

		FOR BHF USE					

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**2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)**

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.

<p>I. IDPH License ID Number: <u>0050286</u></p> <p>Facility Name: <u>Greenfields of Geneva</u></p> <p>Address: <u>0N801 Friendship Way</u> <u>Geneva</u> <u>60134</u> <small>Number City Zip Code</small></p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(630)232-9105</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/28/2013</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Deb Freeland</u> Telephone Number: <u>(317)574-9100</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/1/2016</u> to <u>3/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Jeff Nyberg</u> (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>Deb Freeland</u> <u>Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>9365 Counselors Row, Suite 200, Indianapolis, IN 46240</u> (Telephone) <u>(317)574-9100</u> Fax # <u>(317)574-9707</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jeff Nyberg</u> (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Deb Freeland</u> <u>Principal</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>9365 Counselors Row, Suite 200, Indianapolis, IN 46240</u> (Telephone) <u>(317)574-9100</u> Fax # <u>(317)574-9707</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number Greenfields of Geneva

0050286 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	0	6,036	7,967	14,003	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		6,036	7,967	14,003	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.22%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/28/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 43 and days of care provided 7,967

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 3/31/2017 Fiscal Year: 3/31/2017

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

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	1,432,783	99,958	182,783	1,715,524		1,715,524	(1,170,774)	544,750		1
2	Food Purchase		992,964		992,964		992,964	(678,554)	314,410		2
3	Housekeeping	400,906	53,696	33,750	488,352		488,352	(456,523)	31,829		3
4	Laundry										4
5	Heat and Other Utilities			558,928	558,928		558,928	(522,499)	36,429		5
6	Maintenance	553,855	43,570	1,706,657	2,304,082		2,304,082	(2,153,911)	150,171		6
7	Other (specify):*										7
8	TOTAL General Services	2,387,544	1,190,188	2,482,118	6,059,850		6,059,850	(4,982,261)	1,077,589		8
	B. Health Care and Programs										
9	Medical Director			19,250	19,250		19,250		19,250		9
10	Nursing and Medical Records	2,066,316	101,459	183,748	2,351,523		2,351,523		2,351,523		10
10a	Therapy			735,080	735,080		735,080		735,080		10a
11	Activities	157,924	747	13,887	172,558		172,558		172,558		11
12	Social Services	53,127			53,127		53,127		53,127		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,277,367	102,206	951,965	3,331,538		3,331,538		3,331,538		16
	C. General Administration										
17	Administrative		6,924	2,678,724	2,685,648	97,285	2,782,933	(2,781,035)	1,898		17
18	Directors Fees										18
19	Professional Services			1,484,256	1,484,256		1,484,256		1,484,256		19
20	Dues, Fees, Subscriptions & Promotions			14,945	14,945		14,945		14,945		20
21	Clerical & General Office Expenses	172,168	88	243,348	415,604	(97,285)	318,319	(367,767)	(49,448)		21
22	Employee Benefits & Payroll Taxes			1,628,912	1,628,912		1,628,912	(1,140,238)	488,674		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,331	17,331		17,331		17,331		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			311,209	311,209		311,209		311,209		26
27	Other (specify):*										27
28	TOTAL General Administration	172,168	7,012	6,378,725	6,557,905		6,557,905	(4,289,040)	2,268,865		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,837,079	1,299,406	9,812,808	15,949,293		15,949,293	(9,271,301)	6,677,992		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:

4/1/2016

Ending:

3/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			2,905,842	2,905,842		2,905,842	(2,687,544)	218,298			30
31	Amortization of Pre-Op. & Org.			138,150	138,150		138,150	(96,340)	41,810			31
32	Interest			7,857,503	7,857,503		7,857,503	(7,451,904)	405,599			32
33	Real Estate Taxes			371,166	371,166		371,166	(346,975)	24,191			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,216	49,216		49,216		49,216			35
36	Other (specify):*											36
37	TOTAL Ownership			11,321,877	11,321,877		11,321,877	(10,582,763)	739,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			364,522	364,522		364,522		364,522			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,885	59,885		59,885		59,885			42
43	Other (specify):* AL/IL/Marketing	832,711	69	1,446,503	2,279,283		2,279,283	(2,279,283)				43
44	TOTAL Special Cost Centers	832,711	69	1,870,910	2,703,690		2,703,690	(2,279,283)	424,407			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,669,790	1,299,475	23,005,595	29,974,860		29,974,860	(22,133,347)	7,841,513			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(897)	02		4
5	Telephone, TV & Radio in Resident Rooms	(76,844)	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	(106,522)	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	(7,345,382)	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	(96,906)	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	(14,805,977)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,432,528)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	299,181		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 299,181		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (22,133,347)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Greenfields of Geneva

