FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

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 4/1/2017 to 3/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Jeff Nyberg
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Deb Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen, LLP, 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: 4/1/2017 Ending: 3/31/2018

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	8,817	5,780	14,597	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		8,817	5,780	14,597	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.00%

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 [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 5,780

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: 3/31/2018 Fiscal Year: 3/31/2018

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

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

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	980,427	131,159	718,524	1,830,110		1,830,110	(1,222,731)	607,379			1
2	Food Purchase		1,024,238		1,024,238		1,024,238	(690,913)	333,325			2
3	Housekeeping	416,498	52,323	21,212	490,033		490,033	(458,095)	31,938			3
4	Laundry											4
5	Heat and Other Utilities			504,520	504,520		504,520	(471,637)	32,883			5
6	Maintenance	538,857	28,875	1,054,141	1,621,873		1,621,873	(1,516,166)	105,707			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,935,782	1,236,595	2,298,397	5,470,774		5,470,774	(4,359,542)	1,111,232			8
	B. Health Care and Programs											
9	Medical Director			25,009	25,009		25,009		25,009			9
10	Nursing and Medical Records	2,193,606	103,947	211,978	2,509,531		2,509,531		2,509,531			10
10a	Therapy			658,508	658,508		658,508		658,508			10a
11	Activities	142,057	2,623	9,853	154,533		154,533		154,533			11
12	Social Services	68,728			68,728		68,728		68,728			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,404,391	106,570	905,348	3,416,309		3,416,309		3,416,309			16
	C. General Administration											
17	Administrative		3,690	671,823	675,513		675,513	(924,981)	(249,468)			17
18	Directors Fees											18
19	Professional Services			1,299,634	1,299,634		1,299,634		1,299,634			19
20	Dues, Fees, Subscriptions & Promotions			15,781	15,781		15,781		15,781			20
21	Clerical & General Office Expenses	177,763	187	289,997	467,947		467,947	(398,639)	69,308			21
22	Employee Benefits & Payroll Taxes			1,856,205	1,856,205		1,856,205	(1,295,337)	560,868			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,013	16,013		16,013		16,013			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			346,059	346,059		346,059		346,059			26
27	Other (specify):*											27
28	**TOTAL General Administration**	177,763	3,877	4,495,512	4,677,152		4,677,152	(2,618,957)	2,058,195			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,517,936	1,347,042	7,699,257	13,564,235		13,564,235	(6,978,499)	6,585,736			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: 4/1/2017 Ending: 3/31/2018

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			2,751,559	2,751,559		2,751,559	(2,559,259)	192,300			30
31	Amortization of Pre-Op. & Org.			146,159	146,159		146,159	(115,352)	30,807			31
32	Interest			2,106,098	2,106,098		2,106,098	(1,968,831)	137,267			32
33	Real Estate Taxes			384,045	384,045		384,045	(359,014)	25,031			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,911	60,911		60,911		60,911			35
36	Other (specify):*			(51,781,611)	(51,781,611)		(51,781,611)	51,781,611				36
37	**TOTAL Ownership**			(46,332,839)	(46,332,839)		(46,332,839)	46,779,155	446,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			385,355	385,355		385,355		385,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,593	69,593		69,593		69,593			42
43	Other (specify):* AL/IL/Marketing	1,156,871	5,620	2,038,296	3,200,787		3,200,787	(3,200,737)	50			43
44	**TOTAL Special Cost Centers**	1,156,871	5,620	2,493,244	3,655,735		3,655,735	(3,200,737)	454,998			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,674,807	1,352,662	(36,140,338)	(29,112,869)		(29,112,869)	36,599,919	7,487,050			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: 4/1/2017 Ending: 3/31/2018

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	(6,600)	02		4
5	Telephone, TV & Radio in Resident Rooms	(72,086)	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				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	(1,968,831)	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	(114,874)	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	37,344,719			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 35,182,328		$	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)	1,417,591		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,417,591		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 36,599,919		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: 4/1/2017

Ending: 3/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted Living/Independent Living	$ (1,135,338)	43	1
2	Marketing Expenses	(2,065,399)	43	2
3	Amortization of Bond Costs	(115,352)	31	3
4	Misc. Income	(1,756,297)	17	4
5	Real Estate Taxes	(359,014)	33	5
6	Depreciation	(2,559,259)	30	6
7	Dietary	(1,222,731)	1	7
8	Food Purchase	(684,313)	2	8
9	Housekeeping	(458,095)	3	9
10	Heat & Utilities	(471,637)	5	10
11	Maintenance	(1,516,166)	6	11
12	Administrative	(471,401)	17	12
13	Clerical & General	(326,553)	21	13
14	Employee Benefits	(1,295,337)	22	14
15	Gain on Settlement of Note to Affiliate	4,000,000	36	15
16	Gain on Emergence from Bankruptcy	41,074,932	36	16
17	Gain on Settlement Interco to Affiliate	6,706,679	36	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**	37,344,719		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

