FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 (Number) Geneva (City) 60134 (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:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Deb Freeland **Telephone Number:** 314-569-6230
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 04/01/2013 to 03/31/2014 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) (Date)
(Type or Print Name) Jeff Nyberg
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Deb Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen, 9339 Priority Way W Dr., #200, Indianapolis, IN 46240
(Telephone) 317-569-6230 Fax # 314-925-4350

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: 04/01/2013 Ending: 03/31/2014

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	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	15,695	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		2,209	1,505	3,714	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		2,209	1,505	3,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 23.66%

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 [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 01/28/2013

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 [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 1,505

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 03/31/2014 Fiscal Year: 03/31/2014

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

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	663,955	54,295	414,912	1,133,162		1,133,162	(915,106)	218,056			1
2	Food Purchase		455,879		455,879		455,879	(368,548)	87,331			2
3	Housekeeping	230,205	35,856	23,046	289,107		289,107	(270,264)	18,843			3
4	Laundry											4
5	Heat and Other Utilities			461,081	461,081		461,081	(431,030)	30,051			5
6	Maintenance	454,344	135,886	798,104	1,388,334		1,388,334	(1,297,848)	90,486			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,348,504	681,916	1,697,143	3,727,563		3,727,563	(3,282,796)	444,767			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,070,112	66,339	57,675	1,194,126		1,194,126		1,194,126			10
10a	Therapy			188,134	188,134		188,134		188,134			10a
11	Activities	59,527	1,752	855	62,134		62,134		62,134			11
12	Social Services	31,978			31,978		31,978		31,978			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,161,617	68,091	246,664	1,476,372		1,476,372		1,476,372			16
	C. General Administration											
17	Administrative	189,450	1,186	1,040,681	1,231,317		1,231,317	(1,120,003)	111,314			17
18	Directors Fees											18
19	Professional Services			74,869	74,869		74,869		74,869			19
20	Dues, Fees, Subscriptions & Promotions			8,897	8,897		8,897		8,897			20
21	Clerical & General Office Expenses	68,788		188,301	257,089		257,089	(264,946)	(7,857)			21
22	Employee Benefits & Payroll Taxes			741,759	741,759		741,759	(256,259)	485,500			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,406	18,406		18,406		18,406			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			171,017	171,017		171,017		171,017			26
27	Other (specify):*											27
28	**TOTAL General Administration**	258,238	1,186	2,243,930	2,503,354		2,503,354	(1,641,208)	862,146			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,768,359	751,193	4,187,737	7,707,289		7,707,289	(4,924,004)	2,783,285			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenfields of Geneva #0050286 **Report Period Beginning:** 04/01/2013 **Ending:** 03/31/2014

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,863,460	2,863,460		2,863,460	(2,662,497)	200,963			30
31	Amortization of Pre-Op. & Org.			192,413	192,413		192,413	(150,211)	42,202			31
32	Interest			8,242,232	8,242,232		8,242,232	(7,942,800)	299,432			32
33	Real Estate Taxes			469,419	469,419		469,419	(438,824)	30,595			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,264	5,264		5,264		5,264			35
36	Other (specify):*											36
37	**TOTAL Ownership**			11,772,788	11,772,788		11,772,788	(11,194,332)	578,456			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			72,826	72,826		72,826		72,826			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,485	44,485		44,485		44,485			42
43	Other (specify):* **Marketing/AL/IL**	565,314	8,914	3,295,053	3,869,281		3,869,281	(3,869,281)				43
44	**TOTAL Special Cost Centers**	565,314	8,914	3,412,364	3,986,592		3,986,592	(3,869,281)	117,311			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,333,673	760,107	19,372,889	23,466,669		23,466,669	(19,987,617)	3,479,052			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: 04/01/2013 Ending: 03/31/2014

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	(395)	2		4
5	Telephone, TV & Radio in Resident Rooms	(51,261)	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	(237,764)	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 **Other Non-allowable**	(19,698,197)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,987,617)		$	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)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (19,987,617)		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

