

		FOR BHF USE				

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0050286

Facility Name: Greenfields of Geneva

Address: ON801 Friendship Way Geneva 60134
 Number City Zip Code

County: Kane

Telephone Number: (630) 232-9105 Fax # ()

HFS ID Number: _____

Date of Initial License for Current Owners: 1/28/2013

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Howell **Telephone Number:** 314-925-4497
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 1/28/2013 to 7/31/2013 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) <u>Mike Flynn</u> (Date) _____
	(Title) <u>CFO</u>
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) <u>Steve Howell</u> <u>Director</u>
	(Firm Name & Address) <u>CliftonLarsonAllen</u> <u>600 Washington Avenue, Suite 1800 St Louis, MO 63101</u>
	(Telephone) <u>314-925-4497</u> Fax # <u>314-925-4350</u>

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Greenfields of Geneva

0050286 Report Period Beginning: 1/28/2013 Ending: 7/31/2013

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	43	Skilled (SNF)	43	7,955	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	43	TOTALS	43	7,955	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		1,202		1,202	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		1,202		1,202	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 15.11%

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

None (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 01/28/2013

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: 03/31/2013 Fiscal Year: 03/31/2013

* 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 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	327,221	16,700	(1,830)	342,091		342,091	(315,185)	26,906		
2	Food Purchase		117,632		117,632		117,632	(108,775)	8,857		
3	Housekeeping	96,360	11,242	12,048	119,650		119,650	(111,852)	7,798		
4	Laundry										
5	Heat and Other Utilities			196,395	196,395		196,395	(183,595)	12,800		
6	Maintenance	220,932	77,690	214,819	513,441		513,441	(479,977)	33,464		
7	Other (specify):*										
8	TOTAL General Services	644,513	223,264	421,432	1,289,209		1,289,209	(1,199,384)	89,825		
	B. Health Care and Programs										
9	Medical Director										
10	Nursing and Medical Records	272,455	24,655	133,832	430,942		430,942	(45)	430,897		
10a	Therapy										
11	Activities	23,823	1,192	548	25,563		25,563		25,563		
12	Social Services	7,050			7,050		7,050		7,050		
13	CNA Training										
14	Program Transportation										
15	Other (specify):*										
16	TOTAL Health Care and Programs	303,328	25,847	134,380	463,555		463,555	(45)	463,510		
	C. General Administration										
17	Administrative	179,974	52	445,990	626,016		626,016	(501,524)	124,492		
18	Directors Fees										
19	Professional Services			180	180		180		180		
20	Dues, Fees, Subscriptions & Promotions			2,451	2,451		2,451		2,451		
21	Clerical & General Office Expenses	14,033		198,830	212,863		212,863	(185,757)	27,106		
22	Employee Benefits & Payroll Taxes			319,869	319,869		319,869	(256,259)	63,610		
23	Inservice Training & Education										
24	Travel and Seminar			581	581		581		581		
25	Other Admin. Staff Transportation										
26	Insurance-Prop.Liab.Malpractice										
27	Other (specify):*										
28	TOTAL General Administration	194,007	52	967,901	1,161,960		1,161,960	(943,540)	218,420		
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,141,848	249,163	1,523,713	2,914,724		2,914,724	(2,142,969)	771,755		

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Greenfields of Geneva

#0050286

Report Period Beginning:

1/28/2013

Ending:

7/31/2013

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			1,426,188	1,426,188		1,426,188	(1,333,235)	92,953			30
31	Amortization of Pre-Op. & Org.			122,012	122,012		122,012	(100,911)	21,101			31
32	Interest			4,250,911	4,250,911		4,250,911	(4,125,641)	125,270			32
33	Real Estate Taxes			238,020	238,020		238,020	(222,507)	15,513			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			6,037,131	6,037,131		6,037,131	(5,782,294)	254,837			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			12,374	12,374		12,374		12,374			42
43	Other (specify):* AL/IL/Marketing	233,752	2,164	1,352,091	1,588,007		1,588,007	(2,157,963)	(569,956)			43
44	TOTAL Special Cost Centers	233,752	2,164	1,364,465	1,600,381		1,600,381	(2,157,963)	(557,582)			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,375,600	251,327	8,925,309	10,552,236		10,552,236	(10,083,226)	469,010			45

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

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning: 1/28/2013

Ending: 7/31/2013

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	(395)	02		4
5	Telephone, TV & Radio in Resident Rooms	(10,200)	21		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	(151,788)	32		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 Non-Allowable Expenses	(9,920,843)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,083,226)		\$	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))	\$ (10,083,226)		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