ID# 0050286

Report Period Beginning: 4/1/2016

Ending: 3/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Assisted Living/Independent Living	\$ (1,055,742)	43	1
2	Marketing Expenses	(1,223,541)	43	2
3	Amortization of Bond Costs	(96,340)	31	3
4	Misc. Income	(1,103,356)	17	4
5	Real Estate Taxes	(346,975)	33	5
6	Depreciation	(2,687,544)	30	6
7	Dietary	(1,170,774)	1	7
8	Food Purchase	(677,657)	2	8
9	Housekeeping	(456,523)	3	9
10	Heat & Utilities	(522,499)	5	10
11	Maintenance	(2,153,911)	6	11
12	Administrative	(1,879,954)	17	12
13	Clerical & General	(290,923)	21	13
14	Employee Benefits	(1,140,238)	22	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,805,977)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
1	Dietary	(1,170,774)	0	0	0	0	0	0	0	0	0	0	(1,170,774) 1
2	Food Purchase	(678,554)	0	0	0	0	0	0	0	0	0	0	(678,554) 2
3	Housekeeping	(456,523)	0	0	0	0	0	0	0	0	0	0	(456,523) 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	(522,499)	0	0	0	0	0	0	0	0	0	0	(522,499) 5
6	Maintenance	(2,153,911)	0	0	0	0	0	0	0	0	0	0	(2,153,911) 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(4,982,261)	0	0	0	0	0	0	0	0	0	0	(4,982,261) 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	(3,080,216)	299,181	0	0	0	0	0	0	0	0	0	(2,781,035) 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	(367,767)	0	0	0	0	0	0	0	0	0	0	(367,767) 21
22	Employee Benefits & Payroll Taxes	(1,140,238)	0	0	0	0	0	0	0	0	0	0	(1,140,238) 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	(4,588,221)	299,181	0	0	0	0	0	0	0	0	0	(4,289,040) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,570,482)	299,181	0	0	0	0	0	0	0	0	0	(9,271,301) 29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenfields of Geneva# 0050286

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,687,544)	0	0	0	0	0	0	0	0	0	0	(2,687,544)	30
31	Amortization of Pre-Op. & Org.	(96,340)	0	0	0	0	0	0	0	0	0	0	(96,340)	31
32	Interest	(7,451,904)	0	0	0	0	0	0	0	0	0	0	(7,451,904)	32
33	Real Estate Taxes	(346,975)	0	0	0	0	0	0	0	0	0	0	(346,975)	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	(10,582,763)	0	0	0	0	0	0	0	0	0	0	(10,582,763)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,279,283)	0	0	0	0	0	0	0	0	0	0	(2,279,283)	43
44	TOTAL Special Cost Centers	(2,279,283)	0	0	0	0	0	0	0	0	0	0	(2,279,283)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,432,528)	299,181	0	0	0	0	0	0	0	0	0	(22,133,347)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Friendship Senior Options NFP				Board of Directors - see Page 6 Supplemental		Governance

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 2,554,632	Friendship Village Executive/Corporate Allocation		\$ 2,853,813	\$ 299,181	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		\$ 2,554,632			\$ 2,853,813	\$ * 299,181	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:

4/1/2016

Ending:

3/31/2017

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					Larry Shoemake		Board Chair	2
3					Geoff Roehll		Board Vice Chair	3
4					Clark Delanois		Board Secretary	4
5					Duane Tyler		Board Treasurer	5
6					Jean Schlinkmann		Board Past Chair	6
7					Jan Tucker		Board Member	7
8					Tom Castronovo		Board Member	8
9					Kathy Gilmer		Board Member	9
10					Cathie Tardy		Board Member	10
11					Brad Barrie		Board Member	11
12					Bill Powell		Board Member	12
13					Stephen Yenchek		Board Member	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:

4/1/2016

Ending:

3/31/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Larry Shoemake	Chair							\$ 0	1
2	Geoff Roehll	Vice Chair							0	2
3	Clark Delanois	Secretary							0	3
4	Duane Tyler	Treasurer							0	4
5	Jean Schlinkmann	Past Chair							0	5
6	Jan Tucker	Director							0	6
7	Tom Castronovo	Director							0	7
8	Kathy Gilmer	Director							0	8
9	Cathie Tardy	Director							0	9
10	Brad Barrie	Director							0	10
11	Bill Powell	Director							0	11
12	Stephen Yenchek	Director							0	12
13								TOTAL	\$ 0	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:

4/1/2016

Ending: 3/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Friendship Senior Options
 Street Address 350 W. Schaumburg Road
 City / State / Zip Code Schaumburg, IL 60194
 Phone Number (847) 490-6274
 Fax Number ()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	33	Real Estate Taxes	Square Feet	208,374	2	\$ 371,166	\$ 0	13,581	\$ 24,191	1
2	30	Depreciation Expense	Direct Cost	2,905,842	2	2,905,842	0	218,298	218,298	2
3	1	Dietary	Meals	131,293	2	1,715,524	1,432,783	41,691	544,750	3
4	2	Food Purchase	Meals	131,293	2	992,964	0	41,691	315,307	4
5	3	Housekeeping	Square Feet	208,374	2	488,352	400,906	13,581	31,829	5
6	5	Heat & Utilities	Square Feet	208,374	2	558,928	0	13,581	36,429	6
7	6	Maintenance	Square Feet	208,374	2	2,304,082	553,855	13,581	150,171	7
8	17	Administrative	Employee Ratio	140	2	2,685,648	0	42	805,694	8
9	21	Clerical & General	Employee Ratio	140	2	415,604	172,168	42	124,681	9
10	22	Employee Benefits	Employee Ratio	140	2	1,628,912	0	42	488,674	10
11	32	Interest	Square Feet	208,374	2	7,857,503	0	13,581	512,121	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					\$ 21,924,525	\$ 2,559,712		\$ 3,252,145	25

Facility Name & ID Number

Greenfields of Geneva

0050286

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Revenue Bond Series 2010		X	Bond Issuance			\$ 117,600,000	\$ 96,843,774		Variable	\$ 7,857,503	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 117,600,000	\$ 96,843,774			\$ 7,857,503	9						
B. Non-Facility Related*																		
10	Investment Income											10						
11	Non-Allowable Interest										(7,451,904)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (7,451,904)	14						
15	TOTALS (line 9+line14)						\$ 117,600,000	\$ 96,843,774			\$ 405,599	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.

\$ **485,846** 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.)

\$ **386,743** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(99,103)** 3

4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **470,269** 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.

\$ **371,166** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2012		8
2013	462,459	9
2014	512,216	10
2015	427,240	11
2016	374,343	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-12-102-002</u>	<u>Long Term Care Property</u>	\$ <u>342,608.08</u>	\$ <u>22,329.85</u>
2. <u>11-12-127-001</u>	<u>Long Term Care Property</u>	\$ <u>31,735.20</u>	\$ <u>2,068.38</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>374,343.28</u></u>	\$ <u><u>24,398.23</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

4/1/2016 Ending:

3/31/2017

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Independent Living - 156,590 - 147 units

Assisted Living - 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: 1,355,738 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	<u>Total Land</u>	<u>70,977</u>	<u>2005</u>	<u>\$ 6,150,047</u>	<u>1</u>
2	<u>Non-Allowable</u>	<u>1,018,023</u>	<u>2005</u>	<u>(5,749,211)</u>	<u>2</u>
3	TOTALS	1,089,000		\$ 400,836	3

Facility Name & ID Number Greenfields of Geneva

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	43			2012	\$ 5,053,934	\$ 126,348	40	\$ 126,348	\$	\$ 639,056
5										
6										
7										
8										
	Improvement Type**									
9		Landscape Filter to hide generator		2014	1,213	81	15	81		283
10		Guest Suite - GreenFields of Geneva		2015	156	146	5	146		510
11		Snow shoes for metal roof sections		2014	1,456	774	10	774		2,710
12										
13		Exterior and Interior Signage		2014	7,257	23	15	23		81
14		Apt 2106 Staged Quality Interiors		2016	163	31	7	31		109
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

