



Facility Name & ID Number GENEVA NURSING & REHAB CTR

# 0051540 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	107	Skilled (SNF)	107	39,055	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	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			6,642	6,642	8
9	SNF/PED					9
10	ICF	20,492	3,845	540	24,877	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,492	3,845	7,182	31,519	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.70%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 07/08/01

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 07/08/01 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 107 and days of care provided 6,642

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

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
	<b>A. General Services</b>										
1	Dietary	222,452	21,237		243,689		243,689	5,145	248,834		1
2	Food Purchase		217,584		217,584		217,584		217,584		2
3	Housekeeping	155,234	29,036		184,270		184,270		184,270		3
4	Laundry		1,200	95,191	96,391		96,391		96,391		4
5	Heat and Other Utilities			97,358	97,358		97,358	53	97,411		5
6	Maintenance	31,011	62,835	33,729	127,575		127,575	114	127,689		6
7	Other (specify):*			31,313	31,313		31,313		31,313		7
8	<b>TOTAL General Services</b>	<b>408,697</b>	<b>331,892</b>	<b>257,591</b>	<b>998,180</b>		<b>998,180</b>	<b>5,312</b>	<b>1,003,492</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			34,610	34,610		34,610		34,610		9
10	Nursing and Medical Records	2,227,195	217,425	10,247	2,454,867		2,454,867	19,128	2,473,995		10
10a	Therapy			6,802	6,802		6,802		6,802		10a
11	Activities	105,468	8,099	4,000	117,567		117,567		117,567		11
12	Social Services	42,692	350	2,640	45,682		45,682		45,682		12
13	CNA Training										13
14	Program Transportation			3,362	3,362		3,362		3,362		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,375,355</b>	<b>225,874</b>	<b>61,661</b>	<b>2,662,890</b>		<b>2,662,890</b>	<b>19,128</b>	<b>2,682,018</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	115,318		386,785	502,103		502,103	(386,785)	115,318		17
18	Directors Fees										18
19	Professional Services			271,176	271,176		271,176	(102,809)	168,367		19
20	Dues, Fees, Subscriptions & Promotions			66,010	66,010		66,010	(17,688)	48,322		20
21	Clerical & General Office Expenses	198,803	26,841	80,472	306,116		306,116	(44,762)	261,354		21
22	Employee Benefits & Payroll Taxes			448,442	448,442		448,442		448,442		22
23	Inservice Training & Education			2,617	2,617		2,617	339	2,956		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			15,004	15,004		15,004	2,442	17,446		25
26	Insurance-Prop.Liab.Malpractice			87,050	87,050		87,050	646	87,696		26
27	Other (specify):*			182,590	182,590		182,590	(176,375)	6,215		27
28	<b>TOTAL General Administration</b>	<b>314,121</b>	<b>26,841</b>	<b>1,540,146</b>	<b>1,881,108</b>		<b>1,881,108</b>	<b>(724,992)</b>	<b>1,156,116</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,098,173</b>	<b>584,607</b>	<b>1,859,398</b>	<b>5,542,178</b>		<b>5,542,178</b>	<b>(700,552)</b>	<b>4,841,626</b>		<b>29</b>

\*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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	0
		0
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
	CONTRACTED LAUNDRY SERVICES	95,191
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	21,974
	ELECTRICITY	43,693
	WATER	28,218
	CABLE TV - LOBBY	3,473
		0
		97,358
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	13,846
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	19,883
		0
		0
		0
		0
		33,729
<b>7</b>	<b>OTHER</b>	
	SCAVENGER & EXTERMINATING SERVICE	31,313
	SECURITY SERVICE	0
		0
		0
		31,313
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	34,610
		34,610

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	1,806
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,361
	PHARMACY CONSULTANT XVIII B 39-2	5,080
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		10,247
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,799
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	318
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	3,686
	SPEECH THERAPY CONSULTANT XVIII B 43-2	999
		6,802
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,000
		0
		4,000
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,640
	SOCIAL WORKER XVIII B 45-2	0
		2,640
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>		
	PATIENT TRANSPORTATION		3,362
			0
17	<b>ADMINISTRATIVE</b>		
	MANAGEMENT FEES	XIX B	386,785
	<b>DIRECTORS FEES</b>		
18	DIRECTORS FEES		0
19	<b>PROFESSIONAL SERVICES</b>		
	DATA PROCESSING	XIX C	21,902
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	57,777
	BOOKKEEPING/ADMINISTRATIVE SERVICE		191,497
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>		271,176
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,989
	EMPLOYEE WANT ADS	XIX F	29,142
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	7,002
	LICENSES & PERMITS	XIX F	5,835
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,750
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	
	PATIENT BACKGROUND CHECKS	XIX F	3,292
			66,010
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,466
	EQUIPMENT REPAIR & MAINTENANCE		43,858
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	6,987
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		20,582
	MESSENGER SERVICE		2,579
			0
			80,472

