



Facility Name & ID Number Benjamin Green-Field Residence

# 0041582 Report Period Beginning: 7/1/04 Ending: 6/30/05

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	3,821	1,095		4,916	13
14	TOTALS	3,821	1,095		4,916	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.18%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 6/30/97

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Benjamin Green-Field Residence # 0041582 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary		2,132		2,132	5,873	8,005		8,005		1
2	Food Purchase		47,041		47,041		47,041		47,041		2
3	Housekeeping	19,908	6,033		25,941	(2,069)	23,872		23,872		3
4	Laundry		528		528		528		528		4
5	Heat and Other Utilities			15,002	15,002		15,002		15,002		5
6	Maintenance		49	14,757	14,806	15,764	30,570		30,570		6
7	Other (specify):* Security			7,866	7,866	7,404	15,270		15,270		7
8	<b>TOTAL General Services</b>	19,908	55,783	37,625	113,316	26,972	140,288		140,288		8
	<b>B. Health Care and Programs</b>										
9	Medical Director		5,087		5,087		5,087		5,087		9
10	Nursing and Medical Records	247,234			247,234	66,528	313,762		313,762		10
10a	Therapy					30,524	30,524		30,524		10a
11	Activities		18	2,630	2,648	16,087	18,735		18,735		11
12	Social Services			1,681	1,681		1,681		1,681		12
13	CNA Training										13
14	Program Transportation					33,356	33,356		33,356		14
15	Other (specify):* QMRP					38,197	38,197		38,197		15
16	<b>TOTAL Health Care and Programs</b>	247,234	5,105	4,311	256,650	184,692	441,342		441,342		16
	<b>C. General Administration</b>										
17	Administrative	34,874			34,874	144,640	179,514		179,514		17
18	Directors Fees										18
19	Professional Services			5,964	5,964	1,368	7,332		7,332		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses		1,139	5,019	6,158		6,158		6,158		21
22	Employee Benefits & Payroll Taxes			45,472	45,472	51,834	97,306		97,306		22
23	Inservice Training & Education			3,267	3,267		3,267		3,267		23
24	Travel and Seminar			574	574		574		574		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,066	40,066		40,066		40,066		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	34,874	1,139	100,362	136,375	197,842	334,217		334,217		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	302,016	62,027	142,298	506,341	409,506	915,847		915,847		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.

Benjamin Greenfield Residence  
 Facility ID #6044591  
 Allocated Cost Center Expenses Reclassification-Schedule V  
 Year Ended June 30, 2005

