

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0051540 Facility Name: GENEVA NURSING & REHAB CTR Address: 1101 E STATE ST GENEVA 60134 Number City Zip Code County: KANE Telephone Number: (630) 232-7544 Fax # (630) 232-4409 HFS ID Number: Date of Initial License for Current Owners: 07/08/11 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: SANFORD BOKOR Telephone Number: (847) 675-3585

Email Address:

Facility Name & ID Number GENEVA NURSING & REHAB CTR

0051540 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>107</u>	Skilled (SNF)	<u>107</u>	<u>39,162</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>107</u>	TOTALS	<u>107</u>	<u>39,162</u>	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			<u>6,288</u>	<u>6,288</u>	8
9	SNF/PED					9
10	ICF	<u>21,708</u>	<u>3,794</u>	<u>386</u>	<u>25,888</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,708</u>	<u>3,794</u>	<u>6,674</u>	<u>32,176</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.16%

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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

X

I. On what date did you start providing long term care at this location?

Date started

07/08/11

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

YES

☐

Date

NO

X

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

YES

X

NO

☐

If YES, enter number

of beds certified

107

and days of care provided

6,288

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

X

NO

☐

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number **GENEVA NURSING & REHAB CTR** # **0051540** Report Period Beginning: **01/01/2012** Ending: **12/31/2012**
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	221,218	26,930	11,585	259,733		259,733	(342)	259,391			1
2	Food Purchase		215,686		215,686		215,686	(66)	215,620			2
3	Housekeeping	180,477	27,175		207,652		207,652		207,652			3
4	Laundry	486	1,700	100,010	102,196		102,196		102,196			4
5	Heat and Other Utilities			75,022	75,022		75,022		75,022			5
6	Maintenance	16,598	69,894	21,918	108,410		108,410		108,410			6
7	Other (specify):*			27,303	27,303		27,303		27,303			7
8	TOTAL General Services	418,779	341,385	235,838	996,002		996,002	(408)	995,594			8
	B. Health Care and Programs											
9	Medical Director			17,273	17,273		17,273		17,273			9
10	Nursing and Medical Records	1,886,553	243,843	51,278	2,181,674		2,181,674	(19,877)	2,161,797			10
10a	Therapy	120,302		23,956	144,258		144,258		144,258			10a
11	Activities	124,405	7,171	1,856	133,432		133,432		133,432			11
12	Social Services	24,693	1,028	1,856	27,577		27,577		27,577			12
13	CNA Training											13
14	Program Transportation			17,174	17,174		17,174		17,174			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,155,953	252,042	113,393	2,521,388		2,521,388	(19,877)	2,501,511			16
	C. General Administration											
17	Administrative	105,793		390,767	496,560		496,560	(159,514)	337,046			17
18	Directors Fees											18
19	Professional Services			160,120	160,120		160,120	(73,656)	86,464			19
20	Dues, Fees, Subscriptions & Promotions			66,417	66,417		66,417	(34,237)	32,180			20
21	Clerical & General Office Expenses	193,283	28,260	40,270	261,813		261,813	(11,835)	249,978			21
22	Employee Benefits & Payroll Taxes			424,700	424,700		424,700		424,700			22
23	Inservice Training & Education			4,555	4,555		4,555	295	4,850			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,930	9,930		9,930	2,937	12,867			25
26	Insurance-Prop.Liab.Malpractice			78,676	78,676		78,676	461	79,137			26
27	Other (specify):*			172,600	172,600		172,600	(153,962)	18,638			27
28	TOTAL General Administration	299,076	28,260	1,348,035	1,675,371		1,675,371	(429,511)	1,245,860			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,873,808	621,687	1,697,266	5,192,761		5,192,761	(449,796)	4,742,965			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 11,585	
	REPAIRS & MAINTENANCE 0	
	0 11,585	
3	HOUSEKEEPING	
	0	
	0 0	
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE 899	
	CONTRACTED LAUNDRY SERVICES 99,111	100,010
5	HEAT & OTHER UTILITIES	
	GAS HEAT 17,041	
	ELECTRICITY 35,149	
	WATER 19,534	
	CABLE TV - LOBBY 3,298	
	0 75,022	
6	MAINTENANCE	
	GROUPS MAINTENANCE 12,589	
	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 9,329	
	0	
	0	
	0	
	0 21,918	
7	OTHER	
	SCAVENGER & EXTERMINATING SERVICE 27,303	
	SECURITY SERVICE 0	
	0	
	0 27,303	
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2 17,273	17,273

