

Facility Name & ID Number BRIA OF GENEVA

0051540 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,431	4,431	8
9	SNF/PED					9
10	ICF	26,240	2,209	1,416	29,865	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,240	2,209	5,847	34,296	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.81%

D. How many bed reserve days during this year were paid by the Department?
0 (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 7/1/01

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/1/01 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 4,431

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number **BRIA OF GENEVA** # **0051540** Report Period Beginning: **01/01/2018** Ending: **12/31/2018**

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	86,505	16,066	318,449	421,020	421,020		421,020			1
2	Food Purchase		118,217		118,217	118,217		118,217			2
3	Housekeeping		1,514	228,069	229,583	229,583		229,583			3
4	Laundry		106,892	28,301	135,193	135,193		135,193			4
5	Heat and Other Utilities			106,313	106,313	106,313		106,313			5
6	Maintenance	74,493	66,573	40,303	181,369	181,369	609	181,978			6
7	Other (specify):*			21,740	21,740	21,740	96	21,836			7
8	TOTAL General Services	160,998	309,262	743,175	1,213,435	1,213,435	705	1,214,140			8
	B. Health Care and Programs										
9	Medical Director			13,000	13,000	13,000		13,000			9
10	Nursing and Medical Records	2,605,171	148,354	333,368	3,086,893	3,086,893	14,903	3,101,796			10
10a	Therapy			26,063	26,063	26,063		26,063			10a
11	Activities	85,627	5,497	1,370	92,494	92,494		92,494			11
12	Social Services	55,544	4,547	924	61,015	61,015		61,015			12
13	CNA Training			6,800	6,800	6,800		6,800			13
14	Program Transportation			174	174	174		174			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,746,342	158,398	381,699	3,286,439	3,286,439	14,903	3,301,342			16
	C. General Administration										
17	Administrative	112,033		440,114	552,147	552,147	(429,114)	123,033			17
18	Directors Fees										18
19	Professional Services			162,650	162,650	162,650	(74,293)	88,357			19
20	Dues, Fees, Subscriptions & Promotions			59,154	59,154	59,154	(22,497)	36,657			20
21	Clerical & General Office Expenses	155,252	20,226	134,253	309,731	309,731	6,131	315,862			21
22	Employee Benefits & Payroll Taxes			411,570	411,570	411,570		411,570			22
23	Inservice Training & Education			6,345	6,345	6,345	496	6,841			23
24	Travel and Seminar			3,984	3,984	3,984	2,336	6,320			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			117,718	117,718	117,718	8,923	126,641			26
27	Other (specify):*			173,613	173,613	173,613	(160,103)	13,510			27
28	TOTAL General Administration	267,285	20,226	1,509,401	1,796,912	1,796,912	(668,121)	1,128,791			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,174,625	487,886	2,634,275	6,296,786	6,296,786	(652,513)	5,644,273			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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	64,378
	REPAIRS & MAINTENANCE	
	CONTRACTED DIETARY SERVICES	254,071
		318,449
3	HOUSEKEEPING	
	CONTRACTED HOUSEKEEPING SERVICES	228,069
		228,069
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,960
	CONTRACTED LAUNDRY SERVICES	25,341
		28,301
5	HEAT & OTHER UTILITIES	
	GAS HEAT	18,037
	ELECTRICITY	57,047
	WATER	24,671
	CABLE TV - LOBBY	6,558
		106,313
6	MAINTENANCE	
	GROUPS MAINTENANCE	25,801
	PAINTING & DECORATING	
	BUILDING REPAIRS	
	MAINTENANCE TRAVEL	
	EQUIPMENT MAINTENANCE & REPAIR	
	ELEVATOR MAINTENANCE & REPAIR	
	OUTSIDE LABOR	
	EXTERMINATING SERVICE	
	FIRE SERVICE	14,502
		40,303
7	OTHER	
	SCAVENGER AND EXTERMINATING SERVICES	21,740
	SECURITY SERVICE	
		21,740
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,000
		13,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	320,612
	LABORATORY & XRAY EXPENSE	
	PURCHASED SERVICES	
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	
	PHARMACY CONSULTANT XVIII B 39-2	7,456
	UTILIZATION REVIEW FEES XVIII B __-2	
	PHYSICIANS XVIII B __-2	
	PSYCHIATRIC XVIII B __-2	
	RN CONSULTANT XVIII B 38-2	5,300
		333,368
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	12,498
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	6,210
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	2,966
	SPEECH THERAPY CONSULTANT XVIII B 43-2	4,389
		26,063
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,370
		1,370
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	924
	SOCIAL WORKER XVIII B 45-2	
		924
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	6,800
		6,800

