FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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:** 317-574-9100
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 04/01/2015 to 03/31/2016 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Deb Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-574-9100 Fax # 317-574-9707

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: 04/01/2015 Ending: 03/31/2016

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	0	5,338	8,492	13,830	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		5,338	8,492	13,830	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.12%

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 8,492

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: 3/31/2016 Fiscal Year: 3/31/3016

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

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2015 Ending: 03/31/2016

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	1,465,346	103,826	174,277	1,743,449		1,743,449	(1,243,750)	499,699			1
2	Food Purchase		833,034		833,034		833,034	(595,572)	237,462			2
3	Housekeeping	377,529	61,315	23,982	462,826		462,826	(432,661)	30,165			3
4	Laundry											4
5	Heat and Other Utilities			557,997	557,997		557,997	(521,629)	36,368			5
6	Maintenance	613,812	62,418	881,054	1,557,284		1,557,284	(1,455,786)	101,498			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,456,687	1,060,593	1,637,310	5,154,590		5,154,590	(4,249,398)	905,192			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,948,859	100,342	171,869	2,221,070		2,221,070		2,221,070			10
10a	Therapy			843,446	843,446		843,446		843,446			10a
11	Activities	142,835	5,480	5,282	153,597		153,597		153,597			11
12	Social Services	56,985			56,985		56,985		56,985			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,148,679	105,822	1,020,597	3,275,098		3,275,098		3,275,098			16
	C. General Administration											
17	Administrative		3,034	1,588,688	1,591,722	103,555	1,695,277	(1,012,785)	682,492			17
18	Directors Fees											18
19	Professional Services			1,013,693	1,013,693		1,013,693	(7,500)	1,006,193			19
20	Dues, Fees, Subscriptions & Promotions			11,363	11,363		11,363		11,363			20
21	Clerical & General Office Expenses	247,344	476	212,296	460,116	(103,555)	356,561	(413,892)	(57,331)			21
22	Employee Benefits & Payroll Taxes			1,531,623	1,531,623		1,531,623	(1,108,411)	423,212			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,991	18,991		18,991		18,991			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			285,143	285,143		285,143		285,143			26
27	Other (specify):*											27
28	**TOTAL General Administration**	247,344	3,510	4,661,797	4,912,651		4,912,651	(2,542,588)	2,370,063			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,852,710	1,169,925	7,319,704	13,342,339		13,342,339	(6,791,986)	6,550,353			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: 04/01/2015 Ending: 03/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,942,883	2,942,883		2,942,883	(2,720,912)	221,971			30
31	Amortization of Pre-Op. & Org.			139,303	139,303		139,303	(97,144)	42,159			31
32	Interest			8,002,349	8,002,349		8,002,349	(7,488,173)	514,176			32
33	Real Estate Taxes			265,335	265,335		265,335	(248,042)	17,293			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			82,805	82,805		82,805		82,805			35
36	Other (specify):*											36
37	**TOTAL Ownership**			11,432,675	11,432,675		11,432,675	(10,554,271)	878,404			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			451,373	451,373		451,373		451,373			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,260	64,260		64,260		64,260			42
43	Other (specify):* **Marketing/AL/IL**	1,081,915	4,834	2,120,048	3,206,797		3,206,797	(3,189,709)	17,088			43
44	**TOTAL Special Cost Centers**	1,081,915	4,834	2,635,681	3,722,430		3,722,430	(3,189,709)	532,721			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,934,625	1,174,759	21,388,060	28,497,444		28,497,444	(20,535,966)	7,961,478			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: 04/01/2015 Ending: 03/31/2016

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	(1,298)	02		4
5	Telephone, TV & Radio in Resident Rooms	(78,390)	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	(113,323)	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	(7,374,850)	32		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	(35,255)	17		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	(13,107,224)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,710,340)		$	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)	174,374		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 174,374		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (20,535,966)		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: 04/01/2015

