

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0050286

Facility Name: Greenfields of Geneva

Address: ON801 Friendship Way Geneva 60134
 Number City Zip Code

County: Kane

Telephone Number: (630) 232-9105 **Fax #** (847) 884-5718

HFS ID Number: _____

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Deborah Emerson **Telephone Number:** (317) 574-9100
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2019 to 03/31/2020 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) <u>Jeff Nyberg</u>	
	(Title) <u>Controller</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Deborah Emerson</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>	

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

Facility Name & ID Number Greenfields of Geneva

0050286 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	15,738	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	15,738	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	366	6,678	7,219	14,263	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	366	6,678	7,219	14,263	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.63%

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 6,182

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 03/31/20 Fiscal Year: 03/31/20

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

Facility Name & ID Number Greenfields of Geneva # 0050286 Report Period Beginning: 04/01/2019 Ending: 03/31/2020

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	1,101,831	134,859	710,164	1,946,854		1,946,854	(1,469,806)	477,048		1
2	Food Purchase		1,077,799		1,077,799		1,077,799	(820,169)	257,630		2
3	Housekeeping	455,140	52,523	21,422	529,085		529,085	(494,601)	34,484		3
4	Laundry										4
5	Heat and Other Utilities			585,609	585,609		585,609	(547,441)	38,168		5
6	Maintenance	609,852	67,057	1,669,236	2,346,145		2,346,145	(2,193,232)	152,913		6
7	Other (specify):*										7
8	TOTAL General Services	2,166,823	1,332,238	2,986,431	6,485,492		6,485,492	(5,525,249)	960,243		8
	B. Health Care and Programs										
9	Medical Director			27,500	27,500		27,500		27,500		9
10	Nursing and Medical Records	2,445,633	105,615	105,179	2,656,427		2,656,427		2,656,427		10
10a	Therapy			666,002	666,002		666,002		666,002		10a
11	Activities	116,978	3,616	8,534	129,128		129,128		129,128		11
12	Social Services	30,897			30,897		30,897		30,897		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,593,508	109,231	807,215	3,509,954		3,509,954		3,509,954		16
	C. General Administration										
17	Administrative		12,829	698,592	711,421		711,421	976,475	1,687,896		17
18	Directors Fees										18
19	Professional Services			2,307	2,307		2,307		2,307		19
20	Dues, Fees, Subscriptions & Promotions			52,703	52,703		52,703		52,703		20
21	Clerical & General Office Expenses	222,080		334,193	556,273		556,273	(401,343)	154,930		21
22	Employee Benefits & Payroll Taxes			2,004,643	2,004,643		2,004,643	(1,431,888)	572,755		22
23	Inservice Training & Education										23
24	Travel and Seminar			28,218	28,218		28,218		28,218		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			399,390	399,390		399,390		399,390		26
27	Other (specify):*			19,028	19,028		19,028		19,028		27
28	TOTAL General Administration	222,080	12,829	3,539,074	3,773,983		3,773,983	(856,756)	2,917,227		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,982,411	1,454,298	7,332,720	13,769,429		13,769,429	(6,382,005)	7,387,424		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			2,502,643	2,502,643		2,502,643	(2,325,129)	177,514		30
31	Amortization of Pre-Op. & Org.			112,176	112,176		112,176	(112,176)			31
32	Interest			4,533,923	4,533,923		4,533,923	(4,238,420)	295,503		32
33	Real Estate Taxes			386,591	386,591		386,591	(361,395)	25,196		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			45,451	45,451		45,451		45,451		35
36	Other (specify):*										36
37	TOTAL Ownership			7,580,784	7,580,784		7,580,784	(7,037,120)	543,664		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		281,832	79,499	361,331		361,331		361,331		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			70,261	70,261		70,261		70,261		42
43	Other (specify):*	1,616,996	6,526	1,159,114	2,782,636		2,782,636	(2,782,636)			43
44	TOTAL Special Cost Centers	1,616,996	288,358	1,308,874	3,214,228		3,214,228	(2,782,636)	431,592		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,599,407	1,742,656	16,222,378	24,564,441		24,564,441	(16,201,761)	8,362,680		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	(6,469)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,005)	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	(4,238,420)	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	(19,028)	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 PG5A	(13,442,070)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,709,992)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	1,508,231		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,508,231		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (16,201,761)		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

