

Facility Name & ID Number Benjamin Green-Field Residence

0041582 Report Period Beginning: 7/1/06 Ending: 6/30/07

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 Patient Days by Level of Care and Primary Source of Payment			5 Total
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	4,355	1,095		5,450
14	TOTALS	4,355	1,095		5,450

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.32%

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: 7-1-06 to 6-30-07

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

STATE OF ILLINOIS

Facility Name & ID Number Benjamin Green-Field Residence # 0041582 Report Period Beginning: 7/1/06 Ending: 6/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary		2,201		2,201	5,691	7,892		7,892		1
2	Food Purchase		56,338		56,338		56,338		56,338		2
3	Housekeeping	4,821	3,995		8,816	16,781	25,597		25,597		3
4	Laundry		861		861		861		861		4
5	Heat and Other Utilities										5
6	Maintenance		6,303		6,303	34,519	40,822		40,822		6
7	Other (specify):*					10,855	10,855		10,855		7
8	TOTAL General Services	4,821	69,698		74,519	67,846	142,365		142,365		8
B. Health Care and Programs											
9	Medical Director										9
10	Nursing and Medical Records	246,571	11,268		257,839	65,445	323,284		323,284		10
10a	Therapy										10a
11	Activities					30,437	30,437		30,437		11
12	Social Services					23,245	23,245		23,245		12
13	CNA Training										13
14	Program Transportation					41,705	41,705		41,705		14
15	Other (specify):* Personal Hygiene		1,617		1,617	24,604	26,221		26,221		15
16	TOTAL Health Care and Programs	246,571	12,885		259,456	185,436	444,892		444,892		16
C. General Administration											
17	Administrative	42,851			42,851	168,677	211,528		211,528		17
18	Directors Fees										18
19	Professional Services			8,675	8,675	2,698	11,373		11,373		19
20	Dues, Fees, Subscriptions & Promotions			975	975		975		975		20
21	Clerical & General Office Expenses		2,365	3,239	5,604		5,604		5,604		21
22	Employee Benefits & Payroll Taxes			61,068	61,068	53,401	114,469		114,469		22
23	Inservice Training & Education										23
24	Travel and Seminar			237	237		237		237		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			33,900	33,900		33,900		33,900		26
27	Other (specify):*										27
28	TOTAL General Administration	42,851	2,365	108,094	153,310	224,776	378,086		378,086		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	294,243	84,948	108,094	487,285	478,058	965,343		965,343		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

Benjamin Green-Field Residence

#0041582

Report Period Beginning:

7/1/06

Ending:

6/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			28,259	28,259		28,259		28,259			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			66	66		66		66			35
36	Other (specify):* Utilities			16,300	16,300		16,300		16,300			36
37	TOTAL Ownership			44,625	44,625		44,625		44,625			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,295	37,295		37,295		37,295			42
43	Other (specify):* Reclassification				478,058	(478,058)						43
44	TOTAL Special Cost Centers			37,295	515,353	(478,058)	37,295		37,295			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	294,243	84,948	190,014	1,047,263		1,047,263		1,047,263			45

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

Benjamin Greenfield Residence
 Facility ID #6044591
 Allocated Cost Center Expenses **Reclassification-Schedule V**
 Year Ended June 30, 2007