Ending: 03/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted Living/Independent Living	$ (1,206,000)	43	1
2	Marketing Expenses	(1,983,709)	43	2
3	Amortization of Bond Costs	(97,144)	31	3
4	Misc. Income	(2,523)	21	4
5	Real Estate Taxes	(248,042)	33	5
6	Depreciation	(2,720,912)	30	6
7	Dietary	(1,243,750)	1	7
8	Food Purchase	(594,274)	2	8
9	Housekeeping	(432,661)	3	9
10	Heat & Utilities	(521,629)	5	10
11	Maintenance	(1,455,786)	6	11
12	Administrative	(1,151,904)	17	12
13	Clerical & General	(332,979)	21	13
14	Employee Benefits	(1,108,411)	22	14
15				15
16				16
17	Non-Allowable Legal Fees	(7,500)	19	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**	(13,107,224)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenfields of Geneva # 0050286 **Report Period Beginning:** 04/01/2015 **Ending:** 03/31/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,243,750)	0	0	0	0	0	0	0	0	0	0	(1,243,750)	1
2	Food Purchase	(595,572)	0	0	0	0	0	0	0	0	0	0	(595,572)	2
3	Housekeeping	(432,661)	0	0	0	0	0	0	0	0	0	0	(432,661)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(521,629)	0	0	0	0	0	0	0	0	0	0	(521,629)	5
6	Maintenance	(1,455,786)	0	0	0	0	0	0	0	0	0	0	(1,455,786)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,249,398)	0	0	0	0	0	0	0	0	0	0	(4,249,398)	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	(1,187,159)	174,374	0	0	0	0	0	0	0	0	0	(1,012,785)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,500)	0	0	0	0	0	0	0	0	0	0	(7,500)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(413,892)	0	0	0	0	0	0	0	0	0	0	(413,892)	21
22	Employee Benefits & Payroll Taxes	(1,108,411)	0	0	0	0	0	0	0	0	0	0	(1,108,411)	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**	(2,716,962)	174,374	0	0	0	0	0	0	0	0	0	(2,542,588)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,966,360)	174,374	0	0	0	0	0	0	0	0	0	(6,791,986)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenfields of Geneva # 0050286 **Report Period Beginning:** 04/01/2015 **Ending:** 03/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,720,912)	0	0	0	0	0	0	0	0	0	0	(2,720,912)	30
31	Amortization of Pre-Op. & Org.	(97,144)	0	0	0	0	0	0	0	0	0	0	(97,144)	31
32	Interest	(7,488,173)	0	0	0	0	0	0	0	0	0	0	(7,488,173)	32
33	Real Estate Taxes	(248,042)	0	0	0	0	0	0	0	0	0	0	(248,042)	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**	(10,554,271)	0	0	0	0	0	0	0	0	0	0	(10,554,271)	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):*	(3,189,709)	0	0	0	0	0	0	0	0	0	0	(3,189,709)	43
44	**TOTAL Special Cost Centers**	(3,189,709)	0	0	0	0	0	0	0	0	0	0	(3,189,709)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,710,340)	174,374	0	0	0	0	0	0	0	0	0	(20,535,966)	45

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2015 Ending: 03/31/2016

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	$ 1,504,980	Friendship Village Executive/Corporate Allocation		$ 1,679,354	$ 174,374	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			$ 1,504,980			$ 1,679,354	$ * 174,374	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: 04/01/2015 Ending: 03/31/2016

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: 04/01/2015 Ending: 03/31/2016

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 listing.								$		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: 04/01/2015 Ending: 3/31/2016

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 [X] NO [ ]

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

Name of Related Organization: Friendship Senoir Options
Street Address: 350 W. Schaumburg Road
City / State / Zip Code: Schaumburg, IL 60194
Phone Number: ((847) 490-6274
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 Estate Taxes	Square Feet	208,374	2	$ 265,335	$ 0	13,581	$ 17,293	1
2	30	Depreciation Expense	Direct Cost	2,942,883	2	2,942,883	0	221,971	221,971	2
3	1	Dietary	Meals	145,275	2	1,743,449	1,465,346	41,638	499,699	3
4	2	Food Purchase	Meals	145,275	2	833,034	0	41,638	238,760	4
5	3	Housekeeping	Square Feet	208,374	2	462,826	377,529	13,581	30,165	5
6	5	Heat & Utilities	Square Feet	208,374	2	557,997	0	13,581	36,368	6
7	6	Maintenance	Square Feet	208,374	2	1,557,284	613,812	13,581	101,498	7
8	17	Administrative	Employee Ratio	152	2	1,591,722	0	42	439,818	8
9	21	Clerical & General	Employee Ratio	152	2	460,116	247,344	42	127,137	9
10	22	Employee Benefits	Employee Ratio	152	2	1,531,623	0	42	423,212	10
11	32	Interest	Square Feet	208,374	2	7,889,026	0	13,581	514,176	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					$ 19,835,295	$ 2,704,031		$ 2,650,097	25