Greenfields of Geneva

ID# 0050286

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Assisted Living/Independent Living	(712,427)	43	2
3	Marketing Expenses	(3,156,854)	43	3
4	Amortization of Bond Costs	(150,211)	31	4
5	Misc. Income	(7,722)	21	5
6	Real Estate Taxes	(438,824)	33	6
7	Depreciation	(2,662,497)	30	7
8	Dietary	(915,106)	1	8
9	Food Purchase	(368,153)	2	9
10	Housekeeping	(270,264)	3	10
11	Heat & Utilities	(431,030)	5	11
12	Maintenance	(1,297,848)	6	12
13	Administrative	(1,120,003)	17	13
14	Clerical & General	(205,963)	21	14
15	Employee Benefits	(256,259)	22	15
16	Interest	(7,705,036)	32	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**	(19,698,197)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenfields of Geneva # 0050286 **Report Period Beginning:** 04/01/2013 **Ending:** 03/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(915,106)	0	0	0	0	0	0	0	0	0	0	(915,106)	1
2	Food Purchase	(368,548)	0	0	0	0	0	0	0	0	0	0	(368,548)	2
3	Housekeeping	(270,264)	0	0	0	0	0	0	0	0	0	0	(270,264)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(431,030)	0	0	0	0	0	0	0	0	0	0	(431,030)	5
6	Maintenance	(1,297,848)	0	0	0	0	0	0	0	0	0	0	(1,297,848)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,282,796)	0	0	0	0	0	0	0	0	0	0	(3,282,796)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,120,003)	0	0	0	0	0	0	0	0	0	0	(1,120,003)	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	(264,946)	0	0	0	0	0	0	0	0	0	0	(264,946)	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**	(1,641,208)	0	0	0	0	0	0	0	0	0	0	(1,641,208)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,924,004)	0	0	0	0	0	0	0	0	0	0	(4,924,004)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenfields of Geneva # 0050286 **Report Period Beginning:** 04/01/2013 **Ending:** 03/31/2014

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(2,662,497)	0	0	0	0	0	0	0	0	0	0	(2,662,497)	30
31	Amortization of Pre-Op. & Org.	(150,211)	0	0	0	0	0	0	0	0	0	0	(150,211)	31
32	Interest	(7,942,800)	0	0	0	0	0	0	0	0	0	0	(7,942,800)	32
33	Real Estate Taxes	(438,824)	0	0	0	0	0	0	0	0	0	0	(438,824)	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**	(11,194,332)	0	0	0	0	0	0	0	0	0	0	(11,194,332)	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):*	(3,869,281)	0	0	0	0	0	0	0	0	0	0	(3,869,281)	43
44	**TOTAL Special Cost Centers**	(3,869,281)	0	0	0	0	0	0	0	0	0	0	(3,869,281)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,987,617)	0	0	0	0	0	0	0	0	0	0	(19,987,617)	45

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Management Fees	$ 987,420	Friendship Village Executive/Corporate Allocation		$ 987,420	$	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				$ 987,420			$ 987,420	$ *	14

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

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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: 04/01/2013 Ending: 03/31/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Board of Directors lisitng.								$		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: 04/01/2013 Ending: 3/31/2014

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	33	Real Estat Taxes	Square Feet	208,374	2	$ 469,419	$ 0	13,581	$ 30,595	1
2	30	Depreciation Expense	Square Feet	208,374	2	2,847,870	0	13,581	185,613	2
3	1	Dietary	Meals	81,603	2	1,133,162	857,273	15,703	218,056	3
4	2	Food Purchase	Meals	81,603	2	455,879	0	15,703	87,726	4
5	3	Housekeeping	Square Feet	208,374	2	289,107	230,205	13,581	18,843	5
6	5	Heat & Utilities	Square Feet	208,374	2	461,081	0	13,581	30,051	6
7	6	Maintenance	Square Feet	208,374	2	1,388,334	454,344	13,581	90,486	7
8	17	Administrative	Employee Ratio	176	2	1,398,018	356,151	35	278,015	8
9	21	Clerical & General	Employee Ratio	176	2	257,089	68,788	35	51,126	9
10	22	Employee Benefits	Employee Ratio	176	2	319,869	741,759	35	63,610	10
11	32	Interest	Square Feet	208,374	2	8,242,232	0	13,581	537,196	11
12	30	Depreciation Expense	Direct Cost	1	1	15,350	0	1	15,350	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					$ 17,277,410	$ 2,708,520		$ 1,606,667	25

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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	$ 100,897,602		variable	$ 8,242,232	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 117,600,000	$ 100,897,602			$ 8,242,232	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	$ 100,897,602			$ 8,242,232	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.)**

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 583,855	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.)		$ 462,459	2
3. Under or (over) accrual (line 2 minus line 1).		$ (121,396)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 590,815	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.		$ 469,419	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