Dept.	Payroll 1	Supplies 2	Other 3	Total	FICA	Benefits	Total
	60,383.00	8,997.81	8,619.77	78,000.58	4,181.00	15,524.00	97,706
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
<b>230 Quest</b>	<b>5,736.39</b>	<b>854.79</b>	<b>818.88</b>	<b>7,410.06</b>	<b>397.20</b>	<b>1,474.78</b>	9,282
	171,997.54	6,075.64	65,229.85	243,303.03	12,740.00	24,664.48	280,708
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
<b>270 Recreation/Activities</b>	<b>16,339.77</b>	<b>577.19</b>	<b>6,196.84</b>	<b>23,113.79</b>	<b>1,210.30</b>	<b>2,343.13</b>	26,667
<b>Total Quest/Activities</b>	<b>22,076.15</b>	<b>1,431.98</b>	<b>7,015.71</b>	<b>30,523.84</b>	<b>1,607.50</b>	<b>3,817.91</b>	35,949
	156,783.24	794.04	11,759.80	169,337.08	11,214.97	19,705.80	200,258
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
<b>260 Total Social Services</b>	<b>14,894.41</b>	<b>75.43</b>	<b>1,117.18</b>	<b>16,087.02</b>	<b>1,065.42</b>	<b>1,872.05</b>	19,024
	368,913.53	2,697.40	30,463.14	402,074.07	27,238.69	37,160.65	466,473
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
<b>280/360 Total Behavior Mgmt</b>	<b>35,046.79</b>	<b>256.25</b>	<b>2,894.00</b>	<b>38,197.04</b>	<b>2,587.68</b>	<b>3,530.26</b>	44,315
	59,820.48	296.57	1,704.98	61,822.03	4,594.79	1,956.43	68,373
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
<b>380 Total Dietary Services</b>	<b>5,682.95</b>	<b>28.17</b>	<b>161.97</b>	<b>5,873.09</b>	<b>436.51</b>	<b>185.86</b>	6,495
	561,717.47	9,143.96	129,430.69	700,292.12	41,245.39	60,988.73	802,526
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
<b>370 Total Health Services</b>	<b>53,363.16</b>	<b>868.68</b>	<b>12,295.92</b>	<b>66,527.75</b>	<b>3,918.31</b>	<b>5,793.93</b>	76,240
	191,237.54	8,455.51	20,595.52	220,288.57	28,631.42	34,063.31	282,983
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>800 Maintenance</b>	<b>14,534.05</b>	<b>642.62</b>	<b>1,565.26</b>	<b>16,741.93</b>	<b>2,175.99</b>	<b>2,588.81</b>	21,507
	(17,217.07)	693.54	3,650.77	(12,872.76)	6,113.60	683.67	-6,075
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>860 Security</b>	<b>(1,308.50)</b>	<b>52.71</b>	<b>277.46</b>	<b>(978.33)</b>	<b>464.63</b>	<b>51.96</b>	-462
<b>Total Maint &amp; Security</b>	<b>13,225.56</b>	<b>695.33</b>	<b>1,842.72</b>	<b>15,763.60</b>	<b>2,640.62</b>	<b>2,640.77</b>	21,045
	240,796.72	2,708.15	195,390.01	438,894.88	23,644.13	54,681.72	517,221
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>850 Transportation</b>	<b>18,300.55</b>	<b>205.82</b>	<b>14,849.64</b>	<b>33,356.01</b>	<b>1,796.95</b>	<b>4,155.81</b>	39,309
	58,371.99	919.38	38,128.29	97,419.66	6,760.24	9,222.34	113,402
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>870 Grounds</b>	<b>4,436.27</b>	<b>69.87</b>	<b>2,897.75</b>	<b>7,403.89</b>	<b>513.78</b>	<b>700.90</b>	8,619
	(38,827.89)	1,131.86	10,468.85	(27,227.18)	9,777.96	7,267.25	-10,182
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>820 Housekeeping</b>	<b>(2,950.92)</b>	<b>86.02</b>	<b>795.63</b>	<b>(2,069.27)</b>	<b>743.12</b>	<b>552.31</b>	-774
			18,000.00	18,000.00			18,000
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>950 Audit Fees</b>	<b>-</b>	<b>-</b>	<b>1,368.00</b>	<b>1,368.00</b>		<b>-</b>	1,368
950 Accounting & Finance	262,820.09	2,365.21	18,095.27	283,280.57	18,333.26	27,172.91	328,787
930 Human Resources	116,953.14	(487.70)	4,626.89	121,092.33	8,640.06	11,472.78	141,205
940 Training	161,236.24	4,051.74	10,267.23	175,555.21	12,393.95	5,753.84	193,703
970 Information Services	-		108,552.56	108,552.56		-	108,553
900 General & Admin	96,370.00	37,524.07	178,281.27	312,175.34	6,092.91	(242.27)	318,026
880 Telecommunications	2,419.91	87.00	3,123.93	5,630.84	180.37	(13.00)	5,798
910 CEO's Office	201,614.66	1,992.46	145,091.16	348,698.28	11,435.08	1,621.69	361,755
920 Marketing	269,965.63	7,386.71	81,811.20	359,163.54	20,292.55	17,524.10	396,980
200 Program Management	171,020.97	463.48	17,526.54	189,010.99	11,992.32	22,018.04	223,021
	1,282,400.64	53,382.97	567,376.05	1,903,159.66	89,360.50	85,308.09	2,077,828.25
Notes 2	7.6%	7.6%	7.6%		7.6%	7.6%	
<b>Total Administrative</b>	<b>97,462.45</b>	<b>4,057.11</b>	<b>43,120.58</b>	<b>144,640.13</b>	<b>6,791.40</b>	<b>6,483.41</b>	157,915
<b>Total Benefits</b>				<b>51,834</b>	<b>-22,101</b>	<b>-29,733</b>	0
<b>Grand Total</b>				<b>409,506</b>	<b>0</b>	<b>0</b>	409,506

