

Facility Name & ID Number Benjamin Green Field Residence

0041582 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,862	365		5,227	13
14	TOTALS	4,862	365		5,227	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.50%

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 06/30/1997

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: 07/01/2012-06/30/2013

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

Facility Name & ID Number

Benjamin Green Field Residence

0041582

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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		1,181		1,181	4,210	5,391	5,391			1
2	Food Purchase		63,655		63,655		63,655	63,655			2
3	Housekeeping		2,732		2,732	519	3,251	3,251			3
4	Laundry		605		605		605	605			4
5	Heat and Other Utilities			11,902	11,902		11,902	11,902			5
6	Maintenance		3,648	24,767	28,415	26,204	54,619	54,619			6
7	Other (specify):* Grounds					12,036	12,036	12,036			7
8	TOTAL General Services		71,821	36,669	108,490	42,969	151,459	151,459			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	239,130	12,512		251,642	101,625	353,267	353,267			10
10a	Therapy										10a
11	Activities		1,706		1,706	33,981	35,687	35,687			11
12	Social Services					3,891	3,891	3,891			12
13	CNA Training										13
14	Program Transportation					39,030	39,030	39,030			14
15	Other (specify):* Personal Hygiene		1,107		1,107	42,287	43,394	43,394			15
16	TOTAL Health Care and Programs	239,130	15,325		254,455	220,814	475,269	475,269			16
	C. General Administration										
17	Administrative	43,048			43,048	163,443	206,491	206,491			17
18	Directors Fees										18
19	Professional Services			3,902	3,902	3,260	7,162	7,162			19
20	Dues, Fees, Subscriptions & Promotions			768	768		768	768			20
21	Clerical & General Office Expenses		717	94	811		811	811			21
22	Employee Benefits & Payroll Taxes			64,789	64,789	63,580	128,369	128,369			22
23	Inservice Training & Education										23
24	Travel and Seminar			61	61		61	61			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,732	10,732		10,732	10,732			26
27	Other (specify):*										27
28	TOTAL General Administration	43,048	717	80,346	124,111	230,283	354,394	354,394			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	282,178	87,863	117,015	487,056	494,066	981,122	981,122			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.

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			29,027	29,027	29,027		29,027				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											35
36	Other (specify):*											36
37	TOTAL Ownership			29,027	29,027	29,027		29,027				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			45,680	45,680	45,680		45,680				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			45,680	45,680	45,680		45,680				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	282,178	87,863	191,722	561,763	494,066	1,055,829	1,055,829				45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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, 2013

	Payroll 1	Supplies 2	Other 3	Total	FICA	Benefits	Total
	146,562	13,139	17,671	177,372	10,879	11,438	199,689
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
Quest	13,923	1,248	1,679	16,850	1,034	1,087	18,970
	127,862	44	52,413	180,319	8,760	16,390	205,469
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
Recreation/Activities	12,147	4	4,979	17,130	832	1,557	19,520
Total Quest/Activities	26,070	1,252	6,658	33,981	1,866	2,644	38,490
				Line 11			
	38,094	153	2,707	40,954	2,824	1,656	45,434
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
Total Social Services	3,619	15	257	3,891	268	157	4,316
				Line 12			
	431,171	1,037	12,921	445,129	31,016	30,480	506,625
Note 1	9.5%	9.5%	9.5%		9.5%	9.5%	
Total Behavior Mgmt	40,961	99	1,227	42,287	2,947	2,896	48,129
				Line 15			
	16,195	160	4,697	21,052	1,239		22,291
Note 3	20.0%	20.0%	20.0%		20.0%	20.0%	
Total Dietary Services	3,239	32	939	4,210	248	-	4,458
				Line 1			
	446,650	5,275	56,201	508,126	32,185	46,836	587,147
Note 3	20.0%	20.0%	20.0%		20.0%	20.0%	
Total Health Services	89,330	1,055	11,240	101,625	6,437	9,367	117,429
				Line 10			
	431,713	2,679	(140,164)	294,228	32,377	35,774	362,379
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Maintenance	32,810	204	(6,645)	26,368	2,461	2,719	31,548
	85,272	-	(87,440)	(2,168)	6,294	8,215	12,341
Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Security	6,481	-	(6,645)	(165)	478	624	938
Total Maint & Security	39,291	204	(13,291)	26,204	2,939	3,343	32,486
				Line 6			
	292,523	228	220,800	513,551	21,146	35,205	569,902

	Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Transportation		22,232	17	16,781	39,030	1,607	2,676	43,313
					Line 14			
		144,726	150	13,498	158,374	10,409	19,944	188,727
	Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Grounds		10,999	11	1,026	12,036	791	1,516	14,343
					Line 7			
		230,924	5,385	(233,716)	2,593	17,069	20,075	39,737
	Note 3	20.0%	20.0%	20.0%		20.0%	20.0%	
Housekeeping		46,185	1,077	(46,743)	519	3,414	4,015	7,947
					Line 3			
				42,900	42,900			42,900
	Note 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Audit Fees		-	-	3,260	3,260		-	3,260
					Line 19			
Accounting & Finance		379,246	2,660	13,012	394,918	26,973	43,424	465,315
Human Resources		62,923	1,333	15,393	79,649	4,628	(554)	83,723
Training		170,610	3,402	9,848	183,860	12,726	9,890	206,476
Information Services			247	121,836	122,083			122,083
General & Admin		58,337	5,595	252,130	316,062	3,163	2,957	322,182
Telecommunications		-	72	110,670	110,742			110,742
CEO's Office		207,900	1,051	12,894	221,845	11,635	12,746	246,226
Marketing		251,104	4,384	91,250	346,738	18,286	18,280	383,304
Purchasing		74,865	1,199	25,859	101,923	5,314	10,477	117,714
Program Management		251,333	75	21,342	272,750	18,522	17,982	309,254
		1,456,318	20,018	674,234	2,150,570	101,247	115,202	2,367,019
	Notes 2	7.6%	7.6%	7.6%		7.6%	7.6%	
Total Administrative		110,680	1,521	51,242	163,443	7,695	8,755	179,893
					Line 17			
Total Benefits					63,580	-28,211	-35,369	0
					Line 22			
Grand Total					494,066	0	0	494,066

Notes:

- Ratio of residents 16/169 = 9.5%
- Ratio of residents 16/169 = 9.5% x 80% = 7.6%
- 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: 07/01/2012

Ending: 06/30/2013

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. (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						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: 07/01/2012

Ending: 06/30/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Benjamin Green Field Residence

0041582

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number Benjamin Green Field Residence

0041582

Report Period Beginning:

07/01/2012 Ending:

Summary B

06/30/2013

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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.

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Benjamin Green Field Residence # 0041582 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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:

07/01/2012

Ending: 6/30/2013

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					\$	\$		\$	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:

07/01/2012

Ending:

06/30/2013

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 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 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,520 B. General Construction Type: Exterior Brick Veener 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
- CLF9@12 bed capacity
- Community 2@5 bed capacity
- Community 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1		4,215	1986	\$ 37,500	1
2					2
3	TOTALS	4,215		\$ 37,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1997	1996	\$ 719,380	\$ 17,985	40	\$ 17,985	\$	\$ 296,747	4
5			1998	14,369	359	40	359		5,566	5
6			1999	30,300	758	70	758		10,986	6
7										7
8										8
Improvement Type**										
9	Storage Shed - 0091		1998	2,653	133	20	133		2,058	9
10	Dumpster Control System		1999	3,584	179	20	179		2,597	10
11	Retrofitting Automatic Closers to Doors - 0795		2001	10,450	1,045	10	1,045		11,587	11
12	Bathroom Drains - 0810		2001	1,825	183	10	183		2,148	12
13	Bathroom Drains - 0911		2002	1,825	183	10	183		2,086	13
14	Carpet - 1350		2009	4,787	439	10	439		2,195	14
15	Built-in Oven - 1407		2010	1,660	332	5	332		1,328	15
16	Dishwasher - 1418-20		2010	3,600	720	5	720		2,880	16
17	Vinyl Stripewood Flooring - 1458		2011	2,740	274	10	274		822	17
18	Door Replacement - 1457		2011	4,695	470	10	470		1,410	18
19	Furnance - 1448		2011	3,160	451	7	451		1,353	19
20	Hand Dryers - 1528		2013	2,014	288	7	288		288	20
21	Tile Floor - 1531		2013	2,500	250	10	250		250	21
22	Hand Dryers - 1535		2013	666	95	7	95		95	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:

07/01/2012

Ending:

06/30/2013

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	810,208	\$	24,144	\$	24,144	\$	344,396	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:

07/01/2012

Ending:

06/30/2013

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 847,708	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,144	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,144	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 344,396	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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

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

Facility Name & ID Number Benjamin Green Field Residence # 0041582 Report Period Beginning: 07/01/2012 Ending: 06/30/2013
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input 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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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 prescrpts							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.

Facility Name & ID Number Benjamin Green Field Residence# 0041582Report Period Beginning: 07/01/2012Ending: 06/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2013 (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	\$	\$ 150,935	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		907,894	3
4	Supply Inventory (priced at)		300,493	4
5	Short-Term Investments		4,761,428	5
6	Prepaid Insurance		90,485	6
7	Other Prepaid Expenses		51,624	7
8	Accounts Receivable (owners or related parties)		1,879,154	8
9	Other(specify):		378,223	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 8,520,236	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		3,125,905	12
13	Land		2,228,536	13
14	Buildings, at Historical Cost		5,666,144	14
15	Leasehold Improvements, at Historical Cost		3,474,209	15
16	Equipment, at Historical Cost		4,009,025	16
17	Accumulated Depreciation (book methods)		(9,755,123)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		9,564	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		15,940	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 8,774,200	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 17,294,436	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 151,829	26
27	Officer's Accounts Payable		150,897	27
28	Accounts Payable-Patient Deposits		407	28
29	Short-Term Notes Payable		555,000	29
30	Accrued Salaries Payable		703,909	30
31	Accrued Taxes Payable (excluding real estate taxes)		15,839	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
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 1,577,881	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,349,085	39
40	Mortgage Payable		371,146	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)	\$	\$ 1,720,231	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 3,298,112	46
47	TOTAL EQUITY(page 18, line 24)	\$ (308,230)	\$ 13,996,324	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (308,230)	\$ 17,294,436	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)	(308,230)	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)	\$ (308,230)	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)	\$ (308,230)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 745,599	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 745,599	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)	\$ 745,599	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	151,459	31
32	Health Care	475,269	32
33	General Administration	354,394	33
B. Capital Expense			
34	Ownership	27,027	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	45,680	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,053,829	40
41	Income before Income Taxes (line 30 minus line 40)**	(308,230)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (308,230)	43

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

* 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:

07/01/2012

Ending:

06/30/2013

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				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				18	
19	Laundry				19	
20	Administrator				20	
21	Assistant Administrator				21	
22	Other Administrative				22	
23	Office Manager				23	
24	Clerical				24	
25	Vocational Instruction				25	
26	Academic Instruction				26	
27	Medical Director				27	
28	Qualified MR Prof. (QMRP)				28	
29	Resident Services Coordinator				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)		\$	*	\$	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			37
38	Nurse Consultant			38
39	Pharmacist Consultant			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				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$	
Description			Amount			Less: Public Relations Expense ()		
			\$			Non-allowable advertising ()		
						Yellow page advertising ()		
						TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$			\$		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount	Amount	
			\$			\$		
							Out-of-State Travel	
							\$	
							In-State Travel	
							Seminar Expense	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Benjamin Green Field Residence

0041582

Report Period Beginning: 07/01/2012

Ending: 06/30/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political
action organization? _____ 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? _____ If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? _____ 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 _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. \$ _____
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? _____ 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? _____
- (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? _____ 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. \$ _____ 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? _____
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for
residents? _____ 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? _____
 - d. Have vehicle usage logs been maintained? _____
 - e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? _____
 - f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? _____
 - g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such
transportation during this reporting period.** \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? _____
- (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? _____
Attach invoices and a summary of services for all architect and appraisal fees.