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	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 4,405	
	PHARMACY CONSULTANT XVIII B 39-2 4,873	
	UTILIZATION REVIEW FEES XVIII B -2 0	
	PHYSICIANS XVIII B -2 0	
	PSYCHIATRIC XVIII B -2 0	
	RN CONSULTANT XVIII B 38-2 42,000	
	0	
	0 51,278	
10a	THERAPY	
	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 10,835	
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2 8,680	
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2 2,083	
	SPEECH THERAPY CONSULTANT XVIII B 43-2 2,358	
		23,956
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS 0	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2 1,856	
	0 1,856	
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES 0	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2 1,856	
	SOCIAL WORKER XVIII B 45-2 0	
		1,856
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII 0	0

V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL	
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	17,174	17,174
		0	
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 390,767	390,767
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 21,042	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 18,287	
	BOOKKEEPING/ADMINISTRATIVE SERVICE	120,791	160,120
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 34,549	
	EMPLOYEE WANT ADS	XIX F 15,964	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 7,372	
	LICENSES & PERMITS	XIX F 2,825	
	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 3,163	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 944	
	PATIENT BACKGROUND CHECKS	XIX F 1,600	
			66,417
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,121	
	EQUIPMENT REPAIR & MAINTENANCE	11,501	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	22,812	
	MESSENGER SERVICE	1,836	
		0	40,270

LINE	SCHED REF	TOTAL	
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 218,585	
	UNEMPLOYMENT COMPENSATION	XIX D 72,785	
	WORKERS COMPENSATION INSURANC	XIX D 80,909	
	HOSPITALIZATION INSURANCE	XIX D 41,075	
	EMPLOYEE BENEFITS - OTHER	XIX D 11,346	
	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	424,700
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	4,555	
			4,555
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	9,930	
			9,930
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	78,676	
			78,676
27	OTHER		
	BAD DEBTS	VI 24 172,600	
			172,600

GRAND TOTAL COLUMN 3 OTHER

1,697,266

GENEVA NURSING & REHAB CTR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	215,686
LESS SALES TAX	(66)
NET FOOD	215,620
TOTAL PATIENT CENSUS	32,176
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	96,528
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	96,528
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	96,528
NET FOOD	215,620
DIVIDE TOTAL MEALS/YEAR	96,528
COST PER MEAL	2.23
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			74,679	74,679		74,679	(64,323)	10,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,275	51,275		51,275	(143)	51,132			32
33	Real Estate Taxes			23,287	23,287		23,287		23,287			33
34	Rent-Facility & Grounds			591,706	591,706		591,706	7,837	599,543			34
35	Rent-Equipment & Vehicles			52,305	52,305		52,305	473	52,778			35
36	Other (specify):*											36
37	TOTAL Ownership			793,252	793,252		793,252	(56,156)	737,096			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,172	807,074	961,246		961,246		961,246			39
40	Barber and Beauty Shops		7,296		7,296		7,296		7,296			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			293,789	293,789		293,789		293,789			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		161,468	1,100,863	1,262,331		1,262,331		1,262,331			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,873,808	783,155	3,591,381	7,248,344		7,248,344	(505,952)	6,742,392			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(65,226)	30		9
10	Interest and Other Investment Income	(143)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	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		21		18
19	Entertainment		20		19
20	Contributions	(3,163)	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	(172,600)	27		24
25	Fund Raising, Advertising and Promotional	(34,549)	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 SEE PAGE 5A	(51,639)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (327,386)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(178,566)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (178,566)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (505,952)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:
Ending:

ID# 0051540
01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (51,639)	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	(51,639)		49

Summary B

12/31/2012

[illegible]

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	1	DIETICIAN CONSULTING	\$ 11,250	WEISS MANAGEMENT GROUP		\$	\$ (11,250)	1
2	V	10	NURSE CONSULTING	42,000				(42,000)	2
3	V	17	MANAGEMENT FEES	218,767				(218,767)	3
4	V	19	BKKPNG/ADMIN SERVICES	40,000				(40,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V	17	MANAGEMENT FEES	172,000	BRIA HEALTH SERVICES, LLC			(172,000)	9
10	V	19	BKKPNG/ADMIN SERVICES	37,500				(37,500)	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 521,517			\$	\$ * (521,517)	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	1	DIETARY SALARIES	\$	WEISS MANAGEMENT GROUP		\$ 8,000	\$ 8,000	15
16	V	10	NURSING SALARIES				11,815	11,815	16
17	V	17	ADMINISTRATIVE SALARIES				231,253	231,253	17
18	V	19	PROFESSIONAL FEES				548	548	18
19	V	20	EMPLOYEE WANT ADS				2,638	2,638	19
20	V	21	OFFICE EXPENSES				36,427	36,427	20
21	V	23	SEMINARS				136	136	21
22	V	25	TRANSPORTATION STAFF				2,178	2,178	22
23	V	26	INSURANCE				258	258	23
24	V	27	EMPLOYEE BENEFITS				15,300	15,300	24
25	V	30	DEPRECIATION (SL)				903	903	25
26	V	34	OFFICE RENT				5,843	5,843	26
27	V	35	AUTO LEASE				274	274	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 315,573	\$ * 315,573	39