**Notes:**

- Ratio of residents 16/169 = 9.5%
- Ratio of residents 16/169 = 9.5% x 80% = 7.6%

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			31,912	31,912		31,912		31,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			72	72		72		72			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			31,984	31,984		31,984		31,984			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,068	40,068		40,068		40,068			42
43	Other (specify):* <b>Reclassifications</b>				409,506	(409,506)						43
44	<b>TOTAL Special Cost Centers</b>			40,068	449,574	(409,506)	40,068		40,068			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	302,016	62,027	214,350	987,899		987,899		987,899			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 Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/2004

Ending:

#####

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		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	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Benjamin Green-Field Residence

ID# 0041582

Report Period Beginning: 7/1/04

Ending: 6/30/05

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





VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None				Lambs Residence No 2	Libertyville	Sec 8 Housing
				Lambs III	Libertyville	Sec 811 Housing
				The Lambs Farm, Inc	Libertyville	Vocational, Day Residential

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	2 Food Purchase	\$ 47,041	The Lambs Farm, Inc	100.00%	\$ 47,041	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 47,041			\$ 47,041	\$ *	14

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

Facility Name & ID Number Benjamin Green-Field Residence # 0041582 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

## 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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/2004

Ending: #####

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 The Lambs Farm, Inc  
 Street Address 14245 W. Rockland Rd.  
 City / State / Zip Code Libertyville, IL 60048  
 Phone Number ( 847) 362-4636  
 Fax Number ( 847) 362-0742

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	See Schedule A following PG4				\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Benjamin Green-Field Residence # 0041582 Report Period Beginning: 7/1/04 Ending: 6/30/05

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6																				
7																				
8																				
9	<b>TOTAL Facility Related</b>																			
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>																			
15	<b>TOTALS (line 9+line14)</b>																			

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

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

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

Facility Name & ID Number **Benjamin Green-Field Residence**

# **0041582**

Report Period Beginning:

**7/1/04**

Ending:

**6/30/05**

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

**FOR OHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2004	\$	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.**



Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/04

Ending:

6/30/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,520 B. General Construction Type: Exterior Brick Veneer 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).

Day training work facility

CLF & SLA-9@12 Bed Capacity

Community Homes-2@5 bed capacity

Community Homes-4@4 bed capacity

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: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		<u>4,215</u>	<u>1986</u>	<u>\$ 37,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>4,215</u>		<u>\$ 37,500</u>	<u>3</u>

Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/04

Ending:

6/30/05

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1997	1996	\$ 719,380	\$ 17,984	40	\$ 17,985	\$ 1	\$ 152,868
5			1998	14,369	359	40	359	0	2,694
6			1999	30,300	758	40	758	(1)	4,924
7									
8									
<b>Improvement Type**</b>									
9	Storage Shed		1/1/1998	2,653	133	20	133	(0)	995
10	Dumpster Control System		1/1/1999	3,584	179	20	179	0	1,165
11	Retrofitting Automatic Closers to Existing Doors		7/16/2001	10,450	1,045	10	1,045		4,093
12	Bathroom Drains		9/16/2001	1,825	183	10	183	(1)	685
13	Bathroom Drains		1/8/2002	1,825	183	10	183	(1)	624
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/04

Ending:

6/30/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 784,386		\$ 20,823	\$ (1)	\$ 168,048	70

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

Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/04

Ending:

6/30/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 77,281	\$ 9,075	\$ 9,141	\$ 66	3,5,10	\$ 53,749	71
72	Current Year Purchases	4,351	750	750	(0)	5,7	750	72
73	Fully Depreciated Assets	33,044				3	33,044	73
74								74
75	TOTALS	\$ 114,676	\$ 9,825	\$ 9,891	\$ 66		\$ 87,543	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Donated Vehicle	1994 Nissan Maxima	2003	\$ 3,595	\$ 1,198	\$ 1,198	\$	3	\$ 2,796	76
77										77
78										78
79										79
80	TOTALS			\$ 3,595	\$ 1,198	\$ 1,198	\$		\$ 2,796	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)	\$ 940,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,847	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,912	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 258,387	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 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								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 \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
 (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

