

		FOR BHF USE					

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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: <u>0050286</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Greenfields of Geneva</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/2019</u> to <u>03/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>ON801 Friendship Way</u> <u>Geneva</u> <u>60134</u>																									
Number City Zip Code																									
County: <u>Kane</u>																									
Telephone Number: <u>(630) 232-9105</u> Fax # <u>(847) 884-5718</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jeff Nyberg</u></td></tr><tr><td>(Title) <u>Controller</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Deborah Emerson</u> <u>Principal</u></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>9365 Counselors Row, Suite 200, Indianapolis, IN 46240</u></td></tr><tr><td>(Telephone) <u>(317)574-9100</u> Fax # <u>(317)574-9707</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jeff Nyberg</u>	(Title) <u>Controller</u>	(Signed) _____	Paid Preparer	(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>												
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	(Telephone) <u>(317)574-9100</u> Fax # <u>(317)574-9707</u>																								
Date of Initial License for Current Owners: <u>1/28/2013</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Deborah Emerson</u> Telephone Number: <u>(317) 574-9100</u>																									
Email Address: _____																									

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	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,738</u>	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	<u>43</u>	TOTALS	<u>43</u>	<u>15,738</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>366</u>	<u>6,678</u>	<u>7,219</u>	<u>14,263</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>366</u>	<u>6,678</u>	<u>7,219</u>	<u>14,263</u>	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

ACCUAL ☒ 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.)

	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	(6,469)	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		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)	1,508,231		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,508,231		36
37	(sum of SUBTOTALS 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 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

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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.

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:

04/01/2019Ending: 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
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

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 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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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:

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.

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-12-102-002	Long Term Care Property	\$ 360,411.64	\$ 23,490.22
2. 11-12-127-001	Long Term Care Property	\$ 32,427.94	\$ 2,113.53
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 392,839.58	\$ 25,603.74

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.

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

Assisttd 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	2	3	4	
	Use	Square Feet	Year Acquired	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

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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 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
77		Ford E450 - 2012	2017	13,294	2,216	2,216		3	11,078
78									
79									
80	TOTALS			\$ 46,933	\$ 2,216	\$ 2,216	\$		\$ 44,717

E. Summary of Care-Related Assets					1	2
		Reference			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
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	177,514
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	177,514
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,554,904

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
87				
88				
89				
90				
91	TOTALS	\$ 81,170,906	\$ 2,325,129	\$ 20,621,856

G. Construction-in-Progress		
	Description	Cost
92	CIP - GoG	\$ 1,014
93		
94		
95		\$ 1,014

* 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.

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: *

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.

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

☒ 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

C. CONTRACTUAL INCOME

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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,799	\$ 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 prescrpts				281,832		281,832	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Laboratory/Oxygen	39-3					48,245		48,245	12
13	Other (specify): Radiology/Ambulance	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.

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 73,961)	657,867		3
4	Supply Inventory (priced at cost)	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): See Attached	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	Reserve Expenses	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	See Attached	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		
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.

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			
Name	Function	%	Amount
Anthony Rizzato	Administrator		\$ 116,846
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,846
B. Administrative - Other			
Description			Amount
Management Fees - FSO			\$ 698,592
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 698,592
C. Professional Services			
Vendor/Payee	Type		Amount
Neal, Gerber, Eisenberg	Legal		\$ 1,403
Duane Morris	Legal		904
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,307
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$
Unemployment Compensation Insurance			
FICA Taxes			472,237
Employee Health Insurance			170,385
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Programs			8,831
Transfer from Corporate			1,329,135
Vaccinations			2,419
Employee Physicals			21,636
Less: Non-Reimbursable Benefits			(1,431,888)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 572,755
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			\$ 4,538
Advertising: Employee Recruitment			21,255
Health Care Worker Background Check (Indicate # of checks performed 171)			4,393
Patient Background Checks		346	3,460
Subscriptions and Publications			19,057
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 52,703
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			20,639
Seminar Expense			7,579
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 28,218

*** 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>		

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.