FOR BHF USE

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

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0038232

Facility Name: Briarbrook Place

Address: 228 Briarbrook Place (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 698-9200 **Fax #** (309) 698-9213

HFS ID Number:

Date of Initial License for Current Owners: 08/01/1992

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Tracey Peloza **Telephone Number:** (708) 283-1530
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2012 to 6/30/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Tracey Peloza
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, PO Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,989			4,989	13
14	TOTALS	4,989			4,989	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.43%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] 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 [X]

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 [X] Date 03/08/1999 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	9,880	2,082	1,863	13,825		13,825		13,825			1
2	Food Purchase		23,287		23,287		23,287		23,287			2
3	Housekeeping		2,168		2,168		2,168	13	2,181			3
4	Laundry		323		323		323		323			4
5	Heat and Other Utilities			11,735	11,735		11,735	66	11,801			5
6	Maintenance	10,555	3,558	9,045	23,158		23,158	235	23,393			6
7	Other (specify):*											7
8	**TOTAL General Services**	20,435	31,418	22,643	74,496		74,496	314	74,810			8
	B. Health Care and Programs											
9	Medical Director			660	660		660		660			9
10	Nursing and Medical Records	191,697	3,769	10,239	205,705		205,705		205,705			10
10a	Therapy											10a
11	Activities		1,714		1,714		1,714		1,714			11
12	Social Services			925	925		925		925			12
13	CNA Training											13
14	Program Transportation			7,183	7,183		7,183		7,183			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	191,697	5,483	19,007	216,187		216,187		216,187			16
	C. General Administration											
17	Administrative	12,192		125,053	137,245		137,245	(125,053)	12,192			17
18	Directors Fees							3,163	3,163			18
19	Professional Services			1,614	1,614		1,614	15,026	16,640			19
20	Dues, Fees, Subscriptions & Promotions			1,995	1,995		1,995	1,804	3,799			20
21	Clerical & General Office Expenses	2,614	2,523	7,693	12,830		12,830	59,730	72,560			21
22	Employee Benefits & Payroll Taxes			38,539	38,539		38,539	8,421	46,960			22
23	Inservice Training & Education			151	151		151		151			23
24	Travel and Seminar			1,480	1,480		1,480	5,029	6,509			24
25	Other Admin. Staff Transportation			2,710	2,710		2,710	937	3,647			25
26	Insurance-Prop.Liab.Malpractice			16,434	16,434		16,434	813	17,247			26
27	Other (specify):*											27
28	**TOTAL General Administration**	14,806	2,523	195,669	212,998		212,998	(30,130)	182,868			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	226,938	39,424	237,319	503,681		503,681	(29,816)	473,865			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:** 7/1/2012 **Ending:** 6/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,444	22,444		22,444	2,060	24,504			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,164	44,164		44,164	12,470	56,634			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							6,741	6,741			34
35	Rent-Equipment & Vehicles							1,359	1,359			35
36	Other (specify):*											36
37	**TOTAL Ownership**			66,608	66,608		66,608	22,630	89,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		533		533		533		533			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,443	43,443		43,443		43,443			42
43	Other (specify):* Non-allowable Costs			5,689	5,689		5,689	(5,689)				43
44	**TOTAL Special Cost Centers**		533	49,132	49,665		49,665	(5,689)	43,976			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	226,938	39,957	353,059	619,954		619,954	(12,875)	607,079			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: 7/1/2012 Ending: 6/30/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(5,956)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(189)	43		17
18	Fines and Penalties				18
19	Entertainment	(1,230)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,500)	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 See Page 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,875)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (12,875)		37

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

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

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

Briarbrook Place

ID# 0038232

Report Period Beginning: 7/1/2012

Ending: 6/30/13

	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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Progressive Housing, Inc.	100.00%	$ 13	$ 13	1
2	V	5	Utilities		Progressive Housing, Inc.	100.00%	66	66	2
3	V	6	Maintenance		Progressive Housing, Inc.	100.00%	235	235	3
4	V	17	Administrative	125,053	Progressive Housing, Inc.	100.00%		(125,053)	4
5	V	18	Director Fees		Progressive Housing, Inc.	100.00%	3,163	3,163	5
6	V	19	Professional Services		Progressive Housing, Inc.	100.00%	15,026	15,026	6
7	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,804	1,804	7
8	V	21	Clerical and General Office	44	Progressive Housing, Inc.	100.00%	59,774	59,730	8
9	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	8,421	8,421	9
10	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	5,029	5,029	10
11	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	937	937	11
12	V	26	Insurance		Progressive Housing, Inc.	100.00%	813	813	12
13	V	30	Depreciation		Progressive Housing, Inc.	100.00%	2,060	2,060	13
14	Total			$ 125,097			$ 97,341	$ * (27,756)	14