LINE		SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>		
	FICA TAXES	XIX D	238,193
	UNEMPLOYMENT COMPENSATION	XIX D	74,677
	WORKERS COMPENSATION INSURANC	XIX D	89,379
	HOSPITALIZATION INSURANCE	XIX D	29,135
	EMPLOYEE BENEFITS - OTHER	XIX D	17,058
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			448,442
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>		
	EDUCATION & SEMINARS		2,617
			2,617
24	<b>TRAVEL &amp; SEMINARS</b>		
	EDUCATION & SEMINARS	XIX G	
	TRAVEL	XIX G	0
			0
25	<b>ADMIN. STAFF TRANSPORTATION</b>		
	TRANSPORTATION - STAFF		15,004
			15,004
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>		
	GENERAL INSURANCE		87,050
			87,050
27	<b>OTHER</b>		
	BAD DEBTS	VI 24	182,590
			182,590

GRAND TOTAL COLUMN 3 OTHER

1,859,398

GENEVA NURSING & REHAB CTR  
SCHEDULES  
12/31/2013

EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	217,584
LESS SALES TAX	<u>0</u>
NET FOOD	217,584

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

TOTAL PATIENT CENSUS	31,519
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	94,557

ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	94,557
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	94,557

NET FOOD	217,584
DIVIDE TOTAL MEALS/YEAR	<u>94,557</u>

COST PER MEAL	2.30
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			68,736	68,736	68,736	137,663	206,399				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,484	22,484	22,484	246,738	269,222				32
33	Real Estate Taxes						73,602	73,602				33
34	Rent-Facility & Grounds			778,417	778,417	778,417	(608,023)	170,394				34
35	Rent-Equipment & Vehicles			26,578	26,578	26,578	1,212	27,790				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			896,215	896,215	896,215	(148,808)	747,407				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,345	955,351	1,131,696	1,131,696		1,131,696				39
40	Barber and Beauty Shops			9,142	9,142	9,142		9,142				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			211,176	211,176	211,176		211,176				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		176,345	1,175,669	1,352,014	1,352,014		1,352,014				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,098,173	760,952	3,931,282	7,790,407	7,790,407	(849,360)	6,941,047				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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,770)	30		9
10	Interest and Other Investment Income	(25,795)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(6,987)	21		18
19	Entertainment		20		19
20	Contributions	(1,750)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(182,590)	27		24
25	Fund Raising, Advertising and Promotional	(18,989)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(45,183)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (287,064)</b>		<b>\$</b>	<b>30</b>

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)	(562,296)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (562,296)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (849,360)</b>		<b>37</b>

\*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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

GENEVA NURSING & REHAB CTR

ID# 0051540

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	MARKETING SALARIES	\$ (45,183)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>		(45,183)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number GENEVA NURSING & REHAB CTR# 0051540

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	5,145	0	0	0	0	0	0	0	0	5,145	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	53	0	0	0	0	0	0	0	0	53	5
6	Maintenance	0	0	114	0	0	0	0	0	0	0	0	114	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>5,312</b>	<b>0</b>	<b>5,312</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	19,128	0	0	0	0	0	0	0	0	19,128	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>19,128</b>	<b>0</b>	<b>19,128</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	(386,785)	0	0	0	0	0	0	0	0	(386,785)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(102,809)	0	0	0	0	0	0	0	0	(102,809)	19
20	Fees, Subscriptions & Promotions	(20,739)	0	3,051	0	0	0	0	0	0	0	0	(17,688)	20
21	Clerical & General Office Expenses	(52,170)	0	7,408	0	0	0	0	0	0	0	0	(44,762)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	339	0	0	0	0	0	0	0	0	339	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	2,442	0	0	0	0	0	0	0	0	2,442	25
26	Insurance-Prop.Liab.Malpractice	0	0	646	0	0	0	0	0	0	0	0	646	26
27	Other (specify):*	(182,590)	0	6,215	0	0	0	0	0	0	0	0	(176,375)	27
28	<b>TOTAL General Administration</b>	<b>(255,499)</b>	<b>0</b>	<b>(469,493)</b>	<b>0</b>	<b>(724,992)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(255,499)</b>	<b>0</b>	<b>(445,053)</b>	<b>0</b>	<b>(700,552)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number GENEVA NURSING & REHAB CTR# 0051540