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	(1,222,731)	0	0	0	0	0	0	0	0	0	0	(1,222,731)	1
2	Food Purchase	(690,913)	0	0	0	0	0	0	0	0	0	0	(690,913)	2
3	Housekeeping	(458,095)	0	0	0	0	0	0	0	0	0	0	(458,095)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(471,637)	0	0	0	0	0	0	0	0	0	0	(471,637)	5
6	Maintenance	(1,516,166)	0	0	0	0	0	0	0	0	0	0	(1,516,166)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,359,542)	0	0	0	0	0	0	0	0	0	0	(4,359,542)	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	(2,342,572)	1,417,591	0	0	0	0	0	0	0	0	0	(924,981)	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	(398,639)	0	0	0	0	0	0	0	0	0	0	(398,639)	21
22	Employee Benefits & Payroll Taxes	(1,295,337)	0	0	0	0	0	0	0	0	0	0	(1,295,337)	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	(4,036,548)	1,417,591	0	0	0	0	0	0	0	0	0	(2,618,957)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,396,090)	1,417,591	0	0	0	0	0	0	0	0	0	(6,978,499)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

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	(2,559,259)	0	0	0	0	0	0	0	0	0	0	(2,559,259)	30
31	Amortization of Pre-Op. & Org.	(115,352)	0	0	0	0	0	0	0	0	0	0	(115,352)	31
32	Interest	(1,968,831)	0	0	0	0	0	0	0	0	0	0	(1,968,831)	32
33	Real Estate Taxes	(359,014)	0	0	0	0	0	0	0	0	0	0	(359,014)	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):*	51,781,611	0	0	0	0	0	0	0	0	0	0	51,781,611	36
37	TOTAL Ownership	46,779,155	0	0	0	0	0	0	0	0	0	0	46,779,155	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):*	(3,200,737)	0	0	0	0	0	0	0	0	0	0	(3,200,737)	43
44	TOTAL Special Cost Centers	(3,200,737)	0	0	0	0	0	0	0	0	0	0	(3,200,737)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	35,182,328	1,417,591	0	0	0	0	0	0	0	0	0	36,599,919	45

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

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 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	$ 540,384	Friendship Village Executive/Corporate Allocation		$ 1,957,975	$ 1,417,591	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			$ 540,384			$ 1,957,975	$ * 1,417,591	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: 4/1/2017 Ending: 3/31/2018

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					Cathie Tardy		Board Chair	1
2					Geoff Roehll		Board Secretary	2
3					Tom Castronovo		Board Treasurer	3
4					Ron Ahlman		Board Member	4
5					Steve Smith		Board Member	5
6					Paul Schaffhausen		Board Member	6
7					Chuck Cassell		Board Member	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: 4/1/2017 Ending: 3/31/2018

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	Cathie Tardy	Chair							$ 0		1
2	Geoff Roehll	Secretary							0		2
3	Tom Castronovo	Treasurer							0		3
4	Ron Ahlman	Director							0		4
5	Steve Smith	Director							0		5
6	Paul Schaffhausen	Director							0		6
7	Chuck Cassell	Director							0		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: 4/1/2017 Ending: 3/31/2018

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 Senior 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	$ 384,045	$ 0	13,581	$ 25,031	1
2	30	Depreciation Expense	Direct Cost	2,751,559	2	2,751,559	0	192,300	192,300	2
3	1	Dietary	Meals	132,689	2	1,830,110	980,427	44,037	607,379	3
4	2	Food Purchase	Meals	132,689	2	1,024,238	0	44,037	339,925	4
5	3	Housekeeping	Square Feet	208,374	2	490,033	416,498	13,581	31,938	5
6	5	Heat & Utilities	Square Feet	208,374	2	504,520	0	13,581	32,883	6
7	6	Maintenance	Square Feet	208,374	2	1,621,873	538,857	13,581	105,707	7
8	17	Administrative	Employee Ratio	139	2	675,513	0	42	204,112	8
9	21	Clerical & General	Employee Ratio	139	2	467,947	177,763	42	141,394	9
10	22	Employee Benefits	Employee Ratio	139	2	1,856,205	0	42	560,868	10
11	32	Interest	Square Feet	208,374	2	2,106,098	0	13,581	137,267	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					$ 13,712,141	$ 2,113,545		$ 2,378,804	25