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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$ 3,003	Progressive Housing, Inc.	100.00%	$ 15,473	$ 12,470	15
16	V	34	Rent		Progressive Housing, Inc.	100.00%	6,741	6,741	16
17	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	1,359	1,359	17
18	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	7,186	7,186	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,003			$ 30,759	$ * 27,756	39

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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

VII. RELATED PARTIES

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

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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,066	3Hrs/MTG	1.00	Dir. Fees	$ 534	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,065	3Hrs/MTG	1.00	Dir. Fees	535	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,065	3Hrs/MTG	1.00	Dir. Fees	535	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,065	3Hrs/MTG	1.00	Dir. Fees	535	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,310	3Hrs/MTG	1.00	Dir. Fees	490	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,066	3Hrs/MTG	1.00	Dir. Fees	534	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	169,195	1.18	2.95	Salary	9,847	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,010		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
6/30/2013
SCHEDULE 7A

BOARD OF DIRECTOR FEES

	Progressive Housing, Inc.								
	Edward Childers	Cora Flota	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Total		Larry Manson
Sparta Terrace	446	410	446	447	447	447	2,643	2,643	8,237
Ellner Terrace	464	425	464	463	463	463	2,742	2,742	8,559
Taylorville Terrace	519	475	519	518	518	518	3,067	3,067	9,597
Aviston Terrace	484	444	484	483	483	483	2,861	2,861	8,880
Briarbrook Place	534	490	534	535	535	535	3,163	3,163	9,847
Harris Place	516	474	516	517	517	517	3,057	3,057	9,579
Joshua Manor	462	425	462	463	463	463	2,738	2,738	8,469
Terra Estates	476	437	476	475	475	475	2,814	2,814	8,701
Park Place	455	417	455	454	454	454	2,689	2,689	8,379
Western Gardens	210	194	211	211	211	211	1,248	1,248	3,957
Galaxy	277	254	277	277	277	277	1,639	1,639	5,246
Cardinal	181	165	180	180	180	180	1,066	1,066	3,348
Bill Goat Hill	248	228	248	249	249	249	1,471	1,471	4,673
Country Club Hill	202	186	202	203	203	203	1,199	1,199	3,831
Lee Street	219	200	219	219	219	219	1,295	1,295	4,190
Baker Street	178	163	178	178	178	178	1,053	1,053	3,348
182nd Street	215	197	215	215	215	215	1,272	1,272	4,064
Osage	195	178	195	196	196	196	1,156	1,156	3,670
Oakwood	219	200	218	218	218	218	1,291	1,291	4,118
Blair	242	222	241	242	242	242	1,431	1,431	4,601
Lowell	236	217	236	237	237	237	1,400	1,400	4,440
Marquette	249	228	248	248	248	248	1,469	1,469	4,691
Cherry	234	214	234	234	234	234	1,384	1,384	4,422
Luella	302	277	302	303	303	303	1,790	1,790	5,819
Olivia	315	288	315	316	316	316	1,866	1,866	5,890
Huron	228	209	227	227	227	227	1,345	1,345	4,297
Wilshire	246	225	247	246	246	246	1,456	1,456	4,637
Constance	148	135	149	148	148	147	875	875	2,686
175th Place	271	248	272	271	270	271	1,603	1,603	5,121

Sauganash	0	0	0	0	0	0	0	0	0
Steger	417	383	417	416	417	417	2,467	2,467	7,824
Waltonville	36	31	36	35	35	35	208	208	3,921
Mt. Vernon	176	161	177	176	176	176	1,042	1,042	0
Total PHI	9,600	8,800	9,600	9,600	9,600	9,600	56,800		179,042