Greenfields of Geneva
03/31/2014
RE Tax Reconciliation

	BEGINNING BALANCE	ACCRUAL	ADJUSTMENT/ REFUND	PAYMENT	DESCRIPTION	ENDING BALANCE
4/30/2013	(583,854.56)	(41,666.00)				(625,520.56)
5/31/2013	(625,520.56)	(41,666.00)		231,229.53	Kane County 2012 1st Installment	(435,957.03)
6/30/2013	(435,957.03)	(41,666.00)				(477,623.03)
7/31/2013	(477,623.03)	(41,666.00)				(519,289.03)
8/31/2013	(519,289.03)	(41,666.00)		231,229.53	Kane County 2012 2nd Installment	(329,725.50)
9/30/2013	(329,725.50)	(20,613.58)				(350,339.08)
10/31/2013	(350,339.08)	(20,613.58)				(370,952.66)
11/30/2013	(370,952.66)	(20,613.58)				(391,566.24)
12/31/2013	(391,566.24)	(20,613.58)				(412,179.82)
1/31/2014	(412,179.82)	(20,613.58)				(432,793.40)
2/28/2014	(432,793.40)	(79,866.14)				(512,659.54)
3/31/2014	(512,659.54)	(78,155.01)				(590,814.55)
			-	462,459.06		

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-12-102-002	Long Term Care Property	$ 451,926.62	$ 29,454.80
2.	11-12-127-001	Long Term Care Property	$ 10,532.44	$ 686.46
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 462,459.06	$ 30,141.27

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? X 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

Greenfields of Geneva
03/31/2014
RE Tax Allocation

Tax Index Number	Property Description		Total Tax	Tax Applicable to Nursing Home
11-12-102-002	Long Term Care Property	$	451,927	29,454.80
11-12-127-001	Long Term Care Property	$	10,532	686.46

Allocation Calculation

	Facility Units	Total Units	% Applicable to Nursing Home
Page 8 Housekeeping	13,581	208,374	7%

Tax ID	Total Tax	Allocation %	Tax Applicable to Nursing Home (Total Tax * Allocation %)
11-12-102-002	451,927	7%	29,454.80
11-12-127-001	10,532	7%	686.46

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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? [x] (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? [x] (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 - 38,203 - 77 units

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

1. Total Amount Incurred: 15,035,318
2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 192,413
4. Dates Incurred: 2005, 2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF	70,977	2005	$ 400,836	1
2	Non-Allowable	1,018,023	2005	5,749,211	2
3	TOTALS	1,089,000		$ 6,150,047	3

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43			2012	$ 5,080,035	$	40	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscape Filter to hide generator			2014	1,213		15				9
10	Snow shoes for metal roof sections			2014	1,456		10				10
11	Exterior and Interior Signage			2014	7,257		15				11
12	Apt 2106 Staged Quality Interiors			2014	163		7				12
13	Financial Statement Depreciation					127,755		127,755		261,743	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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	$ 486,947	$	$	$		$	71
72	Current Year Purchases	8,089						72
73	Fully Depreciated Assets							73
74			57,858	57,858			99,871	74
75	TOTALS	$ 495,036	$ 57,858	$ 57,858	$		$ 99,871	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	$ 11,986	$ 11,986	$	5	$ 17,978	76
77		Van	2014	33,639	3,364	3,364		5	3,364	77
78										78
79										79
80	TOTALS			$ 93,567	$ 15,350	$ 15,350	$		$ 21,342	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)	$	11,828,774	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	200,963	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	200,963	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)	$	382,956	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	Non- Allowable	$ 80,288,820	$ 2,662,497	$ 5,186,889	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 80,288,820	$ 2,662,497	$ 5,186,889	91

G. Construction-in-Progress

	Description	Cost	
92	Capital Budget	$ 1,443	92
93			93
94			94
95		$ 1,443	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: 04/01/2013 Ending: 03/31/2014

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? ☐ YES ☐ NO
   If NO, see instructions.