* 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	1	DIETARY SALARIES	\$	BRIA HEALTH SERVICES, LLC		\$ 2,908	\$ 2,908	15
16	V	10	NURSING SALARIES				10,308	10,308	16
17	V	19	PROFESSIONAL FEES				3,296	3,296	17
18	V	20	WANT ADS				837	837	18
19	V	21	TOTAL OFFICE				2,386	2,386	19
20	V	21	CLERICAL SALARIES				991	991	20
21	V	23	SEMINARS				159	159	21
22	V	25	TRANSPORTATIONAL STAFF				759	759	22
23	V	26	INSURANCE				203	203	23
24	V	27	EMPLOYEE BENEFITS				3,338	3,338	24
25	V	34	OFFICE RENT				1,994	1,994	25
26	V	35	AUTO LEASE				199	199	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 27,378	\$ * 27,378	39

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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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				8
9								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

Facility Name & ID Number GENEVA NURSING & REHAB CTR # 0051540 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								\$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIVE	0.00	SEE			SALARY	70,445	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	33.30	SCHEDULE	6	15.00	SALARY	84,952	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	33.40		9	22.50	SALARY	75,856	17.7	6
7											7
8	ALLOCATIONS FROM BRIA HEALTH SERVICES, LLC:										8
9	DOV SEGAL	PURCHASING	CONSULTING	0.00				SALARY	3,267	19-1	9
10		CONSULTANT									10
11											11
12											12
13								TOTAL	\$ 234,520		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: 01/01/2012 Ending: 2/31/2012

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 WEISS MANAGEMENT GROUP
Street Address 6865 N LINCOLN AVE
City / State / Zip Code LINCOLNWOOD, IL 60712
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	1	DIETARY SALARIES	PATIENT CENSUS	193,748	4	\$ 48,175	\$ 48,175	32,176	\$ 8,000	1
2	10	NURSING SALARIES	PATIENT CENSUS	287,415	6	105,543	105,543	32,176	11,815	2
3	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	176,223	4	1,266,537	1,266,537	32,176	231,253	3
4	19	PROFESSIONAL FEES	PATIENT CENSUS	176,223	4	3,003		32,176	548	4
5	20	EMPLOYEE WANT ADS	PATIENT CENSUS	176,223	4	14,450		32,176	2,638	5
6	21	OFFICE EXPENSES	PATIENT CENSUS	176,223	4	199,508	128,614	32,176	36,427	6
7	23	SEMINARS	PATIENT CENSUS	176,223	4	745		32,176	136	7
8	25	TRANSPORTATION STAFF	PATIENT CENSUS	176,223	4	11,934		32,176	2,178	8
9	26	INSURANCE	PATIENT CENSUS	176,223	4	1,416		32,176	258	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	176,223	4	83,794		32,176	15,300	10
11	30	DEPRECIATION (SL)	PATIENT CENSUS	176,223	4	4,949		32,176	903	11
12	34	OFFICE RENT	PATIENT CENSUS	176,223	4	32,000		32,176	5,843	12
13	35	AUTO LEASE	PATIENT CENSUS	176,223	4	1,500		32,176	274	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,773,554	\$ 1,548,869		\$ 315,573	25