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	\$ 614,060	\$ 72,164	\$ 72,164	\$	Various	\$ 324,233	71
72	Current Year Purchases	238	17	17		Various	17	72
73	Fully Depreciated Assets	318					318	73
74								74
75	TOTALS	\$ 614,616	\$ 72,181	\$ 72,181	\$		\$ 324,568	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	\$ 53,935	76
77		Van	2014	33,639	6,728	6,728		5	23,548	77
78										78
79										79
80	TOTALS			\$ 93,567	\$ 18,714	\$ 18,714	\$		\$ 77,483	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)	\$ 6,173,198	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,298	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,298	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)	\$ 1,044,800	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	\$ 80,411,008	\$ 2,689,390	\$ 13,262,365	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 80,411,008	\$ 2,689,390	\$ 13,262,365	91

G. Construction-in-Progress

	Description	Cost	
92	CIP GoG	\$ 1,014	92
93			93
94			94
95		\$ 1,014	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: 4/1/2016

Ending: 3/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 49,216 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		<u>2012 Ford E450</u>	\$ <u>939.00</u>	\$ <u>8,596</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>939.00</u>	\$ <u>8,596</u>	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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,656	\$ 284,705	\$	3,656	\$ 284,705	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,329	101,010		1,329	101,010	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,447	349,051		4,447	349,051	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			\$	9,432	\$ 734,766	\$	9,432	\$ 734,766	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
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0050286
 As of 3/31/2017

Report Period Beginning: 4/1/2016
 (last day of reporting year)

Ending: 3/31/2017

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,592,999	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>114,204</u>)	1,218,719		3
4	Supply Inventory (priced at <u>Cost</u>)	15,901		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	290,050		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,117,669	\$	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	599,464		15
16	Equipment, at Historical Cost	8,042,142		16
17	Accumulated Depreciation (book methods)	(14,305,318)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,574,297		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	8,512,846		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 89,116,256	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 93,233,925	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,229,958	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,620		30
31	Accrued Taxes Payable (excluding real estate taxes)	894		31
32	Accrued Real Estate Taxes(Sch.IX-B)	470,269		32
33	Accrued Interest Payable	2,256,789		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Reserve Expenses</u>	14,166		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,230,696	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,480,953		39
40	Mortgage Payable			40
41	Bonds Payable	96,843,774		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	48,537,238		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 155,861,965	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 163,092,661	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (69,858,736)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 93,233,925	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (56,061,756)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (56,061,756)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(13,796,983)	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) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (13,796,980)	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)	\$ (69,858,736)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning: 4/1/2016

Ending: 3/31/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,499,272	1
2	Discounts and Allowances for all Levels	(183,183)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,316,089	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,983	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 83,983	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	185,812	14
15	Telephone, Television and Radio	76,844	15
16	Rental of Facility Space		16
17	Sale of Drugs	1	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	61,526	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 324,183	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	35,596	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,596	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/IL Revenue</u>	9,314,670	28
28a	<u>Other Revenue</u>	1,103,356	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,418,026	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,177,877	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	6,059,850	31
32	Health Care	3,331,538	32
33	General Administration	6,557,905	33
B. Capital Expense			
34	Ownership	11,321,877	34
C. Ancillary Expense			
35	Special Cost Centers	2,643,805	35
36	Provider Participation Fee	59,885	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 29,974,860	40
41	Income before Income Taxes (line 30 minus line 40)**	(13,796,983)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (13,796,983)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	771,147	45
46	Medicare - Net Inpatient Revenue	4,094,982	46
47	Other-(specify) <u>Hospice/Life Care</u>	449,960	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,316,089	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.