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	174
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	440,114
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,519
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	64,131
	BOOKKEEPING/ADMINISTRATIVE SERVICES	90,000
20	FEES,SUBSCRIPTIONS,PROMOTIONS	162,650
	ENTERTAINMENT & MARKETING VI 19 XIX F	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,862
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	13,743
	CONTRIBUTIONS VI 20 XIX F	
	DUES & SUBSCRIPTIONS XIX F	9,120
	LICENSES & PERMITS XIX F	6,919
	PUBLIC RELATIONS-PATIENT RELATED XIX F	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	11,057
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	633
	PATIENT BACKGROUND CHECKS XIX F	1,820
		59,154
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	15,874
	EQUIPMENT REPAIR & MAINTENANCE	76,688
	OUTSIDE CLERICAL SERVICES	
	PENALTIES / OVERDRAFT CHARGES VI 18	2,160
	HOME OFFICE EXPENSE	
	THEFT & DAMAGE LOSS	
	TELEPHONE	35,316
	MESSENGER SERVICE	4,215
		134,253

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	237,173
	UNEMPLOYMENT COMPENSATION XIX D	14,823
	WORKERS COMPENSATION INSURANCE XIX D	60,326
	HOSPITALIZATION INSURANCE XIX D	63,213
	EMPLOYEE BENEFITS - OTHER XIX D	36,035
	EMPLOYEE PHYSICAL EXAMS XIX D	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	
	PENSION/PROFIT SHARING PLANS XIX D	
		411,570
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	6,345
		6,345
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	3,984
		3,984
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	117,718
		117,718
27	OTHER	
	BAD DEBTS VI 24	173,613
		173,613

GRAND TOTAL COLUMN 3 OTHER **2,634,275**

**BRIA OF GENEVA
SCHEDULES
12/31/2018**

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

TOTAL FOOD PURCHASE	118,217
LESS SALES TAX	<u>0</u>
NET FOOD	118,217

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

TOTAL PATIENT CENSUS	34,296
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	102,888

ADD # EMPLOYEE MEALS/DAY TIMES # DAYS	<u>39,055</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	102,888
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	102,888

NET FOOD	118,217
DIVIDE TOTAL MEALS/YEAR	<u>102,888</u>

COST PER MEAL	1.15
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFIC	<u><u>0</u></u>

Facility Name & ID Number

BRIA OF GENEVA

#0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			95,340	95,340		95,340	214,574	309,914			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,426	4,426		4,426	276,812	281,238			32
33	Real Estate Taxes							115,916	115,916			33
34	Rent-Facility & Grounds			738,000	738,000		738,000	(738,000)				34
35	Rent-Equipment & Vehicles			14,783	14,783		14,783	1,581	16,364			35
36	Other (specify):* STORAGE			636	636		636	57,843	58,479			36
37	TOTAL Ownership			853,185	853,185		853,185	(71,274)	781,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		201,008	731,853	932,861		932,861		932,861			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,765	243,765		243,765		243,765			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		201,008	975,618	1,176,626		1,176,626		1,176,626			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,174,625	688,894	4,463,078	8,326,597		8,326,597	(723,787)	7,602,810			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	(25,021)	30		9
10	Interest and Other Investment Income	(16,754)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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	(2,160)	21		18
19	Entertainment				19
20	Contributions	(11,057)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(173,613)	27		24
25	Fund Raising, Advertising and Promotional	(15,862)	20		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 SEE PAGE 5A	(56,441)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (300,908)		\$	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	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)	(422,879)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (422,879)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (723,787)		37