Facility Name & ID Number GENEVA NURSING & REHAB CTR # 0051540 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 6865 N LINCOLN AVE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (847) 674-5795
Fax Number (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	DIETARY SALARIES	PATIENT CENSUS	322,729	8	\$ 29,170	\$ 29,170	32,176	\$ 2,908	1
	2	NURSING SALARIES	PATIENT CENSUS	322,729	8	103,388	103,388	32,176	10,308	2
	3	PROFESSIONAL FEES	PATIENT CENSUS	322,729	8	33,054	32,765	32,176	3,296	3
	4	WANT ADS	PATIENT CENSUS	322,729	8	8,400		32,176	837	4
	5	TOTAL OFFICE	PATIENT CENSUS	322,729	8	23,931		32,176	2,386	5
	6	CLERICAL SALARIES	PATIENT CENSUS	322,729	8	9,940	9,940	32,176	991	6
	7	SEMINARS	PATIENT CENSUS	322,729	8	1,599		32,176	159	7
	8	TRANSPORTATIONAL STAFF	PATIENT CENSUS	322,729	8	7,616		32,176	759	8
	9	INSURANCE	PATIENT CENSUS	322,729	8	2,036		32,176	203	9
	10	EMPLOYEE BENEFITS	PATIENT CENSUS	322,729	8	33,481		32,176	3,338	10
	11	OFFICE RENT	PATIENT CENSUS	322,729	8	20,000		32,176	1,994	11
	12	AUTO LEASE	PATIENT CENSUS	322,729	8	2,000		32,176	199	12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$ 274,615	\$ 175,263		\$ 27,378	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	08/01/11	150,000	780,000		PRIME+	25,210		6
7	THE PRIVATE BANK	X		WORKING CAPITAL	\$10,472.22	08/03/11	400,000	366,667		7.0000	26,065		7
8													8
9	TOTAL Facility Related				\$10,472.22		\$ 550,000	\$ 1,146,667			\$ 51,275		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$ 550,000	\$ 1,146,667			\$ 51,275		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)				\$	23,287	2
3. Under or (over) accrual (line 2 minus line 1).				\$	23,287	3
4. Real Estate Tax accrual used for 2012 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. (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.				\$	23,287	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007		8		
		2008		9		
		2009		10		
		2010		11		
		2011	23,287	12		
THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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

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				\$	1
2					2
3	TOTALS			\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	REPLACE D/F SIGN INCLUDES NEW ROUND LOGO			2011	6,414	428	15	428		571
10	REPLACE THE 3 RTU'S			2011	11,900	433	27.5	433		487
11	INSTALL TRACO NX SERIES DOUBLE HUNG WINDOWS			2012	109,415	2,155	27.5	2,155		2,155
12	INSTALL 29 EACH SLEEVE UNITS			2012	34,000	567	27.5	567		567
13	NORTH/SOUTH, EAST/WEST RESIDENT ROOMS; FRONT			2012	209,990	2,864	27.5	2,864		2,864
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	1,476	5	1,476		1,476
19	LEVEL 1, HALLWAY, LEVEL 2, BATHROOMS,5 OFFICES									19
20	WINDOW TREATMENTS UPPER FLOOR ONLY			2012	29,696	1,485	5	1,485		1,485
21	INTERIOR SIGNAGE			2012	2,717	45	15	45		45
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									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)		\$ 433,659	\$ 9,453		\$ 9,453	\$	\$ 9,650	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	\$ 44,266	\$	\$	\$		\$	71
72	Current Year Purchases	119,030	65,226		(65,226)			72
73	Fully Depreciated Assets							73
74	RELATED PARTY		903	903				74
75	TOTALS	\$ 163,296	\$ 66,129	\$ 903	\$ (65,226)		\$	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)	\$ 596,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,582	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 10,356	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,226)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,650	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.

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:		107	07/08/11	\$ 591,706	5		3
4	Additions							4
5								5
6								6
7	TOTAL		107		\$ 591,706			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☒ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 52,305
- 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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

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.	07/08/2013	\$ 625,000
13.	07/08/2014	\$ 663,000
14.	07/08/2015	\$ 683,000

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

- (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.

C. CONTRACTUAL INCOME

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

\$

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

- (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.)