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Progressive Housing, Inc.
Street Address: 3615 Park Drive, Suite 100
City / State / Zip Code: Olympia Fields, IL 60461
Phone Number: (708) 283-1530
Fax Number: (708) 283-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Budgeted Rev/Dir Cost	13,188,353	31	$ 237	$	725,487	$ 13	1
2	5	Utilities	Budgeted Rev/Dir Cost	13,188,353	31	1,184		725,487	66	2
3	6	Maintenance	Budgeted Rev/Dir Cost	13,188,353	31	6,456		725,487	235	3
4	18	Director Fees	Budgeted Rev/Dir Cost	13,188,353	31	56,800		725,487	3,163	4
5	19	Professional Services	Budgeted Rev/Dir Cost	13,188,353	31	233,624		725,487	15,026	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	13,188,353	31	27,886		725,487	1,804	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost	13,188,353	31	1,068,896	964,998	725,487	59,774	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost	13,188,353	31	151,773		725,487	8,421	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost	13,188,353	31	41,254		725,487	5,029	9
10	25	Auto Expense	Budgeted Rev/Dir Cost	13,188,353	31	19,131		725,487	937	10
11	26	Insurance	Budgeted Rev/Dir Cost	13,188,353	31	14,561		725,487	813	11
12	30	Depreciation	Budgeted Rev/Dir Cost	13,188,353	31	37,448		725,487	2,060	12
13	32	Interest	Budgeted Rev/Dir Cost	13,188,353	31	281,328		725,487	15,473	13
14	34	Rent	Budgeted Rev/Dir Cost	13,188,353	31	119,600		725,487	6,741	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost	13,188,353	31	31,048		725,487	1,359	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	13,188,353	31	63,622		725,487	7,186	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,154,848	$ 964,998		$ 128,100	25

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 978,827	$ 867,978	08/15/26	6.7500	$ 42,774	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										1,390	6
7	Allocation from Home Office-Interest										14,793	7
8	Allocation from Home Office-Amortization										680	8
9	TOTAL Facility Related						$ 978,827	$ 867,978			$ 59,637	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(3,003)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,003)	14
15	TOTALS (line 9+line14)						$ 978,827	$ 867,978			$ 56,634	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.)

Facility Name & ID Number Briarbrook Place **#** 0038232 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2012**	$ **N/A**	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 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:			
	2008		**8**
	2009		**9**
	2010		**10**
	2011		**11**
	2012		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	47,250	1999	$ 20,000	1
2	Allocated from Home Office			172	2
3	TOTALS	47,250		$ 20,172	3

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 261,633	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		433	10
11	Ceramic Tiles, Sink and Stool			2006	1,240	82	15	82		590	11
12	Bathroom Remodel			2007	266	18	15	18		115	12
13	Water Heater			2008	776	52	15	52		272	13
14	Bathroom Remodel			2008	950	63	15	63		331	14
15	Bathroom Remodel			2008	1,072	71	15	71		368	15
16	Bathroom Remodel			2008	194	13	15	13		67	16
17	Concrete Sidewalk			2008	2,255	150	15	150		638	17
18	Carperts for Bedrooms, Living Room and Activity Rooms			2010	5,970	398	15	398		1,268	18
19	Kitchen and Pantry Remodel			2010	2,214	148	15	148		643	19
20	Kitchen and Pantry Remodel- Paint and Materials for project			2010	1,049	70	15	70		245	20
21	Kitchen and Pantry Remodel - Counter Top, Sink, Plumbing			2010	600	40	15	40		137	21
22	Kitchen and Pantry Remodel - Steel Door			2010	265	18	15	18		60	22
23	AC Installation			2010	2,927	195	15	195		585	23
24	Replace water valve			2010	952	64	15	64		176	24
25	Kitchen fire repair			2011	574	38	15	38		92	25
26	Replace condensor fan and capacitor			2011	700	47	15	47		98	26
27	Replace 2 Furnaces			2011	3,470	231	15	231		405	27
28	Replace Condenser Coil			2012	1,387	77	15	77		77	28
29	Replace Washer Fill Box			2013	542	30	15	30		30	29
30											30
31	Allocated from Home Office				3,579			153	153	675	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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 763,127	$ 20,092		$ 20,245	$ 153	$ 270,531	70