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(5,770)	143,048	385	0	0	0	0	0	0	0	0	137,663	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,795)	272,439	94	0	0	0	0	0	0	0	0	246,738	32
33	Real Estate Taxes	0	73,263	339	0	0	0	0	0	0	0	0	73,602	33
34	Rent-Facility & Grounds	0	(612,000)	3,977	0	0	0	0	0	0	0	0	(608,023)	34
35	Rent-Equipment & Vehicles	0	0	1,212	0	0	0	0	0	0	0	0	1,212	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(31,565)</b>	<b>(123,250)</b>	<b>6,007</b>	<b>0</b>	<b>(148,808)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(287,064)</b>	<b>(123,250)</b>	<b>(439,046)</b>	<b>0</b>	<b>(849,360)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	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	34 RENT	\$ 612,000	GENEVA STATE STREET, LLC		\$	\$ (612,000)	1
2	V	32 INTEREST				257,400	257,400	2
3	V	32 AMORT LOAN COST				15,039	15,039	3
4	V	33 REAL ESTATE TAXES				73,263	73,263	4
5	V	30 DEPRECIATION ( SL )				143,048	143,048	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		\$ 612,000			\$ 488,750	\$ * (123,250)	14

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

VII. RELATED PARTIES (continued)

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)
15	V	17 MANAGEMENT FEES	\$ 386,785	BRIA HEALTH SERVICES, LLC		\$	\$ (386,785)
16	V	19 BKKPNG/ADMIN SERVICES	128,750				(128,750)
17	V						
18	V	1 DIETARY SALARIES				5,145	5,145
19	V	5 UTILITIES				53	53
20	V	6 REPAIR/MAINT				114	114
21	V	10 NURSING SALARIES				19,128	19,128
22	V	19 PROFESSIONAL FEES				25,941	25,941
23	V	20 WANT ADS, LICENSES				3,051	3,051
24	V	21 TOTAL OFFICE				7,408	7,408
25	V	23 SEMINARS				339	339
26	V	25 TRANSPORTATIONAL STAFF				2,442	2,442
27	V	26 INSURANCE				646	646
28	V	27 EMPLOYEE BENEFITS				6,215	6,215
29	V	30 DEPRECIATION ( SL )				385	385
30	V	32 INTEREST				94	94
31	V	33 RE TAX				339	339
32	V	34 OFFICE RENT				3,977	3,977
33	V	35 EQUIPMENT RENTAL				1,212	1,212
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 515,535			\$ 76,489	\$ * (439,046)

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

Facility Name & ID Number

GENEVA NURSING & REHAB CTR

# 0051540

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	DANIEL WEISS	33.3	BELLEVILLE HEALTHCARE & REHAB		WEISS MGMT		MANAGEMENT/	2
3			CENTER	BELLEVILLE	GROUP, INC	LINCOLNWOOD	CLERICAL	3
4	NATAN WEISS	33.4						4
5			PALOS HILLS HEALTHCARE, LLC	PALOS HILLS	BRIA HEALTH		MANAGEMENT	5
6	AVRUM WEINFELD	33.3			SERVICES, LLC	LINCOLNWOOD	SERVICES	6
7			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO				7
8				HEIGHTS	GENEVA STATE		REAL ESTATE	8
9					STREET, LLC	LINCOLNWOOD		9
10			LAKE PARK CENTER	WAUKEGAN				10
11								11
12			WESTMONT NURSING & REHAB					12
13			CENTER, LLC	WESTMONT				13
14								14
15			FOREST EDGE HEALTHCARE REHAB					15
16			CENTER	CHICAGO				16
17								17
18			RIVER OAKS HEALTHCARE REHAB					18
19			CENTER	BURNHAM				19
20								20
21			ATRIUM H.C. & REHAB CENTER OF					21
22			CAHOKIA, LLC	CAHOKIA				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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					SEE				\$	1
2					ATTACHED					2
3					SCHEDULE					3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number GENEVA NURSING & REHAB CTR

