

Facility Name & ID Number Benjamin Green-Field Residence

0041582 Report Period Beginning: 7-1-07 Ending: 6-30-08

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>3,880</u>	<u>1,095</u>		<u>4,975</u>
14	TOTALS	<u>3,880</u>	<u>1,095</u>		<u>4,975</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.19%

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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: 7-1-07 to 6-30-08

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

Facility Name & ID Number Benjamin Green-Field Residence # 0041582 Report Period Beginning: 7-1-07 Ending: 6-30-08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		2,358		2,358	12,882	15,240	15,240			1
2	Food Purchase		53,052		53,052		53,052	53,052			2
3	Housekeeping	10,177	1,947		12,124	46,534	58,658	58,658			3
4	Laundry		369		369		369	369			4
5	Heat and Other Utilities			17,714	17,714		17,714	17,714			5
6	Maintenance		988	22,157	23,145	36,040	59,185	59,185			6
7	Other (specify):*					12,563	12,563	12,563			7
8	TOTAL General Services	10,177	58,714	39,871	108,762	108,019	216,781	216,781			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	263,370	6,950		270,320	114,843	385,163	385,163			10
10a	Therapy										10a
11	Activities		438		438	28,268	28,706	28,706			11
12	Social Services					17,601	17,601	17,601			12
13	CNA Training										13
14	Program Transportation					45,542	45,542	45,542			14
15	Other (specify):* Personal Hygiene		4,550		4,550	27,102	31,652	31,652			15
16	TOTAL Health Care and Programs	263,370	11,938		275,308	233,356	508,664	508,664			16
	C. General Administration										
17	Administrative	40,577			40,577	164,287	204,864	204,864			17
18	Directors Fees										18
19	Professional Services			3,044	3,044	2,766	5,810	5,810			19
20	Dues, Fees, Subscriptions & Promotions			1,581	1,581		1,581	1,581			20
21	Clerical & General Office Expenses		3,596	32	3,628		3,628	3,628			21
22	Employee Benefits & Payroll Taxes			61,493	61,493	70,184	131,677	131,677			22
23	Inservice Training & Education										23
24	Travel and Seminar			31	31		31	31			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			31,665	31,665		31,665	31,665			26
27	Other (specify):*										27
28	TOTAL General Administration	40,577	3,596	97,846	142,019	237,237	379,256	379,256			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	314,124	74,248	137,717	526,089	578,612	1,104,701	1,104,701			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:

7-1-07

Ending:

6-30-08

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			25,708	25,708		25,708		25,708			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			84	84		84		84			35
36	Other (specify):*											36
37	TOTAL Ownership			25,792	25,792		25,792		25,792			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			40,414	40,414		40,414		40,414			42
43	Other (specify):* Reclassification				578,612	(578,612)						43
44	TOTAL Special Cost Centers			40,414	619,026	(578,612)	40,414		40,414			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	314,124	74,248	203,923	1,170,907		1,170,907		1,170,907			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, 2008