Greenfields of Geneva

ID# 0050286

Report Period Beginning: 1/28/2013

Ending: 7/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Assisted Living/Independent Living	(919,365)	43	2
3	Marketing Expenses	(1,238,598)	43	3
4	Amortization of Bond Costs	(100,911)	31	4
5	HCC - Wheel Chair Revenue	(45)	10	5
6	Misc. Income	(5,025)	21	6
7	Real Estate Taxes	(222,507)	33	7
8	Depreciation	(1,333,235)	30	8
9	Dietary	(315,185)	1	9
10	Food Purchase	(108,380)	2	10
11	Housekeeping	(111,852)	3	11
12	Heat & Utilities	(183,595)	5	12
13	Maintenance	(479,977)	6	13
14	Administrative	(501,524)	17	14
15	Clerical & General	(170,532)	21	15
16	Employee Benefits	(256,259)	22	16
17	Interest	(3,973,853)	32	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	(9,920,843)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenfields of Geneva# 0050286

Report Period Beginning:

1/28/2013

Ending:

7/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(315,185)	0	0	0	0	0	0	0	0	0	0	(315,185)	1
2	Food Purchase	(108,775)	0	0	0	0	0	0	0	0	0	0	(108,775)	2
3	Housekeeping	(111,852)	0	0	0	0	0	0	0	0	0	0	(111,852)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(183,595)	0	0	0	0	0	0	0	0	0	0	(183,595)	5
6	Maintenance	(479,977)	0	0	0	0	0	0	0	0	0	0	(479,977)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,199,384)	0	0	0	0	0	0	0	0	0	0	(1,199,384)	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	(45)	0	0	0	0	0	0	0	0	0	0	(45)	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	(45)	0	0	0	0	0	0	0	0	0	0	(45)	16
	C. General Administration													
17	Administrative	(501,524)	0	0	0	0	0	0	0	0	0	0	(501,524)	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	(185,757)	0	0	0	0	0	0	0	0	0	0	(185,757)	21
22	Employee Benefits & Payroll Taxes	(256,259)	0	0	0	0	0	0	0	0	0	0	(256,259)	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	(943,540)	0	0	0	0	0	0	0	0	0	0	(943,540)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,142,969)	0	0	0	0	0	0	0	0	0	0	(2,142,969)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenfields of Geneva# 0050286

Report Period Beginning:

1/28/2013 Ending:

7/31/2013

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	(1,333,235)	0	0	0	0	0	0	0	0	0	0	(1,333,235)	30
31	Amortization of Pre-Op. & Org.	(100,911)	0	0	0	0	0	0	0	0	0	0	(100,911)	31
32	Interest	(4,125,641)	0	0	0	0	0	0	0	0	0	0	(4,125,641)	32
33	Real Estate Taxes	(222,507)	0	0	0	0	0	0	0	0	0	0	(222,507)	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	(5,782,294)	0	0	0	0	0	0	0	0	0	0	(5,782,294)	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):*	(2,157,963)	0	0	0	0	0	0	0	0	0	0	(2,157,963)	43
44	TOTAL Special Cost Centers	(2,157,963)	0	0	0	0	0	0	0	0	0	0	(2,157,963)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(10,083,226)	0	0	0	0	0	0	0	0	0	0	(10,083,226)	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	17 Management Fees	\$ 419,980	Friendship Village Executive/Corporate Allocation		\$ 419,980	\$	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		\$ 419,980			\$ 419,980	\$ *	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	See attached board of directors listing.							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 Greenfields of Geneva # 0050286 Report Period Beginning: 1/28/2013 Ending: 7/31/2013

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	See Attached Board of Directors listng.								\$	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 Greenfields of Geneva

0050286 Report Period Beginning: 1/28/2013

Ending: 7/31/2013

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	33	Real Estat Taxes	Square Feet	208,374	2	\$ 238,020	\$ 0	13,581	\$ 15,513	1
2	30	Depreciation Expense	Square Feet	208,374	2	1,426,188	0	13,581	92,953	2
3	1	Dietary	Meals	47,679	2	342,091	327,221	3,750	26,906	3
4	2	Food Purchase	Meals	47,679	2	117,632	0	3,750	9,252	4
5	3	Housekeeping	Square Feet	208,374	2	119,650	96,360	13,581	7,798	5
6	5	Heat & Utilities	Square Feet	208,374	2	196,395	0	13,581	12,800	6
7	6	Maintenance	Square Feet	208,374	2	513,441	0	13,581	33,464	7
8	17	Administrative	Employee Ratio	176	2	626,016	220,932	35	124,492	8
9	21	Clerical & General	Employee Ratio	176	2	212,863	179,974	35	42,331	9
10	22	Employee Benefits	Employee Ratio	176	2	319,869	14,033	35	63,610	10
11	32	Interest	Square Feet	208,374	2	4,250,911	0	13,581	277,058	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					\$ 8,363,076	\$ 838,520		\$ 706,177	25

