Administrative	209,150	48,544	108,914	366,608	0	366,608	72,283	438,891
30. Depreciation	0	0	22,456	22,456	0	22,456	2,366	24,822
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	44,772	44,772	0	44,772	-15,789	28,983
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	151	151
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	67,228	67,228	0	67,228	-13,272	53,956
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	37,268	37,268	0	37,268	0	37,268
43. Other (specify):*	0	0	199,975	199,975	0	199,975	-199,975	0
44. Total Special Cost Ce	0	0	237,243	237,243	0	237,243	-199,975	37,268
45. Grand Total	209,150	48,544	413,385	671,079	0	671,079	-140,964	530,115

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	300	300
2. Cash - Patient Deposits	4,871	4,871
3. Accounts & Notes Recievable	252,285	252,285
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	67	67
7. Other Prepaid Expenses	318	318
8. Accounts Receivable-Owner/Related Party	2,502,877	2,502,877
9. Other (specify):	0	0
10. Total current assets	2,760,718	2,760,718
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,000	20,000
14. Buildings, at Historical Cost	754,149	754,149
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	86,139	86,139
17. Accumulated Depreciation (book methods)	-302,688	-302,688
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	102,107	102,107
22. Other Long-Term Assets (specify):	12,539	12,539
23. other (specify):	0	0
24. Total Long-Term Assets	672,246	672,246
25. Total Assets	3,432,964	3,432,964
CURRENT LIABILITIES		
26. Accounts Payable	78,885	78,885
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	4,871	4,871
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	16,291	16,291
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	16,654	16,654
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	84,431	84,431
37. Other Current Liabilities (specify):	17,658	17,658
38. Total Current Liabilities	218,790	218,790
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	622,019	622,019
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	622,019	622,019
46.Total Liabilities	840,809	840,809
47.Total Equity	2,592,155	2,592,155
48.Total Liabilities and Equity	3,432,964	3,432,964

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	716,774
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	716,774
4. Day Care	198,393
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	198,393
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	5,134
22. Laundry	0
Subtotal - Other Operating Revenue	5,134
24. Contributions	1,415
25. Interest and Other Investments Income	16,176
Subtotal - Non-Operating Revenue	17,591
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	937,892
31. General Services	91,575
32. Health Care	201,792
33. General Administration	73,241
34. Ownership	67,228
35. Special Cost Centers	199,975
35. Provider Participation Fee	37,268
37. Other	0
40. Total Expenses	671,079
41. Income Before Income Taxes	266,813
42. Income Taxes	0
43. Net Income or Loss for the Year	266,813