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

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

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

BRIA OF GENEVA

ID# 0051540

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (56,441)	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	Total	(56,441)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF GENEVA# 0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	609	0	0	0	0	0	0	0	0	609	6
7	Other (specify):*	0	0	96	0	0	0	0	0	0	0	0	96	7
8	TOTAL General Services	0	0	705	0	0	0	0	0	0	0	0	705	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	14,903	0	0	0	0	0	0	0	0	14,903	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	14,903	0	0	0	0	0	0	0	0	14,903	16
	C. General Administration													
17	Administrative	0	0	(429,114)	0	0	0	0	0	0	0	0	(429,114)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,700	(86,993)	0	0	0	0	0	0	0	0	(74,293)	19
20	Fees, Subscriptions & Promotions	(26,919)	0	4,422	0	0	0	0	0	0	0	0	(22,497)	20
21	Clerical & General Office Expenses	(58,601)	0	64,732	0	0	0	0	0	0	0	0	6,131	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	496	0	0	0	0	0	0	0	0	496	23
24	Travel and Seminar	0	0	2,336	0	0	0	0	0	0	0	0	2,336	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	7,112	1,811	0	0	0	0	0	0	0	0	8,923	26
27	Other (specify):*	(173,613)	0	13,510	0	0	0	0	0	0	0	0	(160,103)	27
28	TOTAL General Administration	(259,133)	19,812	(428,800)	0	0	0	0	0	0	0	0	(668,121)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(259,133)	19,812	(413,192)	0	0	0	0	0	0	0	0	(652,513)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF GENEVA# 0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(25,021)	236,844	2,751	0	0	0	0	0	0	0	0	214,574	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,754)	272,685	20,881	0	0	0	0	0	0	0	0	276,812	32
33	Real Estate Taxes	0	115,916	0	0	0	0	0	0	0	0	0	115,916	33
34	Rent-Facility & Grounds	0	(738,000)	0	0	0	0	0	0	0	0	0	(738,000)	34
35	Rent-Equipment & Vehicles	0	0	1,581	0	0	0	0	0	0	0	0	1,581	35
36	Other (specify):*	0	57,843	0	0	0	0	0	0	0	0	0	57,843	36
37	TOTAL Ownership	(41,775)	(54,712)	25,213	0	(71,274)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(300,908)	(34,900)	(387,979)	0	(723,787)	45							

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	\$ 440,114	BRIA HEALTH SERVICES, LLC		\$	\$ (440,114)
16	V	19 BKKPND/ADMIN SERVICES	90,000				(90,000)
17	V	17 CFO SALARY-A.WEINFELD				11,000	11,000
18	V	10 SALARIES-MEDICARE/NURSING				14,425	14,425
19	V	21 SALARIES-PURCHASING D.SEGAL				7,790	7,790
20	V	21 SALARIES-CLERICAL RELATED PARTIES				1,626	1,626
21	V	21 SALARIES-CLERICAL				44,535	44,535
22	V	6 MAINTENANCE				609	609
23	V	7 SCAVENGER				96	96
24	V	10 NURSING CONSULTANT				478	478
25	V	19 PROFESSIONAL FEES				3,007	3,007
26	V	20 DUES,FEES,SUBSCRIPTIONS				4,422	4,422
27	V	21 OFFICE EXPENSE				10,781	10,781
28	V	23 SEMINARS				496	496
29	V	24 TRAVEL				2,336	2,336
30	V	26 INSURANCE				1,811	1,811
31	V	27 EMPLOYEE BENEFITS				13,510	13,510
32	V	30 DEPRECIATION				2,751	2,751
33	V	32 INTEREST				20,881	20,881
34	V	35 AUTO LEASE				860	860
35	V	35 EQUIPMENT RENTAL				721	721
36	V						
37	V						
38	V						
39	Total		\$ 530,114			\$ 142,135	\$ * (387,979)