Greenfields of Geneva

ID# 0050286

Report Period Beginning: 04/01/2019

Ending: 03/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Assisted Living/Independent Living	\$ (1,451,056)	43	1
2	Marketing Expenses	(1,331,580)	43	2
3	Amortization of Bond Costs	(112,176)	31	3
4	Misc. Income	(4,570)	17	4
5	Real Estate Taxes	(361,395)	33	5
6	Depreciation	(2,325,129)	30	6
7	Dietary	(1,469,806)	1	7
8	Food Purchase	(813,700)	2	8
9	Housekeeping	(494,601)	3	9
10	Heat & Utilities	(547,441)	5	10
11	Maintenance	(2,193,232)	6	11
12	Administrative	(508,158)	17	12
13	Clerical & General	(397,338)	21	13
14	Employee Benefits	(1,431,888)	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	(13,442,070)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenfields of Geneva# 0050286

Report Period Beginning:

04/01/2019

Ending:

03/31/2020

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	(1,469,806)	0	0	0	0	0	0	0	0	0	0	(1,469,806)	1
2	Food Purchase	(820,169)	0	0	0	0	0	0	0	0	0	0	(820,169)	2
3	Housekeeping	(494,601)	0	0	0	0	0	0	0	0	0	0	(494,601)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(547,441)	0	0	0	0	0	0	0	0	0	0	(547,441)	5
6	Maintenance	(2,193,232)	0	0	0	0	0	0	0	0	0	0	(2,193,232)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,525,249)	0	0	0	0	0	0	0	0	0	0	(5,525,249)	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	(531,756)	1,508,231	0	0	0	0	0	0	0	0	0	976,475	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	(401,343)	0	0	0	0	0	0	0	0	0	0	(401,343)	21
22	Employee Benefits & Payroll Taxes	(1,431,888)	0	0	0	0	0	0	0	0	0	0	(1,431,888)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,364,987)	1,508,231	0	0	0	0	0	0	0	0	0	(856,756)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,890,236)	1,508,231	0	0	0	0	0	0	0	0	0	(6,382,005)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning:

04/01/2019

Ending:

03/31/2020

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	(2,325,129)	0	0	0	0	0	0	0	0	0	0	(2,325,129)	30
31	Amortization of Pre-Op. & Org.	(112,176)	0	0	0	0	0	0	0	0	0	0	(112,176)	31
32	Interest	(4,238,420)	0	0	0	0	0	0	0	0	0	0	(4,238,420)	32
33	Real Estate Taxes	(361,395)	0	0	0	0	0	0	0	0	0	0	(361,395)	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	(7,037,120)	0	0	0	0	0	0	0	0	0	0	(7,037,120)	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):*	(2,782,636)	0	0	0	0	0	0	0	0	0	0	(2,782,636)	43
44	TOTAL Special Cost Centers	(2,782,636)	0	0	0	0	0	0	0	0	0	0	(2,782,636)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(17,709,992)	1,508,231	0	0	0	0	0	0	0	0	0	(16,201,761)	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		

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	\$ 698,592	Friendship Village Executive/Corporate Allocation		\$ 2,206,823	\$ 1,508,231	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		\$ 698,592			\$ 2,206,823	\$ * 1,508,231	14

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

Facility Name & ID Number

Greenfields of Geneva

0050286

Report Period Beginning:

04/01/2019

Ending:

03/31/2020

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	Jean Schlinkmann	BOD						1
2	Bill Bowne	BOD						2
3	Geoff Roehl	BOD						3
4	Brad Barrie	BOD						4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Greenfields of Geneva

0050286

Report Period Beginning:

04/01/2019

Ending:

03/31/2020

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	Jean Schlinkmann	Chair							\$		1
2	Bill Bowne	Secretary									2
3	Geoff Roehl	Treasurer									3
4	Brad Barrie	Board Member									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Greenfields of Geneva

0050286 Report Period Beginning: 04/01/2019

Ending: 3/31/2020

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

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	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	\$ 386,591	\$ 0	13,581	\$ 25,196	1
2	30	Depreciation Expense	Direct Cost	2,502,643	2	2,502,643	0	177,514	177,514	2
3	1	Dietary	Meals	172,979	2	1,946,854	1,101,831	42,386	477,048	3
4	2	Food Purchase	Meals	172,979	2	1,077,799	0	42,386	264,099	4
5	3	Housekeeping	Square Feet	208,374	2	529,085	455,140	13,581	34,484	5
6	5	Heat & Utilities	Square Feet	208,374	2	585,609	0	13,581	38,168	6
7	6	Maintenance	Square Feet	208,374	2	2,346,145	609,852	13,581	152,913	7
8	17	Administrative	Employee Ratio	147	2	711,421	0	42	203,263	8
9	21	Clerical & General	Employee Ratio	147	2	556,273	222,080	42	158,935	9
10	22	Employee Benefits	Employee Ratio	147	2	2,004,643	0	42	572,755	10
11	32	Interest	Square Feet	208,374	2	4,533,923	0	13,581	295,503	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					\$ 17,180,986	\$ 2,388,903		\$ 2,399,878	25