**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: 7/1/2012 Ending: 6/30/13

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	$ 15,590	$ 1,711	$ 1,711	$	5-10Yrs	$ 8,344	71
72	Current Year Purchases	3,485	182	182		5-10Yrs	182	72
73	Fully Depreciated Assets	19,535	54	54		5-10Yrs	19,535	73
74	Allocated From Home Office	15,148		1,564	1,564		11,753	74
75	TOTALS	$ 53,758	$ 1,947	$ 3,511	$ 1,564		$ 39,814	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	2002 Ford E350/2004 Dodge Cara	2002/2004	$ 48,319	$	$	$	5	$ 48,319	76
77	Resident Transportation	Capitalized Repairs	2009/2011/2013	2,466	405	405		5	775	77
78										78
79	Allocated from Home Office			7,129		343	343		6,696	79
80	TOTALS			$ 57,914	$ 405	$ 748	$ 343		$ 55,790	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)	$ 894,971	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,444	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,504	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,060	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 366,135	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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: 7/1/2012 Ending: 6/30/13

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		Allocated from Home Office			6,741			6
7	TOTAL				$ 6,741 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 1,359 Description: Allocated from Home Office - postage machine, copier, storage
(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.

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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 Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				533		533	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			$		$	$ 533		$ 533	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: 7/1/2012 Ending: 6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13 (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	$ 60,262	$ 60,262	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,007)	137,820	137,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,819	2,819	6
7	Other Prepaid Expenses	1,669	1,669	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves/Deposits	105,456	105,456	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 308,026	$ 308,026	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,172	13
14	Buildings, at Historical Cost	759,548	763,127	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	89,395	111,672	16
17	Accumulated Depreciation (book methods)	(346,444)	(366,135)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan Costs	10,050	10,050	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 532,549	$ 538,886	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 840,575	$ 846,912	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,643	$ 13,643	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,225	17,225	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,389	1,389	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,327	16,327	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	2,654	2,654	36
37	Deposits/Deferred Income	2,357	2,357	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 53,595	$ 53,595	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	867,978	867,978	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)**	$ 867,978	$ 867,978	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 921,573	$ 921,573	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (80,998)	$ (74,661)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 840,575	$ 846,912	48

***(See instructions.)**

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (109,296)	1
2	Restatements (describe):		2
3	**Rounding**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (109,296)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,653	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)**	$ 33,653	17
	B. Transfers (Itemize):		
18	**Allocation of Progressive Housing, Inc. Balance Sheet**		18
19	**to individual facilities**	(5,355)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (5,355)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (80,998)	24 *

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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 646,223	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 646,223	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,326	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)**	$ 7,326	23
	D. Non-Operating Revenue		
24	Contributions	58	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58	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)**	$ 653,607	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	74,496	31
32	Health Care	216,187	32
33	General Administration	212,998	33
	B. Capital Expense		
34	Ownership	66,608	34
	C. Ancillary Expense		
35	Special Cost Centers	6,222	35
36	Provider Participation Fee	43,443	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 619,954	40
41	**Income before Income Taxes (line 30 minus line 40)****	33,653	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 33,653	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 646,223	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 646,223	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

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

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

Facility Name Briarbrook Place
ID# 0038232
FYE 6/30/2013

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: 7/1/2012 Ending: 6/30/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	54	66	677	10.26	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	939	1,023	9,880	9.66	15
16	Dishwashers					16
17	Maintenance Workers	905	953	10,555	11.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	427	489	12,192	24.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	66	126	2,614	20.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	133	133	2,562	19.26	28
29	Resident Services Coordinator	1,725	1,846	33,845	18.33	29
30	Habilitation Aides (DD Homes)	15,820	16,825	154,613	9.19	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,069	21,461	$ 226,938 *	$ 10.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	25	$ 1,335	L1, C3	35
36	Medical Director	Monthly	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	370	9,238	L10, C3	38
39	Pharmacist Consultant	Monthly	1,001	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	15	925	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	410	$ 13,159		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 12,192
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 12,192

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 125,053
TOTAL (agree to Schedule V, line 17, col. 3)	$ 125,053
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sheakly Payroll Service	Payroll Service	$ 1,614
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,614

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	15,349
FICA Taxes	17,467
Employee Health Insurance	2,129
Employee Meals	3,560
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	8
Other Employee Benefits	26
Allocated from Home Office	8,421
TOTAL (agree to Schedule V, line 22, col.8)	$ 46,960

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 14)	137
Patient Background Checks	
Hiring Expense	1,749
Miscellaneous Dues & Fees	109
Allocated from Home Office	1,804
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,799

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,480
Allocated from Home Office	5,029
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,509

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
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: 7/1/2012 Ending: 6/30/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **N/A** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,089** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **43,443**
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. $ **3,560** 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? **73**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, LTD**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.