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2015 Ending: 03/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	Revenue Bond Series 2010		X	Bond Issuance			117,600,000	96,801,963		Variable	8,002,349	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 117,600,000	$ 96,801,963			$ 8,002,349	9
	B. Non-Facility Related*											
10	Investment Income											10
11	Non-Allowable Interest										(7,488,173)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (7,488,173)	14
15	TOTALS (line 9+line14)						$ 117,600,000	$ 96,801,963			$ 514,176	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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: 04/01/2015 Ending: 03/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 647,751	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.)		$ 427,240	2
3. Under or (over) accrual (line 2 minus line 1).		$ (220,511)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 485,846	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.		$ 265,335	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	462,459	10
2014	512,216	11
2015	427,240	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenfields of Geneva COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0050286

CONTACT PERSON REGARDING THIS REPORT

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 2015 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 2015.

	(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	$ 394,205.34	$ 25,692.76
2.	11-12-127-001	Long Term Care Property	$ 33,034.86	$ 2,153.08
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 427,240.20	$ 27,845.84

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 04/01/2015 Ending: 03/31/2016

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? [ ] 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	Total Land	70,977	2005	$ 6,150,047	1
2	Non-Allowable	1,018,023	2005	(5,749,211)	2
3	TOTALS	1,089,000		$ 400,836	3

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2015 Ending: 03/31/2016

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	$ 5,053,934	$ 126,348	40	$ 126,348	$	$ 512,707	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscape Filter to hide generator			2014	1,213	81	15	81		202	9
10	Guest Suite - GreenFields of Geneva			2015	156	31	5	31		78	10
11	Snow shoes for metal roof sections			2014	1,456	146	10	146		364	11
12	Combo Units construction			2016	11,614	774	15	774		1,936	12
13	Exterior and Interior Signage			2014	7,257	484	15	484		1,209	13
14	Apt 2106 Staged Quality Interiors			2016	163	23	7	23		58	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: 04/01/2015 Ending: 03/31/2016

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	$ 603,038	$ 74,380	$ 74,380	$	Var	$ 251,397	71
72	Current Year Purchases	11,340	990	990		Var	990	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 614,378	$ 75,370	$ 75,370	$		$ 252,387	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	$ 41,950	76
77		Van	2014	33,639	6,728	6,728		5	16,820	77
78										78
79										79
80	TOTALS			$ 93,567	$ 18,714	$ 18,714	$		$ 58,770	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)	$ 6,184,574	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 221,971	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 221,971	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)	$ 827,711	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	$ 80,286,947	$ 2,720,913	$ 10,571,766	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 80,286,947	$ 2,720,913	$ 10,571,766	91

G. Construction-in-Progress

	Description	Cost	
92	CIP GoG	$ 37,976	92
93			93
94			94
95		$ 37,976	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: 04/01/2015 Ending: 03/31/2016

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

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: ____ *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 82,805 Description: Various medical equipment items.
(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	$ #######	$ 12,260	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 12,260	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: 04/01/2015 Ending: 03/31/2016

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.

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	$	5,394	$ 289,152	$	5,394	$ 289,152	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,300	124,779		2,300	124,779	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		7,260	389,710		7,260	389,710	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			$	14,954	$ 803,641	$	14,954	$ 803,641	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 **#** 0050286 **Report Period Beginning:** 04/01/2015 **Ending:** 03/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2016 **(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	$ 771,504	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,423,209		3
4	Supply Inventory (priced at cost)	21,803		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,762		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,234,278	$	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	77,542,778		14
15	Leasehold Improvements, at Historical Cost	540,684		15
16	Equipment, at Historical Cost	8,025,198		16
17	Accumulated Depreciation (book methods)	(11,399,477)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,300,838		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	9,868,584		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 101,028,652	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 103,262,930	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,402,984	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,357		30
31	Accrued Taxes Payable (excluding real estate taxes)	721		31
32	Accrued Real Estate Taxes(Sch.IX-B)	485,846		32
33	Accrued Interest Payable	947,207		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)**	$ 4,081,115	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,025,024		39
40	Mortgage Payable			40
41	Bonds Payable	96,801,963		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	49,416,584		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 155,243,571	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 159,324,686	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (56,061,756)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 103,262,930	$	48