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. \_\_\_\_\_ /2006 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

\* 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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning: 7/1/04

Ending:

6/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/05

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 785,951	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		1,185,566	3
4	Supply Inventory (priced at )		217,010	4
5	Short-Term Investments		3,917,417	5
6	Prepaid Insurance		195,764	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,458,019	8
9	Other(specify): <u>Pledges</u>		6,456	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 7,766,183	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		2,597,315	12
13	Land		5,025,125	13
14	Buildings, at Historical Cost		6,402,950	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		2,131,795	16
17	Accumulated Depreciation (book methods)		(6,381,767)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		88,136	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 9,863,554	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 17,629,737	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 132,200	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		849,397	29
30	Accrued Salaries Payable		750,865	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation		126,987	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued other expenses</u>		161,803	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 2,021,252	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,527,036	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Liabilities under trust agreement</u>		56,182	43
44	<u>Annuity Interest obligations</u>		38,540	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,621,758	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 3,643,010	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	\$ 13,986,727	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	\$ 17,629,737	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 531,478	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 531,478	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 531,478	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	140,288	31
32	Health Care	441,342	32
33	General Administration	334,217	33
	<b>B. Capital Expense</b>		
34	Ownership	31,984	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	40,068	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 987,899	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(456,421)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (456,421)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Benjamin Green-Field Residence

# 0041582

Report Period Beginning:

7/1/04

Ending:

6/30/05

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				4
5	CNAs & Orderlies	16,715	19,291	247,234	12.82
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				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,944	2,086	19,908	9.54
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	2,109	2,109	34,874	16.54
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	20,768	23,486	\$ 302,016 *	\$ 12.86

\* 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	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	24	990	30/3
40	Physical Therapy Consultant	1	150	30/3
41	Occupational Therapy Consultant	2	525	30/3
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	6	861	30/3
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	33	\$ 2,526	49

C. CONTRACT NURSES

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Jenni Von Tobel</u>	<u>Coordinator</u>		\$ <u>34,874</u>	<u>Workers' Compensation Insurance</u>	\$	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	44,807	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	52,499	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 34,874</b>					
<b>(List each licensed administrator separately.)</b>								
<b>B. Administrative - Other</b>								
Description			Amount					
			\$			<u>Less: Public Relations Expense</u>	( )	
						<u>Non-allowable advertising</u>	( )	
						<u>Yellow page advertising</u>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>	<b>TOTAL (agree to Schedule V,</b>	<b>\$ 97,306</b>	<b>TOTAL (agree to Sch. V,</b>	<b>\$</b>	
<b>(Attach a copy of any management service agreement)</b>				<b>line 22, col.8)</b>		<b>line 20, col. 8)</b>		
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>		<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Occupational Therapist</u>			\$ 525			\$	<u>Out-of-State Travel</u>	\$
<u>Physical Therapist</u>			150					
<u>Psychiatrist</u>			1,740					
<u>Speech Therapy</u>			861				<u>In-State Travel</u>	574
<u>Pharmacist</u>			990					
<u>General Consulting</u>	<u>Medial Records</u>		704					
<u>Pre-employment screening</u>			994				<u>Seminar Expense</u>	
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 5,964</b>	<b>TOTAL</b>		<b>\$</b>	<u>Entertainment Expense</u>	( )
<b>(If total legal fees exceed \$2500 attach copy of invoices.)</b>							(agree to Sch. V,	
							<b>line 24, col. 8)</b>	<b>\$ 574</b>

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Benjamin Green-Field Residence

# 0041582

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**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. \_\_\_\_\_
- (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? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line \_\_\_\_\_
- (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. \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
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. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
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? NA  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Blackman Kallick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? NA  
Attach invoices and a summary of services for all architect and appraisal fees