

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0041582

Facility Name: Benjamin Green Field Resid

Address: 14245 W Rocklnd B520 14245 W Rocklnd B520 Libertyville 60048 60048

County: Lake

Telephone Number: 847 362-4636 847 362-4636 Fax # 847 362-0742 847 362-0742

HFS ID Number:

Date of Initial License for Current Owners: 6/30/1997 6/30/1997

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Lynette Coyne

Telephone Number: 847 990-3723 847 990-3723

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2024 7/1/2024 to 6/30/2025 6/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Richard Nonnweiler

(Title) Controller

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE

ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES

2200 Churchill Rd.

Springfield, IL 62702-3406

Phone # (217) 782-1630

Facility Name & ID Number

Benjamin Green Field Resid

#

0041582

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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
1		Skilled (SNF)	
2		Skilled Pediatric (SNF/PED)	
3		Intermediate (ICF)	
4		Intermediate/DD	
5		Sheltered Care (SC)	
6		ICF/DD 16 or Less	16
7		TOTALS	16

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9
	Level of Care	Patient Days by Level of Care and Primary Source of Payment						
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other
				Medicaid Primary	Medicare Primary			
8	SNF							
9	SNF/PED							
10	ICF							
11	ICF/DD							
12	SC							
13	DD 16 OR LESS	5,345						5,345
14	TOTALS	5,345						5,345

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

91.52%

D. How many bed reserve days during this year were paid by the Department?

114 (Do not include bed reserve days in Section B.)

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

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 X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES X NO

I. On what date did you start providing long term care at this location?

Date started 6/30/1997

J. Was the facility purchased or leased after January 1, 1978?

YES Date NO X

K. Was the facility certified for Medicare during the reporting year?

YES NO X If YES, enter certified beds. number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?

YES X NO

Tax Year: Fiscal Year: 7/1/2024-6/30/2025

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	17,896			17,896		17,896	0	17,896			1
2	Food Purchase		78,647		78,647		78,647	0	78,647			2
3	Housekeeping	22,031			22,031		22,031	0	22,031			3
4	Laundry				0	0	0	0	0			4
5	Heat and Other Utilities			12,932	12,932		12,932	0	12,932			5
6	Maintenance	11,386		17,352	28,738		28,738	0	28,738			6
7	Other (specify):* Security/Equip Renta	379		5,297	5,676		5,676	0	5,676			7
8	TOTAL General Services	51,692	78,647	35,581	165,920	0	165,920	0	165,920			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	555,264	2,578	94,458	652,300		652,300	0	652,300			10
10a	Therapy				0		0	0	0			10a
11	Activities	92,408	785		93,193		93,193	0	93,193			11
12	Social Services			2,584	2,584		2,584	0	2,584			12
13	CNA Training				0		0	0	0			13
14	Program Transportation	13,895			13,895		13,895	0	13,895			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	661,567	3,363	97,042	761,972	0	761,972	0	761,972			16
	C. General Administration											
17	Administrative	37,004			37,004		37,004	0	37,004			17
18	Directors Fees				0		0	0	0			18
19	Professional Services				0		0	0	0			19
20	Dues, Fees, Subscriptions & Promotions				0		0	0	0			20
21	Clerical & General Office Expenses	60,316	10,137	1,126	71,579		71,579	0	71,579			21
22	Employee Benefits & Payroll Taxes			162,784	162,784		162,784	0	162,784			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar				0		0	0	0			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			31,108	31,108		31,108	0	31,108			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	97,320	10,137	195,018	302,475	0	302,475	0	302,475			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	810,579	92,147	327,641	1,230,367	0	1,230,367	0	1,230,367			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,478	44,478		44,478	0	44,478			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			44,478	44,478	0	44,478	0	44,478			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			61,249	61,249		61,249	0	61,249			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	61,249	61,249	0	61,249	0	61,249			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	810,579	92,147	433,368	1,336,094	0	1,336,094	0	1,336,094			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				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)	\$ 0		\$ 0	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 0		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$0	20	1
2	Other Expenses Related to Lobbying Activities			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

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[illegible]

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
Lambs Farm, Inc.	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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 (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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

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 Resid # 0041582 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	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 Resid # 0041582 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	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					\$	\$		0	25

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						\$	0	\$	0		\$	0	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	0	14
15	TOTALS (line 9+line14)						\$	0	\$	0		\$	0	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 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).				\$	03
4. Real Estate Tax accrual used for 2025 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.				\$	07
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Benjamin Green Field Resid 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 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 0.00	\$ 0.00

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 5,520
- B. General Construction Type: Exterior Brick VeneerFrame WoodNumber 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).

CLF 9 @ 12 Bed Capacity
Community 4 @ 5 Bed Capacity
CLF Apartment

- F. List the bed capacity for the building if it differs from the licensed total.
- G. Have you properly capitalized all major repairs and equipment purchases? Yes
- H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
- I. Are you presently operating under a sublease agreement? No
- J. 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.