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Revenue Bond Series 2010		X	Bond Issuance			$ 117,600,000	$		Variable	$ 414,042	1
2	Revenue Bond Series 2017		X	Bond Issuance			65,000,000	65,000,000		Variable	1,692,056	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 182,600,000	$ 65,000,000			$ 2,106,098	9
	B. Non-Facility Related*											
10	Investment Income											10
11	Non-Allowable Interest										(1,968,831)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,968,831)	14
15	TOTALS (line 9+line14)						$ 182,600,000	$ 65,000,000			$ 137,267	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: 4/1/2017 Ending: 3/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	470,269	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.)	$	374,343	2
3. Under or (over) accrual (line 2 minus line 1).	$	(95,925)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	479,970	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.	$	384,045	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	462,459	8
	2014	512,216	9
	2015	427,240	10
	2016	374,343	11
	2017	382,066	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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	$ 349,722.18	$ 22,793.52
2.	11-12-127-001	Long Term Care Property	$ 32,343.48	$ 2,108.02
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 382,065.66	$ 24,901.54

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 4/1/2017 Ending: 3/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Independent Living - 156,590 - 147 units
Assisted Living - 38,203 - 77 units

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

1. Total Amount Incurred: 16,391,056
2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 1,374,956
4. Dates Incurred: 2005, 2014, 2018

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: 4/1/2017 Ending: 3/31/2018

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	$	$ 754,875	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscape Filter to hide generator			2014	1,213	81	15	81		357	9
10	Guest Suite - GreenFields of Geneva			2015	156	31	5	31		138	10
11	Snow shoes for metal roof sections			2014	1,456	146	10	146		643	11
12				2014							12
13	Exterior and Interior Signage			2014	7,257	484	15	484		2,137	13
14	Apt 2106 Staged Quality Interiors			2016	163	23	7	23		103	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: 4/1/2017 Ending: 3/31/2018

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	$ 499,591	$ 52,744	$ 52,744	$	Various	$ 265,547	71
72	Current Year Purchases	16,785	1,284	1,284		Various		72
73	Fully Depreciated Assets	73,288					73,288	73
74								74
75	TOTALS	$ 589,664	$ 54,028	$ 54,028	$		$ 338,835	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	2014	$ 33,639	$ 6,728	$ 6,728	$	5	$ 29,715	76
77		Van	2017	13,294	4,431	4,431		5	6,278	77
78										78
79										79
80	TOTALS			$ 46,933	$ 11,159	$ 11,159	$		$ 35,993	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)	$ 6,101,612	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,300	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,300	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)	$ 1,133,081	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	$ 86,486,372	$ 2,559,259	$ 15,925,642	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 86,486,372	$ 2,559,259	$ 15,925,642	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: 4/1/2017 Ending: 3/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 60,911 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

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		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	$	4,192	$ 236,048	$	4,192	$ 236,048	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,254	71,751		1,254	71,751	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,200	350,708		5,200	350,708	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			$	10,646	$ 658,508	$	10,646	$ 658,508	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: 4/1/2017 Ending: 3/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 3/31/2018 (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	$ 1,624,239	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,752)	2,618,878		3
4	Supply Inventory (priced at Cost)	27,650		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	54,736		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,325,503	$	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	664,835		15
16	Equipment, at Historical Cost	8,230,324		16
17	Accumulated Depreciation (book methods)	(17,058,723)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	289		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	20,144,019		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 95,673,569	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 99,999,072	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,836,853	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	330,704		30
31	Accrued Taxes Payable (excluding real estate taxes)	908		31
32	Accrued Real Estate Taxes(Sch.IX-B)	479,970		32
33	Accrued Interest Payable	1,692,056		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Reserve Expenses	19,937		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,360,428	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	863,933		39
40	Mortgage Payable			40
41	Bonds Payable	62,286,714		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	50,456,160		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 113,606,807	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 118,967,235	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (18,968,163)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 99,999,072	$	48

***(See instructions.)**

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (69,858,736)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (69,858,736)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	45,674,866	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	5,215,710	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)**	$ 50,890,573	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)**	$ (18,968,163)	24 *

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

Facility Name & ID Number GreenFields of Geneva # 0050286 Report Period Beginning: 4/1/2017 Ending: 3/31/2018