# 0051540

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

BRIA HEALTH SERVICES, LLC

Street Address

6865 N LINCOLN AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

( 847 ) 674-5795

Fax Number

( 847 ) 674-5794

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT CENSUS	475,523	8	\$ 77,622	\$ 77,622	31,519	\$ 5,145	1
2	5	UTILITIES	PATIENT CENSUS	475,523	8	806		31,519	53	2
3	6	REPAIR/MAINT	PATIENT CENSUS	475,523	8	1,722		31,519	114	3
4	10	NURSING SALARIES	PATIENT CENSUS	475,523	8	288,582	288,582	31,519	19,128	4
5	19	PROFESSIONAL FEES	PATIENT CENSUS	475,523	8	391,370	100,000	31,519	25,941	5
6	20	WANT ADS, LICENSES	PATIENT CENSUS	475,523	8	46,030		31,519	3,051	6
7	21	TOTAL OFFICE	PATIENT CENSUS	475,523	8	111,765	36,036	31,519	7,408	7
8	23	SEMINARS	PATIENT CENSUS	475,523	8	5,110		31,519	339	8
9	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	475,523	8	36,847		31,519	2,442	9
10	26	INSURANCE	PATIENT CENSUS	475,523	8	9,739		31,519	646	10
11	27	EMPLOYEE BENEFITS	PATIENT CENSUS	475,523	8	93,769		31,519	6,215	11
12	30	DEPRECIATION ( SL )	PATIENT CENSUS	475,523	8	5,805		31,519	385	12
13	32	INTEREST	PATIENT CENSUS	475,523	8	1,420		31,519	94	13
14	33	RE TAX	PATIENT CENSUS	475,523	8	5,109		31,519	339	14
15	34	OFFICE RENT	PATIENT CENSUS	475,523	8	60,000		31,519	3,977	15
16	35	EQUIPMENT RENTAL	PATIENT CENSUS	475,523	8	18,286		31,519	1,212	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,153,982	\$ 502,240		\$ 76,489	25

Facility Name & ID Number

GENEVA NURSING & REHAB CTR

# 0051540

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY: GENEVA STATE STREET, LLC						\$	\$			\$	1						
2	THE PRIVATE BANK	X		MORTGAGE	\$12,500.00	04/30/13	7,800,000		04/30/18	5.5000	257,400	2						
3	LOAN COST			AMORT OVER 5 YEARS			112,791				15,039	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	08/01/11	150,000	550,000		PRIME+	12,409	6						
7	THE PRIVATE BANK	X		WORKING CAPITAL		08/03/11	400,000			7.0000	10,075	7						
8	RELATED PARTY ALLOCATION										94	8						
9	TOTAL Facility Related				\$12,500.00		\$ 8,462,791	\$ 550,000			\$ 295,017	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 8,462,791	\$ 550,000			\$ 295,017	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # 36

\* 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

<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2012 report.		\$	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.)		\$	73,263 2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	73,263 3																			
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	73,263 7																			
Real Estate Tax History:																						
Real Estate Tax Bill for Calendar Year:	2008 _____	8	<table border="1"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2012</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2012	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																						
13	FROM R. E. TAX STATEMENT FOR 2012	\$		13																		
14	PLUS APPEAL COST FROM LINE 5	\$		14																		
15	LESS REFUND FROM LINE 6	\$		15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																			
	2009 _____	9																				
	2010 _____	10																				
	2011 <u>23,287</u>	11																				
	2012 <u>73,263</u>	12																				
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>																						
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.</b>																						

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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GENEVA NURSING & REHAB CTR COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0051540

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-02-429-009</u>	<u>NURSING HOME</u>	\$ <u>71,439.98</u>	\$ <u>71,439.98</u>
2. <u>12-02-429-005</u>	<u>NURSING HOME</u>	\$ <u>1,822.90</u>	\$ <u>1,822.90</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>73,262.88</u></u>	\$ <u><u>73,262.88</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?                 YES            X       NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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: 36,000 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 2

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).