***(See instructions.)**

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2015 Ending: 03/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (47,076,699)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (47,076,699)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,932,569)	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)**	$ (12,932,569)	17
	B. Transfers (Itemize):		
18	**Transfer Pledged Assets to Subsidiary**	3,947,512	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 3,947,512	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (56,061,756)	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	$ 5,918,716	1
2	Discounts and Allowances for all Levels	(403,237)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,515,479	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	67,510	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 67,510	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	106,463	14
15	Telephone, Television and Radio	78,390	15
16	Rental of Facility Space		16
17	Sale of Drugs	6	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	36,817	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 221,676	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	110,172	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 110,172	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL Revenue	9,647,515	28
28a	Other Revenue	2,523	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,650,038	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,564,875	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,154,590	31
32	Health Care	3,275,098	32
33	General Administration	4,912,651	33
	B. Capital Expense		
34	Ownership	11,432,675	34
	C. Ancillary Expense		
35	Special Cost Centers	3,658,170	35
36	Provider Participation Fee	64,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 28,497,444	40
41	**Income before Income Taxes (line 30 minus line 40)****	(12,932,569)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (12,932,569)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue	483,720	45
46	Medicare - Net Inpatient Revenue	4,620,934	46
47	Other-(specify) Hospice/Life Care	410,825	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,515,479	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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	1,392	1,625	$ 81,772	$ 50.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,407	28,973	1,074,517	37.09	3
4	Licensed Practical Nurses	107	107	3,412	31.89	4
5	CNAs & Orderlies	36,668	40,705	590,552	14.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,086	9,952	183,652	18.45	10
11	Social Service Workers	3,656	4,096	100,767	24.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	75,017	81,287	1,061,293	13.06	15
16	Dishwashers	6,917	7,337	81,246	11.07	16
17	Maintenance Workers	7,820	8,517	216,783	25.45	17
18	Housekeepers	27,557	29,725	376,988	12.68	18
19	Laundry	714	721	8,721	12.10	19
20	Administrator	1,877	2,188	103,555	47.33	20
21	Assistant Administrator					21
22	Other Administrative	16,324	17,924	728,523	40.65	22
23	Office Manager					23
24	Clerical	19,621	21,250	314,689	14.81	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	1,013	1,080	15,330	14.19	31
32	Other Health C: AL/IL	54,674	60,122	966,886	16.08	32
33	Other(specify) Marketing	976	1,000	25,940	25.94	33
34	TOTAL (lines 1 - 33)	289,826	316,609	$ 5,934,626 *	$ 18.74	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	20	1,283	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	20	$ 1,283		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	791	$ 44,293	10-3	50
51	Licensed Practical Nurses	237	11,256	10-3	51
52	Certified Nurse Assistants/Aides	995	24,780	10-3	52
53	TOTAL (lines 50 - 52)	2,023	$ 80,329		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynn Blackburn	Administrator of HC		$ 103,555
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,555

B. Administrative - Other

Description	Amount
Management Fees FSO	$ 1,588,688
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,588,688
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Geneva Chamber of Commerce	Membership	$ 320
MEPC	HVAC Engineering	63,595
CliftonLarsonAllen	Accounting	27,635
3rd Coast Imaging Inc	Digital Printing Services	1,238
Chicago Print Group Inc	Digital Printing Services	67
Duane Morris LLP	Legal Services	836,678
ADR Systems of America	Legal Services	3,300
American Arbitration Association	Legal Services	54,250
Magna Legal Services	Legal Services	3,997
Stahl Cowen Crowley Addis LLC	Legal Services	13,240
Cramer, Cary	Legal Services	1,873
Smith, Hemmesch, Burke, Etal	Legal Services	7,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,013,693

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	410,526
Employee Health Insurance	130,737
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Recruitment	41,007
Employee Programs	6,640
Transfer from Corporate	925,316
Physicals	17,397
Less: Non-Reimbursable Benefits	(1,108,411)
TOTAL (agree to Schedule V, line 22, col.8)	$ 423,212

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 150	1,500
Subscriptions and Publications	9,863
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,363

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,227
Seminar Expense	6,764
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,991

* Attach copy of IMRF notifications

**See instructions.

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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 $40,198 CARF $8,700**

(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 Year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,710** Line **10-2**

(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. $ **64,260**
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. $ **1,298**

(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. $ **N/A**
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**

(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