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

Facility Name & ID Number

BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DANIEL WEISS	33.3	BRIA OF BELLEVILLE	BELLEVILLE	WEISS MGMT	SKOKIE	MANAGEMENT/	1
2					GROUP, INC		CLERICAL	2
3	NATAN WEISS	33.4	BRIA OF PALOS HILLS	PALOS HILLS				3
4					BRIA HEALTH	SKOKIE	MANAGEMENT	4
5	AVRUM WEINFELD	33.3	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO HEIGHTS	SERVICES, LLC		SERVICES	5
6								6
7					GENEVA STATE	SKOKIE	REAL ESTATE	7
8			LAKE PARK CENTER	WAUKEGAN	STREET, LLC			8
9								9
10								10
11			BRIA OF WESTMONT	WESTMONT				11
12								12
13								13
14			BRIA OF FOREST EDGE	CHICAGO				14
15								15
16								16
17			BRIA OF RIVER OAKS	BURNHAM				17
18								18
19								19
20			BRIA OF CAHOKIA	CAHOKIA				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

BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1 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	ALLOCATIONS FROM BRIA	SHAREHOLDER	ADMINISTRATIVE						\$		1
2	AVRUM WEINFELD	SHAREHOLDER	ADMINISTRATIVE	33.30	SEE	4	10.00	SALARY	11,000	17-7	2
3					ATTACHED						3
4					SCHEDULE						4
5											5
6	ALLOCATIONS FROM WESS MANAGEMENT GROUP:										
7	DANIEL WEISS	SHAREHOLDER	ADMINISTRATIVE	33.40		4	10.00	SALARY	12,000	17-7	7
8											8
9	NATAN WEISS	CFO	FINANCE/MGMT	33.30		4	10.00	SALARY	12,000	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 35,000		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 BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization BRIA HEALTH SERVICES, LLC
 Street Address 5151 CHURCH STREET
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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	17	CFO SALARY-A.WEINFELD	wghtd avr hours	9	\$ 99,000	\$ 99,000		\$ 11,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	9	217,425	217,425	34,296	14,425	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours	9	148,012	148,012		7,790	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours	9	41,826	41,826		1,626	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	9	671,273	671,273	34,296	44,535	5
6	6	MAINTENANCE	CENSUS DAYS	9	9,177		34,296	609	6
7	7	SCAVENGER	CENSUS DAYS	9	1,451		34,296	96	7
8	10	NURSING CONSULTANT	CENSUS DAYS	9	7,200		34,296	478	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	9	45,319		34,296	3,007	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	9	66,654		34,296	4,422	10
11	21	OFFICE EXPENSE	CENSUS DAYS	9	162,507		34,296	10,781	11
12	23	SEMINARS	CENSUS DAYS	9	7,477		34,296	496	12
13	24	TRAVEL	CENSUS DAYS	9	35,214		34,296	2,336	13
14	26	INSURANCE	CENSUS DAYS	9	27,300		34,296	1,811	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	9	203,639		34,296	13,510	15
16	30	DEPRECIATION	CENSUS DAYS	9	41,469		34,296	2,751	16
17	32	INTEREST	CENSUS DAYS	9	314,739		34,296	20,881	17
18	35	AUTO LEASE	CENSUS DAYS	9	12,960		34,296	860	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	9	10,875		34,296	721	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,123,517	\$ 1,177,536		\$ 142,135	25

Facility Name & ID Number

BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY: GENEVA STATE STREET, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY CAPI	X		MORTGAGE	\$55,547.78	11/1/16	8,310,000	7,995,124	9/1/49	3.2900	265,294	2						
3	LOAN COST	X		AMORT OVER 5 YEARS			243,911	227,281			7,391	3						
4												4						
5												5						
Working Capital																		
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	8/1/11	150,000	250,000		PRIME+	3,515	6						
7		X		INSURANCE							911	7						
8	RELATED PARTY ALLOCATION										20,881	8						
9	TOTAL Facility Related				\$55,547.78		\$ 8,703,911	\$ 8,472,405			\$ 297,992	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 8,703,911	\$ 8,472,405			\$ 297,992	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 57,843 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