N/A

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	<u>NURSING HOME</u>		<u>2013</u>	<u>\$ 700,000</u>	1
2					2
3	<b>TOTALS</b>			\$	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	107	2013		\$ 6,117,660	\$ 111,111	39	\$ 111,111	\$	\$ 111,111	4
5	OFFICE	2013		135,450	3,276	39	3,276		3,276	5
6										6
7										7
8	RELATED PARTY ALLOCATION				280		280			8
	Improvement Type**									
9	REPLACE D/F SIGN INCLUDES NEW ROUND LOGO		2011	6,414	428	15	428		999	9
10	REPLACE THE 3 RTU'S		2011	11,900	433	27.5	433		920	10
11	INSTALL TRACO NX SERIES DOUBLE HUNG WINDOWS		2012	109,415	3,979	27.5	3,979		6,134	11
12	INSTALL 29 EACH SLEEVE UNITS		2012	34,000	1,236	27.5	1,236		1,803	12
13	NORTH/SOUTH, EAST/WEST RESIDENT ROOMS; FRONT		2012	209,990	7,636	27.5	7,636		10,500	13
14	WAITING AREA, NORTH/SOUTH CORRIDOR, NURSING									14
15	STATION, OFFICES, SALON, VESTIBULE, CONFERENCE									15
16	ROOM, GUEST BATHROOMS:FLOORING,HANDRAIL,									16
17	WALLCOVERING,DRYWALL,CERAMIC TILE									17
18	PAINTING WALLS , CEILINGS AND WINDOW FRAMES -		2012	29,527	11,220	5	11,220		12,696	18
19	LEVEL 1, HALLWAY, LEVEL 2, BATHROOMS,5 OFFICES									19
20	WINDOW TREATMENTS UPPER FLOOR ONLY		2012	29,696	11,284	5	11,284		12,769	20
21	INTERIOR SIGNAGE		2012	2,717	181	15	181		226	21
22	VESTIBULE, LOBBY, LOWER LEVEL RESIDENT ROOMS:									22
23	WALL BASE INSTALLATION, FLOORING		2013	54,274	1,069	27.5	1,069		1,069	23
24	INSTALL ELEVEN NEW 20 AMPERE CIRCUITS AND OUTLETS									24
25	FOR PTEC UNITS IN ROOM #S 302-3012		2013	11,000	350	27.5	350		350	25
26	FURNISH & INSTALLED (2) PEDESTRIAN ENTRY DOORS									26
27	AND FRAME		2013	9,400	214	27.5	214		214	27
28	NORTH AND SOUTH PARKING LOT:GRAIND & PATCH,									28
29	ASPHALTING,SEALCOATING, STRIPING,CRACK FILLING		2013	10,879	423	15	423		423	29
30	PAINTING OUTSIDE OF THE BUILDING: SOFFITS, WOODS,									30
31	DOORS,METAL FENCES AND COLLUMS.		2013	8,100	1,620	5	1,620		1,620	31
32	LOWER LEVEL CORRIDOR HANDRAIL, DOORS HANDRAIL		2013	25,489	502	27.5	502		502	32
33	THE BASEMENT: INSTALL NEW RAILINGS, BAMPERS,									33
34	CONERGUARDS, DOORS KICK PLATE		2013	15,043	296	27.5	296		296	34
35	LAUNDRY ROOM:BUILD NEW WALLS WITH NEW METAL									35
36	DOORS, NEW CERAMIC TILE		2013	2,500	42	27.5	42		42	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)

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALLED NEW MULE-HIDE TPO ROOF SYSTEM & NEW		\$	\$		\$	\$	\$	37
38	JOHNS MANSVILLE MODIFIELD BITUMEN	2013	6,675	71	27.5	71		71	38
39	WIRE UP 22 ROOMS ON BASEMENT LEVEL	2013	4,950	23	27.5	23		23	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,835,079	\$ 155,674		\$ 155,674	\$	\$ 165,044	70

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

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	\$ 163,296	\$ 21,522	\$ 21,395	\$ (127)	5-10	\$ 38,334	71
72	Current Year Purchases	10,345	6,207	564	(5,643)	8-10	564	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY ALLOCATION</b>		28,766	28,766				74
75	<b>TOTALS</b>	\$ 173,641	\$ 56,495	\$ 50,725	\$ (5,770)		\$ 38,898	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 7,008,720	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 212,169	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 206,399	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,770)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 203,942	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: FNR HEALTHCARE LLC

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:	<u>107</u>	<u>07/08/11</u>	\$ <u>166,417</u>			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	<b>107</b>		\$ <b>166,417</b>			<b>7</b>

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. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

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: \$ 26,578 Description: SEE SCHEDULE ATTACHED

(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			<u>N/A</u>		19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