Facility Name & ID Number

Greenfields of Geneva

0050286

Report Period Beginning:

04/01/2019

Ending:

03/31/2020

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 2017		X	Bond Issuance			\$ 65,000,000	\$ 64,050,000		variable	\$ 4,533,923	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 65,000,000	\$ 64,050,000			\$ 4,533,923	9						
B. Non-Facility Related*																		
10												10						
11	Non-Allowable Interest										(4,238,420)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (4,238,420)	14						
15	TOTALS (line 9+line14)						\$ 65,000,000	\$ 64,050,000			\$ 295,503	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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 2019 report.		\$	479,970	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.)		\$	384,071	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(95,899)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	482,490	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.		\$	386,591	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	427,240	8
	2016	374,343	9
	2017	382,066	10
	2018	384,071	11
	2019	392,840	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenfields of Geneva COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0050286

CONTACT PERSON REGARDING THIS REPORT Jeff Nyberg

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(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>360,411.64</u>	\$ <u>23,490.22</u>
2. <u>11-12-127-001</u>	<u>Long Term Care Property</u>	\$ <u>32,427.94</u>	\$ <u>2,113.53</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>392,839.58</u></u>	\$ <u><u>25,603.74</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Greenfields of Geneva

0050286 Report Period Beginning:

04/01/2019 Ending:

03/31/2020

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: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

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	\$	\$ 1,018,101	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Landscape Filter to hide generator		2014	1,213	81	15	81		526	9
10	Guest Suite - GreenFields of Geneva		2015	156		5			156	10
11	Snow shoes for metal roof sections		2014	1,456	146	10	146		947	11
12	Exterior and Interior Signage		2014	7,257	484	15	484		3,144	12
13	Apt 2106 Staged Quality Interiors		2016	163	23	7	23		151	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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	\$ 483,057	\$ 44,479	\$ 44,479	\$	Varioius	\$ 320,579	71
72	Current Year Purchases	65,104	3,737	3,737		Various	3,737	72
73	Fully Depreciated Assets	162,846					162,846	73
74								74
75	TOTALS	\$ 711,007	\$ 48,216	\$ 48,216	\$		\$ 487,162	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		Honda Odyssey - 2014	2014	\$ 33,639	\$	\$	\$	10	\$ 33,639	76
77		Ford E450 - 2012	2017	13,294	2,216	2,216		3	11,078	77
78										78
79										79
80	TOTALS			\$ 46,933	\$ 2,216	\$ 2,216	\$		\$ 44,717	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)	\$ 6,222,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,514	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 177,514	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)	\$ 1,554,904	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	\$ 81,170,906	\$ 2,325,129	\$ 20,621,856	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 81,170,906	\$ 2,325,129	\$ 20,621,856	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: 04/01/2019

Ending: 03/31/2020

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 45,451 Description: Various Equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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.

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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,799	\$ 239,139						3,799	\$ 239,139			1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,641	103,294						1,641	103,294			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		5,115	323,569						5,115	323,569			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-2	# of prescripts								281,832		281,832			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Laboratory/Oxygen</u>	39-3									48,245		48,245			12
13	Other (specify): <u>Radiology/Ambulance</u>	39-3									31,254		31,254			13
14	TOTAL			\$	10,555	\$ 666,002	\$	361,331	\$	10,555	\$	1,027,333				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 **03/31/2020**

Report Period Beginning: **04/01/2019**
 (last day of reporting year)

Ending: **03/31/2020**

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	\$ 5,316,943	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>73,961</u>)	657,867		3
4	Supply Inventory (priced at <u>cost</u>)	22,833		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	192,250		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,189,893	\$	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	812,586		15
16	Equipment, at Historical Cost	8,638,676		16
17	Accumulated Depreciation (book methods)	(22,178,975)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	12,300,642		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 83,265,754	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 89,455,647	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,406,865	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	428,200		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	482,490		32
33	Accrued Interest Payable	1,880,608		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Reserve Expenses</u>	17,008		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,215,171	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	306,745		39
40	Mortgage Payable			40
41	Bonds Payable	61,561,887		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	55,901,275		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 117,769,907	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 122,985,078	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (33,529,431)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 89,455,647	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (30,301,314)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (30,301,314)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,288,117)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (6,288,117)	17
	B. Transfers (Itemize):		
18	Net Assets Transferred from Parent	3,060,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3,060,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (33,529,431)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning: 04/01/2019