Dept.	Payroll 1	Supplies 2	Other 3	Total	FICA	Benefits	Total
	67,427	3,191	32,371	102,989	4,151	21,699	128,839
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
230 Quest	6,406	303	3,075	9,784	394	2,061	12,240
	148,629	4,719	64,050	217,398	10,828	24,681	252,907
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
270 Recreation/A	14,120	448	6,085	20,653	1,029	2,345	24,026
Total Quest/A	20,525	751	9,160	30,437	1,423	4,406	36,266
	227,612	532	16,539	244,683	16,240	22,233	284,156
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
260 Total Social S	21,623	51	1,571	23,245	1,543	2,207	26,995
	242,859	1,383	14,752	258,994	17,312	32,832	309,138
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
360 Total Behaviv	23,072	131	1,401	24,604	1,645	3,119	29,368
	58,450	5	1,450	59,905	4,472	1,943	66,320
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
380 Total Dietary	5,553	0	138	5,691	425	185	6,300
	556,494	12,460	119,939	688,893	41,992	69,086	799,971
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
370 Total Health	52,867	1,184	11,394	65,445	3,989	6,563	75,997
	372,883	3,794	30,552	407,229	27,199	42,609	477,037
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
800 Maintenance	28,339	288	247	28,874	2,067	3,238	34,180
	70,979	51	3,247	74,277	5,430	1,446	81,153
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
860 Security	5,394	4	247	5,645	413	110	6,168
Total Maint	33,734	292	494	34,519	2,480	3,348	40,347
	305,863	1,123	241,763	548,749	21,991	39,947	610,687
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
850 Transportat	23,246	85	18,374	41,705	1,671	3,036	46,412
	97,769	894	44,164	142,827	7,145	10,646	160,618
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
870 Grounds	7,430	68	3,356	10,855	543	809	12,207
	204,834	5,323	10,641	220,798	15,271	17,726	253,795
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
820 Housekeepin	15,567	405	809	16,781	1,161	1,347	19,288
			35,500	35,500			35,500
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
950 Audit Fees	-	-	2,698	2,698	-	-	2,698
950 Accounting &	253,934	2,561	15,201	271,696	18,243	26,243	316,182
930 Human Resou	108,784	1,554	32,604	142,942	9,193	1,774	153,909
940 Training	163,380	4,807	5,323	173,510	9,935	5,001	188,446
970 Information Sc	-	1,141	208,018	209,159			209,159
900 General & Ad	51,888	22,377	306,897	381,162	4,673	900	386,735
880 Telecommunic	-	4,672	108,732	113,404			113,404
910 CEO's Office	192,872	1,191	44,060	238,123	9,749	2,410	250,282
920 Marketing	269,883	5,714	84,540	360,137	19,877	15,459	395,473
140 Purchasing	69,312	4,824	15,249	89,385	4,762	13,028	107,175
200 Program Manu	213,194	314	26,411	239,919	15,432	20,975	276,326
Note 2	1,323,247	49,155	847,035	2,219,437	91,864	85,790	2,397,091
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Total Admini	100,567	3,736	64,375	168,677	6,982	6,520	182,179
				53,401	-21,861	-31,540	0
Total Benefits							
				478,058	0	0	478,058

Notes:
 1. Ratio of residents 16/169 = 9.5% 9.5%
 2. Ratio of residents 16/169 = 9.5% x 80% = 7 7.6%

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	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	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY						
48		49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Benjamin Green-Field Residence

ID# 0041582

Report Period Beginning: 7/1/06

Ending: 6/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
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 Benjamin Green-Field Residence

0041582

Report Period Beginning:

7/1/06

Ending:

6/30/07

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
				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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food Purchase	\$ 26,212	The Lambs Farm, Inc.	100.00%	\$ 26,212	\$	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		\$ 26,212			\$ 26,212	\$ *	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: 7/1/06 Ending: 6/30/07

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: 7/1/06 Ending: 6/30/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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: **7/1/06** Ending: **6/30/07**

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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: **7/1/06**

Ending: **6/30/07**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2006 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 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2006 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2002	8																										
2003	9																										
2004	10																										
2005	11																										
2006	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2006 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Benjamin Green-Field Residence COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0041582

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2006 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 2006

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

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

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.