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

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

Facility Name & ID Number GENEVA NURSING & REHAB CTR # 0051540 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 389,144	\$		\$ 389,144	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			115,346			115,346	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			450,861			450,861	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				155,589		155,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <b>RADIOLOGY, LAB</b>	39-2					17,082		17,082	12
13	Other (specify): <b>MEDICAL SUPPLIES</b>	39-2					3,674		3,674	13
14	<b>TOTAL</b>			\$		\$ 955,351	\$ 176,345		\$ 1,131,696	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 GENEVA NURSING & REHAB CTR# 0051540Report Period Beginning: 01/01/2013Ending: 12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (8,494)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>252,600</u> )	1,798,198		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,780		6
7	Other Prepaid Expenses	37,865		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,918,349	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	581,969		15
16	Equipment, at Historical Cost	173,641		16
17	Accumulated Depreciation (book methods)	(187,878)		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>CONSTRUCTION ESCROW</u>	59,400		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 627,132	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,545,481	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 609,497	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	612,504		29
30	Accrued Salaries Payable	163,978		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,412		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,399,391	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,399,391	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,146,090	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,545,481	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,164,575	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,164,578	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(18,488)	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)	\$ (18,488)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,146,090	24 *

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

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,745,856	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,745,856	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	25,795	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 25,795	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	268	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 268	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,771,919	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	998,180	31
32	Health Care	2,662,890	32
33	General Administration	1,881,108	33
<b>B. Capital Expense</b>			
34	Ownership	896,215	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,140,838	35
36	Provider Participation Fee	211,176	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,790,407	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(18,488)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (18,488)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,242,279	44
45	Private Pay - Net Inpatient Revenue	922,098	45
46	Medicare - Net Inpatient Revenue	3,871,402	46
47	Other-(specify) <b>HOSPICE</b>	513,240	47
48	Other-(specify) <b>MANAGED CARE</b>	196,837	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,745,856	49

**\*\*TAX RETURN PREPARED ON CASH BASIS**

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? **NO\*\*** 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 **GENEVA NURSING & REHAB CTR**

# **0051540**

Report Period Beginning: **01/01/2013**

Ending:

**12/31/2013**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,944	2,080	\$ 87,077	\$ 41.86	1
2	Assistant Director of Nursing	2,244	2,377	84,672	35.62	2
3	Registered Nurses	22,961	23,550	711,039	30.19	3
4	Licensed Practical Nurses	11,634	12,099	300,498	24.84	4
5	CNAs & Orderlies	66,498	68,224	930,887	13.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,132	8,478	105,468	12.44	10
11	Social Service Workers	2,040	2,149	42,692	19.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,761	19,427	222,452	11.45	15
16	Dishwashers					16
17	Maintenance Workers	1,408	1,424	31,011	21.78	17
18	Housekeepers	13,851	14,751	155,234	10.52	18
19	Laundry					19
20	Administrator	1,972	2,080	115,318	55.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,138	11,634	198,803	17.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	972	1,122	15,704	14.00	31
32	Other Health C: Care Plan Coord	2,629	2,685	97,318	36.25	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,184	172,080	\$ 3,098,173 *	\$ 18.00	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	M	\$ 0	1-3	35
36	Medical Director	O	34,610	9-3	36
37	Medical Records Consultant	N	3,361	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,080	10-3	39
40	Physical Therapy Consultant	L	1,799	10a-3	40
41	Occupational Therapy Consultant	Y	318	10a-3	41
42	Respiratory Therapy Consultant		3,686	10a-3	42
43	Speech Therapy Consultant	F	999	10a-3	43
44	Activity Consultant	E	4,000	11-3	44
45	Social Service Consultant	E	2,640	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,493		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	86	1,806	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	86	\$ 1,806		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
SCOTT HOCHSTADT	ADMINISTRATOR	0.00	\$ 115,318	Workers' Compensation Insurance	\$ 89,379	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	74,677	Advertising: Employee Recruitment	29,142	
				FICA Taxes	238,193	Health Care Worker Background Check	0	
				Employee Health Insurance	29,135	(Indicate # of checks performed )		
				Employee Meals	0	Patient Background Checks	329 3,292	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,750	
				EMPLOYEE BENEFITS - OTHER	17,058	MARKETING/ADV/PROMO	18,989	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	8,857	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	3,051	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,750)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(18,989)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,318	TOTAL (agree to Schedule V, line 22, col.8)	\$ 448,442	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,322	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
BRIA HEALTH SERVICES, LLC MANAGEMENT FEES			\$ 386,785				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 386,785				Seminar Expense	0
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$					
SEE SCHEDULE ATTACHED			271,176					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 271,176					

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8					N/A							
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number GENEVA NURSING &amp; REHAB CTR

# 0051540

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

## 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. IL COUNCIL ON LONG TERM CARE \$ 4,754
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? \_\_\_\_\_
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,221 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 211,176  
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? NO 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- 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? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.