Facility Name & ID Number

Greenfields of Geneva

0050286

Report Period Beginning:

1/28/2013

Ending:

7/31/2013

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		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	Revenue Bonds Series 2010		x	Bond Issuance			\$ 117,600,000	\$ 105,125,000		variable	\$ 4,250,911	1												
2												2												
3												3												
4												4												
5												5												
Working Capital																								
6												6												
7												7												
8												8												
9	TOTAL Facility Related						\$ 117,600,000	\$ 105,125,000				\$ 4,250,911	9											
B. Non-Facility Related*																								
10												10												
11												11												
12												12												
13												13												
14	TOTAL Non-Facility Related						\$	\$				\$	14											
15	TOTALS (line 9+line14)						\$ 117,600,000	\$ 105,125,000				\$ 4,250,911	15											

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.		\$	<u>562,538</u>		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.)		\$	<u>281,269</u>		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(281,269)</u>		3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>519,289</u>		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.		\$	<u>238,020</u>		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 Greenfields of Geneva COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0050286

CONTACT PERSON REGARDING THIS REPORT Jeff Nyberg

TELEPHONE 847-843-4259 FAX #: 847-884-5718

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. <u>See Attached</u>	<u>Long Term Care Property</u>	\$ <u>231,229.53</u>	\$ <u>15,513.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>231,229.53</u></u>	\$ <u><u>15,513.00</u></u>

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.**

Facility Name & ID Number Greenfields of Geneva

0050286 Report Period Beginning:

1/28/2013 Ending:

7/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 208,374 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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).

Independent Living - 156,590 - 147 units

Assisted Living - 28,317 - 51 units

Memory Support - 9,886 - 26 units

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: 14,897,278 2. Number of Years Over Which it is Being Amortized: 30
 3. Current Period Amortization: 122,012 4. Dates Incurred: 2005

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	<u>SNF</u>	<u>70,977</u>	<u>2005</u>	<u>\$ 400,836</u>	1
2	<u>Non-Allowable</u>	<u>1,018,023</u>	<u>2005</u>	<u>5,749,211</u>	2
3	TOTALS	1,089,000		\$ 6,150,047	3

Facility Name & ID Number Greenfields of Geneva

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	43		2012	\$ 5,080,035	\$ 28,643	40	\$ 28,643	\$	\$ 171,860
5									
6									
7									
8									
	Improvement Type**								
9	GreenFields Geneva Equipment FY2012		2012	24,408	4,882	5	4,882		9,763
10	GreenFields Geneva Furnishings FY 2012		2012	35,486	5,069	7	5,069		10,139
11	GreenFields Geneva Hardware & Software		2012	17,011	3,402	5	3,402		6,804
12	GreenFields Geneva Fixtures FY 2013		2013	243,870	16,258	15	16,258		16,258
13	GreenFields FF&E		2013	216	43	5	43		43
14	GreenFields Geneva Furnishings FY2013		2013	97,477	13,925	7	13,925		13,925
15	GreenFields Geneva Hardware & Software		2013	27,994	5,599	5	5,599		5,599
16	Ipads 32GB WIFI (9)		2013	318	106	3	106		106
17	GreenFields Geneva Equipment FY2013		2013	40,167	8,034	5	8,034		8,033
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Greenfields of Geneva

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)	\$ 5,566,982	\$ 85,961		\$ 85,961	\$	\$ 242,530	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	\$ 76,905	\$ 13,353	\$ 13,353	\$		\$ 26,706	71
72	Current Year Purchases	409,724	43,965	43,965			43,964	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 486,629	\$ 57,318	\$ 57,318	\$		\$ 70,670	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		Van	2013	\$ 59,928	\$ 6,992	\$ 6,992	\$	5	\$ 13,984	76
77										77
78										78
79										79
80	TOTALS			\$ 59,928	\$ 6,992	\$ 6,992	\$		\$ 13,984	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)	\$ 12,263,586	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,953	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,953	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 256,514	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	Independent Living	\$ 64,187,739	\$ 1,071,759	\$ 2,730,404	86
87	Assited Living	11,607,409	193,812	493,753	87
88	Memory Support	4,052,366	67,664	172,379	88
89					89
90					90
91	TOTALS	\$ 79,847,514	\$ 1,333,235	\$ 3,396,536	91

G. Construction-in-Progress

	Description	Cost	
92	Capital Budget	\$ 93,479	92
93			93
94			94
95		\$ 93,479	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.