		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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 5,623 Description: Medical Equipment
    (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		2012 Ford E450	$ 1,245.00	$ 14,995	17
18					18
19					19
20					20
21	TOTAL		$ 1,245.00	$ 14,995	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: 04/01/2013 Ending: 03/31/2014

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	650	$ 56,041	$	650	$ 56,041	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		314	26,951		314	26,951	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		965	89,327		965	89,327	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			$	1,929	$ 172,319	$	1,929	$ 172,319	14

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

STATE OF ILLINOIS

Facility Name & ID Number Greenfields of Geneva # 0050286 **Report Period Beginning:** 04/01/2013 **Ending:** 03/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 03/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,406,710	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,737,898		3
4	Supply Inventory (priced at cost)	22,790		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,764		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,186,162	$	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	336,818		15
16	Equipment, at Historical Cost	7,688,934		16
17	Accumulated Depreciation (book methods)	(5,569,845)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	13,142,444		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Marketing/Issue	12,481,102		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 112,172,738	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 117,358,900	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,081,691	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	290,688		30
31	Accrued Taxes Payable (excluding real estate taxes)	650		31
32	Accrued Real Estate Taxes(Sch.IX-B)	590,815		32
33	Accrued Interest Payable	981,219		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,945,063	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,786,370		39
40	Mortgage Payable			40
41	Bonds Payable	100,897,602		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	40,019,162		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 146,703,134	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 150,648,197	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (33,289,297)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 117,358,900	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (16,120,301)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (16,120,301)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(17,168,996)	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)**	$ (17,168,996)	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)**	$ (33,289,297)	24	*

*** This must agree with page 17, line 47.**

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,262,284	1
2	Discounts and Allowances for all Levels	(122,810)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,139,474	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	18,999	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 18,999	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	112,762	14
15	Telephone, Television and Radio	51,261	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	1,643	20
21	Other Medical Services	19,211	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 184,877	23
	D. Non-Operating Revenue		
24	Contributions	30,000	24
25	Interest and Other Investment Income***	(122,251)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (92,251)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL Revenue	5,038,851	28
28a	Other Revenue	7,723	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,046,574	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,297,673	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,727,563	31
32	Health Care	1,476,372	32
33	General Administration	2,503,354	33
	B. Capital Expense		
34	Ownership	11,772,788	34
	C. Ancillary Expense		
35	Special Cost Centers	3,942,107	35
36	Provider Participation Fee	44,485	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 23,466,669	40
41	**Income before Income Taxes (line 30 minus line 40)****	(17,168,996)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (17,168,996)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue	110,150	45
46	Medicare - Net Inpatient Revenue	719,816	46
47	Other-(specify) Hospice/Life Center	309,508	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,139,474	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,584	1,728	$ 77,113	$ 44.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,180	14,663	487,798	33.27	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	16,144	19,530	262,365	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,221	4,418	76,782	17.38	10
11	Social Service Workers	1,888	2,080	47,546	22.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	43,909	47,605	567,553	11.92	15
16	Dishwashers	5,740	6,133	61,320	10.00	16
17	Maintenance Workers	2,126	2,318	51,023	22.01	17
18	Housekeepers	15,045	16,531	179,774	10.87	18
19	Laundry					19
20	Administrator	1,536	1,737	80,476	46.33	20
21	Assistant Administrator	342	410	14,393	35.10	21
22	Other Administrative	11,967	13,308	491,865	36.96	22
23	Office Manager					23
24	Clerical	24,364	26,460	361,184	13.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Assisted Living	34,963	38,366	574,481	14.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,009	195,287	$ 3,333,673 *	$ 17.07	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	10	615	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	12	840	10-3	45
46	Other(specify) MDS Coordinator	120	10,835	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	142	$ 12,290		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	236	5,422	10-3	52
53	TOTAL (lines 50 - 52)	236	$ 5,422		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Flanagan	Administrator		$ 42,402
Lynn Blackburn	Administrator		34,231
See Attachment			112,817
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 189,450

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Society for Human Resource Management		$ 440
Shea, Rogal & Associates	Legal	9,000
Smith, Hemmesch, Burke & Brannig	Legal	65,429
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 74,869

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20
Unemployment Compensation Insurance	
FICA Taxes	243,636
Employee Health Insurance	62,333
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Recruitment	17,129
Employee Programs	17,988
Transfer From Corporate	384,092
Physicals	16,561
Less:Non-Reimburseable Benefits	(256,259)
TOTAL (agree to Schedule V, line 22, col.8)	$ 485,500

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,522
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 70	700
Subscriptions & Publications	5,675
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,897

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel and Mileage	6,970
Seminar Expense	
Seminars and Education	11,436
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,406

* Attach copy of IMRF notifications

**See instructions.

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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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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 $31,603 CARF $5,356**

(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. $ **6,326** 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. $ **44,485**
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. $ **395**

(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? 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? **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) 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.