Ending: 03/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,572,985	1
2	Discounts and Allowances for all Levels	373,862	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,946,847	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	69,123	6
7	Oxygen	749	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 69,872	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	6,469	14
15	Telephone, Television and Radio	4,005	15
16	Rental of Facility Space		16
17	Sale of Drugs	(154)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	44,219	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 54,539	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	456,062	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 456,062	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>AL/IL Revenue</u>	11,744,434	28
28a	<u>Other Revenue</u>	4,570	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,749,004	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,276,324	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	6,485,492	31
32	Health Care	3,509,954	32
33	General Administration	3,773,983	33
B. Capital Expense			
34	Ownership	7,580,784	34
C. Ancillary Expense			
35	Special Cost Centers	3,143,967	35
36	Provider Participation Fee	70,261	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 24,564,441	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,288,117)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,288,117)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 132,504	44
45	Private Pay - Net Inpatient Revenue	309,205	45
46	Medicare - Net Inpatient Revenue	3,989,996	46
47	Other-(specify) <u>Hospice/Life Care</u>	1,515,142	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,946,847	49

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

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

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

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

Facility Name & ID Number Greenfields of Geneva

0050286

Report Period Beginning: 04/01/2019

Ending: 03/31/2020

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	2,240	2,240	\$ 122,638	\$ 54.75	1
2	Assistant Director of Nursing	3,132	3,132	140,547	44.87	2
3	Registered Nurses	23,112	23,112	840,911	36.38	3
4	Licensed Practical Nurses	43	43	1,487	34.78	4
5	CNAs & Orderlies	38,256	38,256	640,338	16.74	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,080	2,080	60,824	29.24	9
10	Activity Assistants	2,229	2,229	30,752	13.80	10
11	Social Service Workers	8,545	8,545	228,197	26.71	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	2,430	2,430	48,133	19.81	14
15	Cook Helpers/Assistants	68,504	68,504	973,782	14.21	15
16	Dishwashers	5,843	5,843	73,493	12.58	16
17	Maintenance Workers	12,881	12,881	330,109	25.63	17
18	Housekeepers	2,080	2,080	59,554	28.63	18
19	Laundry	3,926	3,926	54,427	13.86	19
20	Administrator	2,080	2,080	116,846	56.18	20
21	Assistant Administrator	2,124	2,124	45,412	21.38	21
22	Other Administrative	2,080	2,080	200,022	96.16	22
23	Office Manager	0	0	0		23
24	Clerical	23,147	23,147	377,117	16.29	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	4,158	4,158	138,132	33.22	29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	88,951	88,951	1,699,266	19.10	32
33	Other(specify)	7,812	7,812	417,421	53.44	33
34	TOTAL (lines 1 - 33)	305,653	305,653	\$ 6,599,407 *	\$ 21.59	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	27,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	16	923	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	\$ 28,423		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	108	\$ 6,556		50
51	Licensed Practical Nurses	16	790		51
52	Certified Nurse Assistants/Aides	820	24,433		52
53	TOTAL (lines 50 - 52)	944	\$ 31,779		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	
Anthony Rizzato	Administrator		\$ 116,846	Workers' Compensation Insurance	\$	IDPH License Fee	\$ 4,538	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	21,255	
				FICA Taxes	472,237	Health Care Worker Background Check (Indicate # of checks performed 171)	4,393	
				Employee Health Insurance	170,385	Patient Background Checks	3,460	
				Employee Meals		Subscriptions and Publications	19,057	
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 116,846	Employee Programs	8,831			
(List each licensed administrator separately.)				Transfer from Corporate	1,329,135			
				Vaccinations	2,419	Less: Public Relations Expense	()	
				Employee Physicals	21,636	Non-allowable advertising	()	
				Less: Non-Reimbursable Benefits	(1,431,888)	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 698,592	TOTAL (agree to Schedule V, line 22, col.8)	\$ 572,755	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 52,703	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount
Vendor/Payee	Type							
Neal, Gerber, Eisenberg	Legal		\$ 1,403			\$	Out-of-State Travel	\$
Duane Morris	Legal		904					
							In-State Travel	20,639
							Seminar Expense	7,579
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 2,307	TOTAL		\$	TOTAL	\$ 28,218
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

LEGAL FEES - GreenFields
3/31/2020

Invoice Date	Firm Name	Invoice Number	Allowable Amount	Non-Allowable Amount	Description of Service
GL 20-01-95-8430-00 GreenFields Legal Fees					
12/5/2019	Neal Gerber Eisenberg	401673	1,402.50	-	General legal matters
4/18/2019	Duane Morris	2526111	904.00	-	General legal matters
			<u>2,306.50</u>		

Facility Name & ID Number Greenfields of Geneva# 0050286Report Period Beginning: 04/01/2019Ending: 03/31/2020**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. IASN - \$2,938
- (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. \$ 21,714 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. \$ 70,261
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. \$ (6,469)
- (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: CLA (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.