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning:

1/28/2013

Ending: 7/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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: \$ 6,623

Description: Vehicle rental

(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 Greenfields of Geneva # 0050286 Report Period Beginning: 1/28/2013 Ending: 7/31/2013
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>No CNA training took place at the facility, all training was completed off-site.</u></p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of 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 Greenfields of Geneva# 0050286Report Period Beginning: 1/28/2013

Ending:

7/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 7/31/2013

(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	\$ 492,333	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,269,288		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(60,668)		6
7	Other Prepaid Expenses	9,851		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,710,804	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,150,047		13
14	Buildings, at Historical Cost	77,943,238		14
15	Leasehold Improvements, at Historical Cost	93,476		15
16	Equipment, at Historical Cost	7,531,187		16
17	Accumulated Depreciation (book methods)	(3,652,722)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	21,882,706		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Marketing/Issue</u>	13,227,555		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 123,175,487	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 124,886,291	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,007,473	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,752		30
31	Accrued Taxes Payable (excluding real estate taxes)	116		31
32	Accrued Real Estate Taxes(Sch.IX-B)	519,289		32
33	Accrued Interest Payable	3,848,012		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Reserve Expenses</u>	6,400		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,526,042	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,433,812		39
40	Mortgage Payable			40
41	Bonds Payable	104,139,468		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	31,554,366		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 141,127,646	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 146,653,688	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (21,767,397)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 124,886,291	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (14,087,375)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (14,087,375)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(7,680,022)	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)	\$ (7,680,022)	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)	\$ (21,767,397)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Greenfields of Geneva# 0050286Report Period Beginning: 1/28/2013Ending: 7/31/2013

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	\$ 205,815	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 205,815	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	46,910	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	4,415	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,325	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(130,485)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (130,485)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL Revenue	2,719,522	28
28a	Other Revenue	26,037	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,745,559	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,872,214	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,289,209	31
32	Health Care	463,555	32
33	General Administration	1,161,960	33
B. Capital Expense			
34	Ownership	6,037,131	34
C. Ancillary Expense			
35	Special Cost Centers	1,600,381	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,552,236	40
41	Income before Income Taxes (line 30 minus line 40)**	(7,680,022)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (7,680,022)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	146,253	45
46	Medicare - Net Inpatient Revenue	29	46
47	Other-(specify) <u>Hospice/Life Center</u>	59,533	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 205,815	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 Greenfields of Geneva

0050286

Report Period Beginning:

1/28/2013

Ending:

7/31/2013

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	768	856	\$ 37,037	\$ 43.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,735	4,906	148,905	30.35	3
4	Licensed Practical Nurses	2,313	2,412	54,608	22.64	4
5	CNAs & Orderlies	5,652	5,954	76,178	12.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	446	446	6,643	14.89	10
11	Social Service Workers	928	1,040	22,203	21.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,438	19,269	215,950	11.21	15
16	Dishwashers	3,164	3,195	29,605	9.27	16
17	Maintenance Workers	1,667	1,773	24,858	14.02	17
18	Housekeepers	6,673	7,150	78,388	10.96	18
19	Laundry	1,016	1,031	11,122	10.79	19
20	Administrator	944	1,040	46,745	44.95	20
21	Assistant Administrator					21
22	Other Administrative	5,152	5,900	210,424	35.67	22
23	Office Manager	1,016	1,040	25,814	24.82	23
24	Clerical	24,911	26,633	314,760	11.82	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	879	950	14,309	15.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,702	83,595	\$ 1,317,549 *	\$ 15.76	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	5	270	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	516	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	8	560	10-3	45
46	Other(specify) <u>Therapy Part C</u>	Monthly	240	10-3	46
47	<u>Interim Director of Nursing</u>	2	170	10-3	47
48	<u>Temp Labor/Agency Supp/AL</u>	240	25,620	43-3	48
49	TOTAL (lines 35 - 48)	255	\$ 27,376		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	410	\$ 39,731	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	410	\$ 39,731		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	
Cathy Flanagan	Administrator		\$ 46,745	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
Michelle Orwig	DON		37,113	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	111,008	Health Care Worker Background Check		
				Employee Health Insurance	25,822	(Indicate # of checks performed <u>25</u>)	750	
				Employee Meals		Recruitment	1,701	
				Illinois Municipal Retirement Fund (IMRF)*				
See Attachment			96,116	Employee Programs	558			
				Transfer From Corporate	182,481			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 179,974					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 319,869	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Society for Human Resource Management			\$ 180			\$	Out-of-State Travel	\$
							In-State Travel	
							Travel and Mileage	312
							Seminar Expense	
							Seminars and Education	269
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 180	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 581

* 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	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Greenfields of Geneva# 0050286Report Period Beginning: 1/28/2013Ending: 7/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$508
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,914 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 12,374
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes 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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 130
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ NA
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.