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

1. Real Estate Tax accrual used on 2017 report.	\$	169,215	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.)	\$	141,876	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(27,339)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	143,295	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.	\$	115,956	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	99,964	8
	2014	121,084	9
	2015	119,011	10
	2016	142,096	11
	2017	141,876	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF GENEVA COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0051540

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>12-02-429-005</u>	<u>NURSING HOME</u>	\$ <u>2,285.46</u>	\$ <u>2,285.46</u>
2. <u>12-02-429-009</u>	<u>NURSING HOME</u>	\$ <u>114,291.22</u>	\$ <u>114,291.22</u>
3. <u>12-02-429-014</u>	<u>OFFICE BUILDING</u>	\$ <u>11,932.78</u>	\$ <u>11,932.78</u>
4. <u>12-02-429-015</u>	<u>OFFICE BUILDING</u>	\$ <u>13,366.70</u>	\$ <u>13,366.70</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>141,876.16</u></u>	\$ <u><u>141,876.16</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Rows include NURSING HOME, OFFICE BUILDING, and TOTALS.

Facility Name & ID Number BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 222,460	27.5	\$ 222,460	\$	\$ 1,223,411	4
5	OFFICE		2013		135,450	3,473	39	3,473		20,641	5
6											6
7											7
8	RELATED PARTY ALLOCATION				47,983	1,354		1,354			8
	Improvement Type**										
9	REPLACE D/F SIGN INCLUDES NEW ROUND LOGO		2011		6,414	428	15	428		3,139	9
10	REPLACE THE 3 RTU'S		2011		11,900	433	27.5	433		3,085	10
11	INSTALL TRACO NX SERIES DOUBLE HUNG WINDOWS		2012		109,415	3,979	27.5	3,979		26,029	11
12	INSTALL 29 EACH SLEEVE UNITS		2012		34,000	1,236	27.5	1,236		7,983	12
13	NORTH/SOUTH, EAST/WEST RESIDENT ROOMS; FRONT		2012		209,990	7,636	27.5	7,636		48,680	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		5			29,527	18
19	LEVEL 1, HALLWAY, LEVEL 2, BATHROOMS,5 OFFICES										19
20	WINDOW TREATMENTS UPPER FLOOR ONLY		2012		29,696		5			29,696	20
21	INTERIOR SIGNAGE		2012		2,717	181	15	181		1,131	21
22	VESTIBULE, LOBBY, LOWER LEVEL RESIDENT ROOMS:										22
23	WALL BASE INSTALLATION, FLOORING		2013		54,274	1,974	27.5	1,974		10,939	23
24	INSTALL ELEVEN NEW 20 AMPERE CIRCUITS AND OUTLETS										24
25	FOR PTEC UNITS IN ROOM #S 302-3012		2013		11,000	400	27.5	400		2,350	25
26	FURNISH & INSTALLED (2) PEDESTRIAN ENTRY DOORS										26
27	AND FRAME		2013		9,400	342	27.5	342		1,924	27
28	NORTH AND SOUTH PARKING LOT:GRAIND & PATCH,										28
29	ASPHALTING,SEALCOATING, STRIPING,CRACK FILLING		2013		10,879	725	15	725		4,048	29
30	PAINTING OUTSIDE OF THE BUILDING: SOFFITS, WOODS,										30
31	DOORS,METAL FENCES AND COLLUMS.		2013		8,100	467	5	467		8,100	31
32	LOWER LEVEL CORRIDOR HANDRAIL, DOORS HANDRAIL		2013		25,489	927	27.5	927		5,137	32
33	THE BASEMENT: INSTALL NEW RAILINGS, BAMPERS,										33
34	CONERGUARDS, DOORS KICK PLATE		2013		15,043	547	27.5	547		3,031	34
35	LAUNDRY ROOM:BUILD NEW WALLS WITH NEW METAL										35
36			2013		2,500	91	27.5	91		497	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BRIA OF GENEVA