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning:

4/1/2016

Ending:

3/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,912	2,160	\$ 109,162	\$ 50.54	1
2	Assistant Director of Nursing	1,992	2,149	97,504	45.37	2
3	Registered Nurses	26,926	29,155	1,083,365	37.16	3
4	Licensed Practical Nurses	5,205	5,692	164,671	28.93	4
5	CNAs & Orderlies	52,291	55,448	659,960	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,620	12,501	194,701	15.57	10
11	Social Service Workers	3,864	4,320	103,180	23.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,112	2,288	45,761	20.00	14
15	Cook Helpers/Assistants	65,387	69,941	894,474	12.79	15
16	Dishwashers	4,556	4,970	54,802	11.03	16
17	Maintenance Workers	9,504	10,445	260,044	24.90	17
18	Housekeepers	28,348	30,936	393,346	12.71	18
19	Laundry	3,401	3,740	44,142	11.80	19
20	Administrator	1,832	2,160	97,285	45.04	20
21	Assistant Administrator					21
22	Other Administrative	4,200	4,843	217,715	44.95	22
23	Office Manager	1,896	2,160	207,720	96.17	23
24	Clerical	22,819	24,513	361,030	14.73	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	1,954	2,127	32,558	15.31	31
32	Other Health C: <u>AL/IL/Home</u>	45,300	48,384	648,370	13.40	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	295,119	317,932	\$ 5,669,790 *	\$ 17.83	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	19,250	9-3	36
37	Medical Records Consultant	12	733	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	4,447	349,051	10a-3	40
41	Occupational Therapy Consultant	3,656	284,705	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,329	101,010	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9,444	\$ 754,749		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	678	\$ 35,967	10-3	50
51	Licensed Practical Nurses	218	11,150	10-3	51
52	Certified Nurse Assistants/Aides	2,452	61,722	10-3	52
53	TOTAL (lines 50 - 52)	3,348	\$ 108,839		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Lynn Blackburn</u>	<u>Administrator of HC</u>		\$ <u>97,285</u>	<u>Workers' Compensation Insurance</u>	\$	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>395,720</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>181,444</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>365</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Subscriptions and Publications</u>	<u>11,295</u>	
				<u>Recruitment</u>	<u>21,767</u>			
				<u>Employee Programs</u>	<u>7,498</u>			
				<u>Transfer from Corporate</u>	<u>1,008,654</u>			
				<u>Physicals</u>	<u>13,829</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 97,285	TOTAL (agree to Schedule V, line 22, col.8)		\$ 488,674		
(List each licensed administrator separately.)						Less: Public Relations Expense ()		
						Non-allowable advertising ()		
						Yellow page advertising ()		
						TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 14,945		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees FSO</u>			\$ <u>2,678,724</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	<u>6,408</u>
							<u>Seminar Expense</u>	<u>10,923</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,678,724	TOTAL			\$	
(Attach a copy of any management service agreement)							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							\$ 17,331	
C. Professional Services			Amount					
Vendor/Payee	Type							
<u>MEPC</u>	<u>HVAC Engineering</u>		<u>11,234</u>					
<u>CliftonLarsonAllen LLP</u>	<u>Accounting</u>		<u>19,330</u>					
<u>Raths, Raths & Johnson Inc.</u>	<u>Mold Remediation</u>		<u>4,480</u>					
<u>3rd Coast Imaging Inc</u>	<u>Reverse Pmt - Digital Print</u>		<u>(1,238)</u>					
<u>Chicago Print Group Inc</u>	<u>Reverse Pmt - Digital Print</u>		<u>(67)</u>					
<u>UMB Bank</u>	<u>Trustee Activity/Legal</u>		<u>662,581</u>					
<u>Solic Capital Advisors</u>	<u>Restructure Services</u>		<u>78,966</u>					
<u>Duane Morris LLP</u>	<u>Legal Services</u>		<u>383,926</u>					
<u>Stahl Cowen Crowley Addis LLC</u>	<u>Legal Services</u>		<u>252,895</u>					
<u>American Arbitration Association</u>	<u>Legal Services</u>		<u>38,384</u>					
<u>ADR Systems of America</u>	<u>Legal Services</u>		<u>3,900</u>					
<u>See Attached Schedule</u>	<u>Legal Services</u>		<u>29,865</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,484,256					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

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 \$42,427, CARF \$8,750
- (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. \$ 16,892 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. \$ 59,885
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. \$ 897
- (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? No
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