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	$ 5,614,812	1
2	Discounts and Allowances for all Levels	(43,739)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,571,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,048	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 99,048	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	79,471	14
15	Telephone, Television and Radio	72,086	15
16	Rental of Facility Space		16
17	Sale of Drugs	12	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	80,660	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 232,229	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(53,777)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (53,777)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**AL/IL Revenue**	8,957,127	28
28a	**Other Revenue**	1,756,297	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,713,424	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,561,997	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,470,774	31
32	Health Care	3,416,309	32
33	General Administration	4,677,152	33
	B. Capital Expense		
34	Ownership	(46,332,839)	34
	C. Ancillary Expense		
35	Special Cost Centers	3,586,142	35
36	Provider Participation Fee	69,593	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ (29,112,869)	40
41	**Income before Income Taxes (line 30 minus line 40)****	45,674,866	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 45,674,866	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue	1,394,036	45
46	Medicare - Net Inpatient Revenue	3,445,484	46
47	Other-(specify) **Hospice/Life Care**	731,553	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,571,073	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,856	2,080	$ 110,278	$ 53.02	1
2	Assistant Director of Nursing	1,904	2,080	98,383	47.30	2
3	Registered Nurses	27,513	29,221	1,122,400	38.41	3
4	Licensed Practical Nurses	328	328	9,830	29.97	4
5	CNAs & Orderlies	33,772	35,698	574,430	16.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,916	7,269	133,166	18.32	10
11	Social Service Workers	3,776	4,160	105,754	25.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,097	2,300	45,881	19.95	14
15	Cook Helpers/Assistants	66,817	70,182	927,958	13.22	15
16	Dishwashers	5,673	5,969	70,172	11.76	16
17	Maintenance Workers	7,330	8,141	225,878	27.75	17
18	Housekeepers	30,416	32,422	396,840	12.24	18
19	Laundry	3,096	3,304	44,199	13.38	19
20	Administrator	1,824	2,080	102,739	49.39	20
21	Assistant Administrator					21
22	Other Administrative	3,376	3,752	155,179	41.36	22
23	Office Manager	1,840	2,080	188,939	90.84	23
24	Clerical	19,497	20,247	193,765	9.57	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	1,914	2,090	34,802	16.65	31
32	Other Health C: AL/IL	52,973	56,221	1,134,214	20.17	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	272,918	289,624	$ 5,674,807 *	$ 19.59	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	Monthly	25,009	9-3	36
37	Medical Records Consultant	15	943	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,252	10-3	39
40	Physical Therapy Consultant	5,200	347,881	10a-3	40
41	Occupational Therapy Consultant	4,192	234,686	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,254	71,751	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)	10,660	$ 683,522		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	576	$ 32,873	10-3	50
51	Licensed Practical Nurses	326	18,350	10-3	51
52	Certified Nurse Assistants/Aides	3,492	90,744	10-3	52
53	TOTAL (lines 50 - 52)	4,394	$ 141,967		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Casey Pudwill	Administrator of HC		$ 102,739
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,739

B. Administrative - Other

Description	Amount
Management Fees FSO	$ 671,823
TOTAL (agree to Schedule V, line 17, col. 3)	$ 671,823
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Donlinc, Recano & Co	Case Management for Bankr	$ 77,564
CliftonLarsonAllen LLP	Accounting	7,689
UMB Bank	Trustee activity/Legal	666,179
Solic Capital Advisors	Case Management for Bankrupt	68,208
Illinois Finance Authority	Application Fee for bond financi	1,000
ECS Midwest LLC	Phase I Environmental Site Asse	2,400
Globic Advisors Inc	Illinois Finance Authority Reven	50,862
Miller Advertising	New bond advertising	1,543
Duane Morris LLP	Legal Services	66,458
Stahl Cowen Crowley Addis LLC	Legal Services	304,106
U.S. Trustee Payment Center	Legal Services	51,125
Trustee Collateral Fees	Legal Services	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,299,634

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	397,759
Employee Health Insurance	175,893
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Recruitment	20,470
Employee Programs	4,771
Transfer from Corporate	1,242,883
Physicals	14,429
Less: Non-Reimbursable Benefits	(1,295,337)
TOTAL (agree to Schedule V, line 22, col.8)	$ 560,868

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 231	2,310
Subscriptions and Publications	13,471
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,781

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,723
Seminar Expense	11,290
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,013

* 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 $49,026, CARF $8,800, IASN $1,304**

(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. $ **24,755** 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. $ **69,593**
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. $ **6,600**

(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?
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