0051540

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	243	27.5	243		1,286	38
39	WIRE UP 22 ROOMS ON BASEMENT LEVEL	2013	4,950	180	27.5	180		923	39
40	PASSENGER ELEVATOR-REPLACE CONTROLLER; PROVIDE								40
41	NEW HOISTWAY WIRING, TANK, MOTOR, PUMP & VALVE	2014	59,400	2,160	27.5	2,160		10,710	41
42	LOWER LEVEL RESIDENT ROOMS, SOLARIUM, DINING								42
43	ROOM-WINDOW TREATMENTS	2014	18,771	2,162	5	2,162		17,689	43
44	REMODEL DINING ROOM IN BASEMENT-INSTALL NEW								44
45	CORNER GUARDS,OUTLETS, LIGHT FIXTURES,WALLCOVE-								45
46	RING, HANDRAILS, CEILING TILE	2014	62,892	2,287	27.5	2,287		10,959	46
47	INSTALL FIVE NEW 20 AMPERE CIRCUITS AND OUTLETS								47
48	FOR PTEC UNITS IN ROOM #201,203,205,207,204	2014	5,000	182	27.5	182		872	48
49	LOWER LEVEL DINING ROOM-WALLCOVERING,								49
50	FLOORING	2014	13,278	483	27.5	483		2,314	50
51	LOWER LEVEL SOLARIUM AND CORRIDOR-FLOORING	2014	6,621	241	27.5	241		1,095	51
52	REMODEL SHOWER ROOM IN BASEMENT-DRYWALL,								52
53	SOFFITS, COVER WITH PLASTIC 2 DOORS	2014	11,650	424	27.5	424		1,890	53
54	REINFORCE THE FIRE WALL ABOVE THE FIRE DOOR IN								54
55	THE NORTHWEST AND EAST SIDE OF THE BUILDING	2014	16,600	604	27.5	604		2,693	55
56	INSTALLED DELAYED EGRESS MAGNETIC LOCKS	2016	4,275	155	27.5	155		420	56
57	SHOWER ROOMS: INSTALL FLOOR TILE, WALL TILE,								57
58	PAINTING, CEILING, DOOR FRAME, REPLACE DRAIN	2016	64,506	2,346	27.5	2,346		5,181	58
59	PARKING LOT: GRIND ASPHALT, PRIME AND POVE,								59
60	INSTALL CONCRETE RINGS AT CATCH BASINS	2016	23,900	1,593	15	1,593		3,319	60
61	INSTALL SLIDING PATIO DOOR	2016	7,400	247	15	247		4,318	61
62	DECK: INSTALL HAND RAILS, PLANTER BOXES, BENCH								62
63	SEATS AND DECK BOARDS	2016	5,098	170	15	170		2,974	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,182,453	\$ 260,130		\$ 260,130	\$	\$ 1,495,991	70