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 ground (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 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		4,215	1986	\$ 37,500	1
2					2
3	TOTALS	4,215		\$ 37,500	3

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning:

7/1/06

Ending:

6/30/07

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		1997	1996	\$ 719,380	\$ 17,985	40	\$ 17,985		\$ 188,838
5			1998	14,369	359	40	359		3,412
6			1999	30,300	758	40	758		6,439
7									
8									
Improvement Type**									
9	Storage Shed		1/1/1998	2,653	133	20	133		1,261
10	Dumpster Control System		1/1/1999	3,584	179	20	179		1,523
11	Retrofitting Automatic Closer to Doors		7/16/2001	10,450	1,045	10	1,045		6,183
12	Bathroom Drains		9/16/2001	1,825	183	10	183		1,050
13	Bathroom Drains		1/8/2002	1,825	183	10	183		989
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

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	\$ 20,825		\$ 20,825	\$	\$ 209,695	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 81,632	\$ 7,434	\$ 7,434	\$	3, 5, 10	\$ 71,484	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	33,044					33,044	73
74								74
75	TOTALS	\$ 114,676	\$ 7,434	\$ 7,434	\$		\$ 104,528	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	\$	\$	\$		\$ 3,595	76
77										77
78										78
79										79
80	TOTALS			\$ 3,595	\$	\$	\$		\$ 3,595	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)	\$ 28,259	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,259	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 317,818	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)

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. _____ /2008 \$ _____
13. _____ /2009 \$ _____
14. _____ /2010 \$ _____

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning: 7/1/06

Ending:

6/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/07

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 167,121	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,892)	1,054,653	3
4	Supply Inventory (priced at First in/First ou)	220,273	4
5	Short-Term Investments	3,361,971	5
6	Prepaid Insurance	55,754	6
7	Other Prepaid Expenses	66,228	7
8	Accounts Receivable (owners or related parties)	1,511,815	8
9	Other(specify): Pledges	328,883	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,766,699	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	2,793,912	12
13	Land	1,660,710	13
14	Buildings, at Historical Cost	5,767,963	14
15	Leasehold Improvements, at Historical Cost	3,239,902	15
16	Equipment, at Historical Cost	3,472,543	16
17	Accumulated Depreciation (book methods)	(7,409,115)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,525,915	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,292,614	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 244,464	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	243	28
29	Short-Term Notes Payable	1,124,590	29
30	Accrued Salaries Payable	600,967	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,715	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	Deposits	24,913	36
37	Annuities	140,847	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,163,739	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,488,238	39
40	Mortgage Payable		40
41	Bonds Payable		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)	\$ 1,488,238	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,651,977	46
47	TOTAL EQUITY(page 18, line 24)	\$ (340,102)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,292,614	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(340,102)	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)	\$ (340,102)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (340,102)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning: 7/1/06

Ending:

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6/30/07

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 702,860	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 702,860	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		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	4,301	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,301	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)	\$ 707,161	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	142,365	31
32	Health Care	444,892	32
33	General Administration	378,086	33
B. Capital Expense			
34	Ownership	44,625	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	37,295	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,047,263	40
41	Income before Income Taxes (line 30 minus line 40)**	(340,102)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (340,102)	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:

7/1/06

Ending:

6/30/07

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	19,170	21,480	246,571	11.48
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	284	429	4,821	11.24
19	Laundry				19
20	Administrator				20
21	Assistant Administrator	2,038	2,346	42,851	18.27
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				29
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)	21,492	24,255	\$ 294,243 *	\$ 12.13

* 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	813	19/3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,891	19/3	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			45
46	Other(specify)			46
47	Physician	4,596	19/3	47
48	Psychiatrist	375	19/3	48
49	TOTAL (lines 35 - 48)	\$ 8,675		49

C. CONTRACT NURSES

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

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning: 7/1/06

Ending: 6/30/07

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 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? NA
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,617 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. \$ 37,295
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 benefit: on Schedule V. \$ NA Has any meal income been offset against related costs? _____ 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? 100%
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? NO If no, please explain. Report is not yet available. It will be s
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? NA
Attach invoices and a summary of services for all architect and appraisal fees.