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Benjamin Green Field Resid

0041582

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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			1997	1996	\$ 719,380	\$ 17,985	40	\$ 17,985	\$	\$ 512,559
5				1998	14,369	758	40	758		10,277
6				1999	30,300	359	70	359		19,676
7										
8										
	Improvement Type**									
9	Bathroom Renovations 1723-1730			2017	10,700	1,070	10	1,070		8,471
10	Two Bathrooms - 1830			2017	1,101	110	10	110		862
11	New Roof - 1849/1853/1865-68/1870-71			2018	44,559	4,456	10	4,456		30,132
12	Windows - 1850-51/1859			2018	6,243	250	10	250		2,374
13	Fire Alarm Panel -1854			2018	5,360	536	10	536		3,663
14	Single Hung Door - 1864			2018	371	37	10	37		253
15	Tuckpointing - 1866			2018	1,080	108	10	108		729
16	Front Doors - 1869			2018	1,823	182	10	182		1,229
17	Baseboards - 1872			2018	156	16	10	16		106
18	Relocate Fire Alarm Boxes - 2154/2157			2020	4,838	718	10	718		3,718
19	Complete Remodel start 2016-2022			2016	258,002	6,615	40	6,615		56,230
20	New Appliance start 2016 -2222			2016	4,344	290	15	290		2,631
21	Driveway/Curbs/Basin 2224			2016	29,660	1,977	15	1,977		17,301
22	Gazebo -2271			2021	3,762	537	10	537		2,060
23	Outdoor Patio Seating Area - 2361			2023	3,900	390	10	390		748
24	Greenfield rehab - 2365			2024	31,947	3,195	10	3,195		4,518
25	Greenfield - new furntiure & fixtures-2369			2024	18,806	3,761	5	3,761		5,427
26	GF 2024 additions			2024	11,204	968	10	968		968
27	GF PATIO UMBRELLA			2024	800	160	5	160		160
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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)		\$ 1,202,704	\$ 44,478		\$ 44,478	\$ 0	\$ 684,092	70

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

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	\$	\$	\$	\$ 0		\$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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	N/A			\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 1,240,204	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,478	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,478	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)	\$ 684,092	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?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

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

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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.

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	\$	\$ 5,378,172	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		831,120	3
4	Supply Inventory (priced at)		328,039	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		63,154	7
8	Accounts Receivable (owners or related parties)		2,516,624	8
9	Other(specify):		1,951,016	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 0	\$ 11,068,125	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		9,339,443	12
13	Land		3,248,147	13
14	Buildings, at Historical Cost		8,673,905	14
15	Leasehold Improvements, at Historical Cost		3,624,635	15
16	Equipment, at Historical Cost		5,601,852	16
17	Accumulated Depreciation (book methods)		(13,958,413)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,406)	20
21	Restricted Funds		261,256	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		15,940	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 0	\$ 16,801,359	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 0	\$ 27,869,484	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 564,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		736,885	30
31	Accrued Taxes Payable (excluding real estate taxes)		45,237	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			(392,413)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 0	\$ 953,872	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		683,449	39
40	Mortgage Payable		28,891	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LT Lease		39,718	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 752,058	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 0	\$ 1,705,930	46
47	TOTAL EQUITY(page 18, line 24)	\$ (63,475)	\$ 26,163,554	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (63,475)	\$ 27,869,484	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 140,051	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 140,051	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(203,526)	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)	\$ (203,526)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (63,475)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Benjamin Green Field Resid

0041582

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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	\$ 1,132,568	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,132,568	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)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,132,568	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	165,920	31
32	Health Care	761,972	32
33	General Administration	302,475	33
	B. Capital Expense		
34	Ownership	44,478	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	61,249	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,336,094	40
41	Income before Income Taxes (line 30 minus line 40)**	(203,526)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (203,526)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) Social Security	254,408.00	50
51	Other-(specify) Donations	12,026.00	51
52	Other-(specify) IL Dept of Health & Family Services	866,134.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,132,568	56

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	2,494	2,598	72,728	27.99	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	20,392	21,074	482,536	22.90	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	756	788	17,896	22.71	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	492	513	11,386	22.19	17
18	Housekeepers	1,351	1,407	22,031	15.66	18
19	Laundry					19
20	Administrator	1,054	1,098	37,004	33.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,045	2,130	60,316	28.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator	3,133	3,264	92,408	28.31	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Security/Transpor	829	759	14,274	18.81	33
34	TOTAL (lines 1 - 33)	32,546	33,631	\$ 810,579 *	\$ 24.10	34

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	Monthly	3,876	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,584	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,460		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	2,114	90,582	L10, C3	52
53	TOTAL (lines 50 - 52)	2,114	\$ 90,582		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|------------------|----------------|
| | |
| | |
| | |
| | <u>0</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|----------|----------------|
| <u>0</u> | |
| <u>0</u> | |
| <u>0</u> | <u>0</u> |
| | |
| | <u>0</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|----------|----------------|
| <u>0</u> | <u>0</u> |
| <u>0</u> | <u>0</u> |
| <u>0</u> | <u>0</u> |
| | <u>0</u> |
| | <u>0</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ Line
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,249
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Indicate the amount. \$
- (12) 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? N/A
- 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. \$
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sikich, LLP
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.