	Payroll 1	Supplies 2	Other 3	Total	FICA	Benefits	Total
Note 1	84,608	4,232	11,211	100,051	5,406	20,742	126,199
	9.5%	9.5%	9.5%		9.5%	9.5%	
Quest	8,038	402	1,065	9,505	514	1,970	11,989
Note 1	125,086	3,538	68,883	197,507	8,990	20,387	226,884
	9.5%	9.5%	9.5%		9.5%	9.5%	
Recreation/Activities	11,883	336	6,544	18,763	854	1,937	21,554
Total Quest/Activities	19,921	738	7,609	28,268	1,368	3,907	33,543
				Line 11			
Note 1	169,086	571	15,621	185,278	12,414	17,881	215,573
	9.5%	9.5%	9.5%		9.5%	9.5%	
Total Social Services	16,063	54	1,484	17,601	1,179	1,699	20,479
				Line 12			
Note 1	260,407	636	24,241	285,284	19,418	35,732	340,434
	9.5%	9.5%	9.5%		9.5%	9.5%	
Total Behavior Mgmt	24,739	60	2,303	27,102	1,845	3,395	32,341
				Line 15			
Note 3	62,744	30	1,635	64,409	4,585	2,208	71,202
	20.0%	20.0%	20.0%		20.0%	20.0%	
Total Dietary Services	12,549	6	327	12,882	917	442	14,240
				Line 1			
Note 3	464,803	8,648	100,766	574,217	33,373	70,718	678,308
	20.0%	20.0%	20.0%		20.0%	20.0%	
Total Health Services	92,961	1,730	20,153	114,843	6,675	14,144	135,662
				Line 10			
Note 2	392,096	4,206	41,058	437,360	28,973	37,336	503,669
	7.6%	7.6%	7.6%		7.6%	7.6%	
Maintenance	29,799	320	179	30,298	2,202	2,838	35,337
Note 2	73,108	92	2,351	75,551	5,593	1,270	82,414
	7.6%	7.6%	7.6%		7.6%	7.6%	
Security	5,556	7	179	5,742	425	97	6,263
Total Maint & Security	35,356	327	357	36,040	2,627	2,934	41,601
				Line 6			
Note 2	319,245	739	279,257	599,241	23,145	39,542	661,928
	7.6%	7.6%	7.6%		7.6%	7.6%	
Transportation	24,263	56	21,224	45,542	1,759	3,005	50,307
				Line 14			
Note 2	115,609	437	49,262	165,308	8,368	16,129	189,805
	7.6%	7.6%	7.6%		7.6%	7.6%	
Grounds	8,786	33	3,744	12,563	636	1,226	14,425
				Line 7			
Note 3	216,482	5,149	11,038	232,669	16,030	19,101	267,800
	20.0%	20.0%	20.0%		20.0%	20.0%	
Housekeeping	43,296	1,030	2,208	46,534	3,206	3,820	53,560
				Line 3			
Note 2	-	-	36,400	36,400	-	-	36,400
	7.6%	7.6%	7.6%		7.6%	7.6%	
Audit Fees	-	-	2,766	2,766	-	-	2,766
				Line 19			
Accounting & Finance	275,819	2,116	11,841	289,776	19,635	33,448	342,859
Human Resources	100,603	1,851	26,196	128,650	7,426	2,627	138,703
Training	166,347	3,638	7,262	177,247	12,447	15,713	205,407
Information Services	-	1,093	110,264	111,357	-	-	111,357
General & Admin	107,322	8,379	303,335	419,036	3,987	1,372	424,395
Telecommunications	-	4,672	108,732	113,404	-	-	113,404
CEO's Office	209,804	3,312	39,623	252,739	10,772	6,077	269,588
Marketing	292,781	4,604	50,920	348,305	21,442	17,696	387,443
Purchasing	72,995	1,441	17,164	91,600	5,056	14,000	110,656
Program Management	218,960	387	10,214	229,561	15,887	15,074	260,522
	1,444,631	31,493	685,351	2,161,675	96,652	106,007	2,364,334
	7.6%	7.6%	7.6%		7.6%	7.6%	
Total Administrative	109,792	2,393	52,102	164,287	7,346	8,057	179,689
				Line 17			
Total Benefits				70,184	-27,557	-42,627	0
				Line 22			
Grand Total				\$78,614	0	0	\$78,614

Notes:
 1. Ratio of residents 16/169 = 9.5% 9.5%
 2. Ratio of residents 16/169 = 9.5% x 80% = 7.6% 7.6%
 3. Due to ICF regulations and the higher needs of the residents more time is needed by these Departments for the individuals in Greenfield.

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning: 7-1-07

Ending:

6-30-08

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

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.

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

BHF USE ONLY						
48		49		50		51
						52

Benjamin Green-Field Residence

ID# 0041582

Report Period Beginning: 7-1-07

Ending: 6-30-08

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

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning:

7-1-07

Ending:

6-30-08

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

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		\$			\$	\$	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		\$			\$	\$ *	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: 7-1-07 Ending: 6-30-08

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: 7-1-07

Ending: 6-30-08

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: 7-1-07 Ending: 6-30-08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										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: **7-1-07**

Ending: **6-30-08**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 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:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 REAL ESTATE TAX COST DOCUMENTATION

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

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

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

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Benjamin Green-Field Residence COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0041582

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Benjamin Green-Field Residence

0041582 Report Period Beginning:

7-1-07 Ending:

6-30-08

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 9@12 bed capacity

Community Homes 2@5 bed capacity

Community Homes 4@4 bed capacity

CLF apartment

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>	1
2					2
3	TOTALS	4,215		\$ 37,500	3

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning:

7-1-07

Ending:

6-30-08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1997	1996	\$ 719,380	\$ 17,985	40	\$ 17,985		\$ 206,822	4
5				1998	14,369	359	40	359		3,771	5
6				1999	30,300	758	40	758		7,196	6
7											7
8											8
Improvement Type**											
9		Storage Shed		1/1/1998	2,653	133	20	133		1,393	9
10		Dumpster Control System		1/1/1999	3,584	179	20	179		1,702	10
11		Retrofitting Automatic Closer to Doors		7/16/2001	10,450	1,045	10	1,045		7,228	11
12		Bathroom Drains		9/16/2001	1,825	183	10	183		1,233	12
13		Bathroom Drains		1/8/2002	1,825	183	10	183		1,171	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

*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:

7-1-07

Ending:

6-30-08

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	\$	\$ 230,516	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: 7-1-07 Ending: 6-30-08

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	\$ 4,883	\$ 4,883	\$	3,5,10	\$ 76,367	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	33,044						73
74								74
75	TOTALS	\$ 114,676	\$ 4,883	\$ 4,883	\$		\$ 76,367	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)	\$ 25,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,708	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)	\$ 310,478	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning: 7-1-07

Ending:

6-30-08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 138,802	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 15,892)		847,018	3
4	Supply Inventory (priced at)		222,071	4
5	Short-Term Investments		3,244,766	5
6	Prepaid Insurance		25,938	6
7	Other Prepaid Expenses		38,207	7
8	Accounts Receivable (owners or related parties)		1,450,112	8
9	Other(specify): <u>Pledges Receivable</u>		70,910	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 6,037,824	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		3,066,274	12
13	Land		1,660,710	13
14	Buildings, at Historical Cost		5,773,582	14
15	Leasehold Improvements, at Historical Cost		3,271,154	15
16	Equipment, at Historical Cost		3,557,651	16
17	Accumulated Depreciation (book methods)		(7,907,092)	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
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 9,422,279	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 15,460,103	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 384,992	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		234	28
29	Short-Term Notes Payable		693,077	29
30	Accrued Salaries Payable		845,641	30
31	Accrued Taxes Payable (excluding real estate taxes)		29,798	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				36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 1,953,742	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,467,782	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,467,782	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 3,421,524	46
47	TOTAL EQUITY (page 18, line 24)	\$ (511,562)	\$ 12,038,579	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (511,562)	\$ 15,460,103	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)	(511,562)	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)	\$ (511,562)	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)	\$ (511,562)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Benjamin Green-Field Residence

0041582

Report Period Beginning: 7-1-07

Ending: 6-30-08

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	\$ 659,345	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 659,345	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		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 659,345	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	216,781	31
32	Health Care	510,245	32
33	General Administration	377,675	33
B. Capital Expense			
34	Ownership	25,792	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,414	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,170,907	40
41	Income before Income Taxes (line 30 minus line 40)**	(511,562)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (511,562)	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: 7-1-07

Ending: 6-30-08

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	15,115	16,211	263,370	16.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	886	902	10,177	11.28	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,962	2,080	40,577	19.51	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					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)	17,963	19,193	\$ 314,124 *	\$ 16.37	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant		634	19/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,200	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) <u>Psychologist</u>		210	19/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 3,044		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: 7-1-07

Ending: 6-30-08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Geneva Olokun	Coordinator	0	\$ 40,577	Workers' Compensation Insurance	\$	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	22,957	Health Care Worker Background Check			
				Employee Health Insurance	38,536	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Pre-Employment Expenses	1,581		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 40,577						
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,581
(Attach a copy of any management service agreement)				(attach copy of IMRF notifications)			TOTAL (agree to Sch. V, line 24, col. 8)		\$
C. Professional Services									
Vendor/Payee	Type	Amount							
Greenberg & Assoc	Medical Records	\$ 634							
Phamrakon	Pharmacist	2,200							
North Shore Psychological	Psychologist	210							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,044						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Benjamin Green-Field Residence

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? NA
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,108 Line 15
- (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? _____
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. \$ 40,414
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. \$ 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 not yet available. Will be sent
- (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.