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

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		
1	Totals from Page 12A, Carried Forward	\$ 7,182,453	\$ 260,130		\$ 260,130	\$	\$ 1,495,991		1
2	RELATED PARTY - GENEVA STATE STREET, LLC								2
3	1ST FLOOR CLOSETS-INSTALLED FLUSH BOLTS,								3
4	CLOSERS AND COORDINATORS	2015	6,811	248	27.5	248			4
5	WIRE UP 31 ROOMS ON BASEMENT LEVEL	2015	6,975	254	27.5	254			5
6	MAIN HALL 100, 2 WINGS & COMMON LOUNGE:								6
7	INSTALL LVT AND BASE PER LAYOUT PLAN	2015	45,588	1,658	27.5	1,658			7
8	ELEVATOR: REPLACED PANELS, INSTALL COFFERED								8
9	CEILING, NEW HANDRAILS & BUMPER	2015	7,000	255	27.5	255			9
10	INSTALLED NEW ALUMINIUM COATING, TPO FLAT ROOF								10
11	OVER THE KITCHEN AND DINING AREA ON WEST SIDE	2017	55,150	2,005	27.5	2,005			11
12	REPLACEMENT ROOF TOP HVAC UNIT	2018	10,900	314	27.5	314			12
13	REMOVE AND REPLACE FRONT PORCH	2018	67,800	2,260	27.5	2,260			13
14	PAINTING: DINING AND RESIDENTS ROOMS, BUILDING,								14
15	FIRST FLOOR WINDOWS.THERAPY GYM	2018	29,520	2,952	5	2,952			15
16	RESIDENT BATHS-FLOORING	2018	70,720	965	27.5	965			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	TOTAL (lines 1 thru 33)	\$ 7,482,917	\$ 271,041		\$ 271,041	\$	\$ 1,495,991		34

**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	\$ 315,272	\$ 10,295	\$ 34,866	\$ 24,571	5-10	\$ 178,242	71
72	Current Year Purchases	52,202	52,202	2,610	(49,592)	10	2,610	72
73	Fully Depreciated Assets	21,794					21,794	73
74	RELATED PARTY ALLOCATION		1,397	1,397				74
75	TOTALS	\$ 389,268	\$ 63,894	\$ 38,873	\$ (25,021)		\$ 202,646	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	TOTALS			\$	\$	\$	\$		\$	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)	\$ 8,632,185	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 334,935	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 309,914	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (25,021)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,698,637	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	TOTALS	\$	\$	\$	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.

Facility Name & ID Number BRIA OF GENEVA

0051540

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. _____	\$ _____
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: \$ 14,783

Description: SEE ATTACHED SCHEDULE

(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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		6,800		6,800
9	TOTALS	\$	\$ 6,800	\$	\$ 6,800
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,800		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 242,668	\$		\$ 242,668	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			103,979			103,979	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			385,206			385,206	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				136,011		136,011	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): RENTALS,AMBULAN	39-2					29,541 35,456		29,541 35,456	13
14	TOTAL			\$		\$ 731,853	\$ 201,008		\$ 932,861	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	\$ (57,699)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>273,000</u>)	2,977,053		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,943		6
7	Other Prepaid Expenses	46,005		7
8	Accounts Receivable (owners or related parties)	246,166		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,271,468	\$	10
	B. Long-Term Assets			
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	881,361		15
16	Equipment, at Historical Cost	367,474		16
17	Accumulated Depreciation (book methods)	(607,316)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 641,519	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,912,987	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 406,343	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000		29
30	Accrued Salaries Payable	77,634		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,266		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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 745,243	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 745,243	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,167,744	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,912,987	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,650,862	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,650,867	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	516,877	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)	\$ 516,877	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,167,744	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,835,349	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,835,349	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	2,795	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,795	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,754	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,754	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,854,898	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,213,435	31
32	Health Care	3,286,439	32
33	General Administration	1,796,912	33
B. Capital Expense			
34	Ownership	853,185	34
C. Ancillary Expense			
35	Special Cost Centers	932,861	35
36	Provider Participation Fee	243,765	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,326,597	40
41	Income before Income Taxes (line 30 minus line 40)**	528,301	41
42	Income Taxes	(11,424)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 516,877	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,168,277	44
45	Private Pay - Net Inpatient Revenue	653,155	45
46	Medicare - Net Inpatient Revenue	2,665,733	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	712,470	47
48	Other-(specify) <u>MANAGED CARE</u>	635,714	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,835,349	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 **BRIA OF GENEVA**

0051540

Report Period Beginning: **01/01/2018**

Ending:

12/31/2018

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	1,880	2,040	\$ 97,150	\$ 47.62	1
2	Assistant Director of Nursing	5,617	5,769	272,591	47.25	2
3	Registered Nurses	18,593	19,220	637,919	33.19	3
4	Licensed Practical Nurses	11,612	12,044	382,136	31.73	4
5	CNAs & Orderlies	59,896	62,007	969,963	15.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,409	5,511	85,627	15.54	10
11	Social Service Workers	2,434	2,498	55,544	22.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,053	6,176	86,505	14.01	15
16	Dishwashers					16
17	Maintenance Workers	3,308	3,475	74,493	21.44	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,064	2,080	112,033	53.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,265	7,531	155,252	20.62	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	2,073	2,329	33,684	14.46	31
32	Other Health C: Care plan Coord	5,829	6,098	211,728	34.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,033	136,778	\$ 3,174,625 *	\$ 23.21	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	\$ 64,378	1-3	35
36	Medical Director	O	13,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	5,300	10-3	38
39	Pharmacist Consultant	H	7,456	10-3	39
40	Physical Therapy Consultant	L	12,498	10a-3	40
41	Occupational Therapy Consultant	Y	6,210	10a-3	41
42	Respiratory Therapy Consultant		2,966	10a-3	42
43	Speech Therapy Consultant	F	4,389	10a-3	43
44	Activity Consultant	E	1,370	11-3	44
45	Social Service Consultant	E	924	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 118,491		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,247	56,328	10-3	51
52	Certified Nurse Assistants/Aides	9,452	264,284	10-3	52
53	TOTAL (lines 50 - 52)	10,699	\$ 320,612		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	
PATRICIA LONG	ADMINISTRATOR	0	\$ 112,033	Workers' Compensation Insurance	\$ 60,326	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	14,823	Advertising: Employee Recruitment	13,743	
				FICA Taxes	237,173	Health Care Worker Background Check	633	
				Employee Health Insurance	63,213	(Indicate # of checks performed 16)		
				Employee Meals	0	Patient Background Checks	182	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	11,057	
				EMPLOYEE BENEFITS - OTHER	36,035	MARKETING/ADV/PROMO	15,862	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	14,049	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	4,422	
				INSURANCE - EXECUTIVE LIFE	0	TRUST/FRANCHISE/CONTRIB/ETC	(11,057)	
						Less: Public Relations Expense	(0)	
						Non-allowable advertising	(15,862)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 112,033	INSURANCE - EXECUTIVE LIFE VI 21	0			
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 411,570	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,657	
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			\$ 440,114				Out-of-State Travel	\$
							In-State Travel	3,984
							MGMT CO ALLOC	2,336
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 440,114				Seminar Expense	0
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
ALPHA DATA SERVICES	DATA PROCESSING		\$ 6,997	TOTAL		\$	TOTAL	\$ 6,320
NATIONAL DATACARE	DATA PROCESSING		1,522					
KBKB, LTD	ACCOUNTING FEE		12,200					
STOUN RISIUS ROSS	APPRAISAL FEES		4,890					
ACHIEVE ACCREDITATION	ACCREDITATION CONSULT		2,609					
RICHARD PEELO & ASSOCIAT	MEDICARE CONSULTANT		4,500					
PERSONNEL PLANNERS	UC CONSULTANT		5,725					
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN		90,000					
MAPLE LEAF INSURANCE	SPC CONSULTANT FEES		14,957					
SEE LEGAL SCHEDULE ATTACHED			19,250					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 162,650					

* Attach copy of IMRF notifications

**See instructions.

BRIA OF GENEVA
LEGAL SCHEDULE
12/31/2018

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
10/1/2018	GARY A WEINTRAUB PC	LOAN MODIFICATION	950
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	550
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	171
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	506
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
9/4/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
9/4/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	173
11/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
11/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
10/29/2018	SEYFARTH SHAW LLP	LOAN MODIFICATION	2,500
1/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
2/28/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
3/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
4/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
5/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
6/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
7/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
8/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
9/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
10/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
11/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
12/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
TOTAL			19,250

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 OF LONG TERM CARE \$7,312
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 45,322 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. \$ 243,765
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 benefit 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) 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