12345678										
	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	\$		\$ 304,393	\$		\$ 304,393	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			99,576			99,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			403,105			403,105	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				139,150		139,150	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY	39-2					7,587		7,587	12
13	Other (specify): LABORATORY	39-2					7,435		7,435	13
14	TOTAL			\$		\$ 807,074	\$ 154,172		\$ 961,246	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 618,123	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,863,913		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,893		6
7	Other Prepaid Expenses	39,401		7
8	Accounts Receivable (owners or related parties)	20,409		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,626,739	\$	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	433,659		15
16	Equipment, at Historical Cost	163,296		16
17	Accumulated Depreciation (book methods)	(119,142)		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 (spe OPTION DEPOSIT	160,500		22
23	Other(specify): CONSTRUCTION ESCROW	26,788		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 665,101	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,291,840	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 793,880	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,188,853		29
30	Accrued Salaries Payable	135,551		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,981		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)	\$ 2,127,265	\$	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)	\$ 2,127,265	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,164,575	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,291,840	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 598,036	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 598,036	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	566,539	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)	\$ 566,539	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)	\$ 1,164,575	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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,643,675	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,643,675	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,170,900	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,170,900	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	30	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)	\$ 30	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	143	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 143	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	135	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 135	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,814,883	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	996,002	31
32	Health Care	2,521,388	32
33	General Administration	1,675,371	33
	B. Capital Expense		
34	Ownership	793,252	34
	C. Ancillary Expense		
35	Special Cost Centers	968,542	35
36	Provider Participation Fee	293,789	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,248,344	40
41	Income before Income Taxes (line 30 minus line 40)**	566,539	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 566,539	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,033,434	44
45	Private Pay - Net Inpatient Revenue	921,272	45
46	Medicare - Net Inpatient Revenue	1,542,761	46
47	Other-(specify) <u>MANAGED CARE</u>	146,208	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,643,675	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,080	\$ 85,398	\$ 41.06	1
2	Assistant Director of Nursing	1,997	2,080	62,743	30.16	2
3	Registered Nurses	12,594	12,818	383,852	29.95	3
4	Licensed Practical Nurses	15,824	16,255	411,210	25.30	4
5	CNAs & Orderlies	62,935	64,179	828,823	12.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,872	4,106	120,302	29.30	8
9	Activity Director					9
10	Activity Assistants	9,834	10,129	124,405	12.28	10
11	Social Service Workers	1,120	1,202	24,693	20.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,502	19,145	221,218	11.55	15
16	Dishwashers					16
17	Maintenance Workers	864	902	16,598	18.40	17
18	Housekeepers	16,532	17,202	180,477	10.49	18
19	Laundry	57	57	486	8.53	19
20	Administrator	2,032	2,080	105,793	50.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,040	11,291	193,283	17.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,912	2,010	30,321	15.09	31
32	Other Health C: Care Plan Coord	2,338	2,378	84,206	35.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,477	167,914	\$ 2,873,808 *	\$ 17.11	34

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	\$ 11,585	1-3	35
36	Medical Director	O	17,273	9-3	36
37	Medical Records Consultant	N	4,405	10-3	37
38	Nurse Consultant	T	42,000	10-3	38
39	Pharmacist Consultant	H	4,873	10-3	39
40	Physical Therapy Consultant	L	10,835	10a-3	40
41	Occupational Therapy Consultant	Y	8,680	10a-3	41
42	Respiratory Therapy Consultant		2,083	10a-3	42
43	Speech Therapy Consultant	F	2,358	10a-3	43
44	Activity Consultant	E	1,856	11-3	44
45	Social Service Consultant	E	1,856	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 107,804		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			10-3	51
52	Certified Nurse Assistants/Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

GENEVA NURSING & REHAB CTR

0051540

Report Period Beginning:

01/01/2012

Page 21

Ending:

12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

SCOTT HOCHSTADT

ADMINISTRATOR

0

\$ 105,793

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 105,793

B. Administrative - Other

Description

Amount

WEISS MANAGEMENR GROUP MANAGEMENT FEES

\$ 218,767

BRIA HEALTH SERVICES, LLC MANAGEMENT FEES

172,000

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 390,767

C. Professional Services

Vendor/Payee

Type

Amount

\$

SEE SCHEDULE ATTACHED

160,120

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 160,120

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 80,909

Unemployment Compensation Insurance

72,785

FICA Taxes

218,585

Employee Health Insurance

41,075

Employee Meals

0

Illinois Municipal Retirement Fund (IMRF)*

EMPLOYEE BENEFITS - OTHER

11,346

EMPLOYEE PHYSICAL EXAMS

0

PENSION/PROFIT SHARING PLANS

0

CHICAGO HEAD TAX

0

INSURANCE - EXECUTIVE LIFE

0

INSURANCE - EXECUTIVE LIFE VI 21

0

TOTAL (agree to Schedule V, line 22, col.8)

\$ 424,700

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

15,964

Health Care Worker Background Check

944

(Indicate # of checks performed 25)

Patient Background Checks

160

1,600

TRUST/FRANCHISE/CONTRIB/ETC

3,163

MARKETING/ADV/PROMO

34,549

LICENSES/DUES/SUBSCRIPTIONS

10,197

MGMT CO ALLOC

3,475

TRUST/FRANCHISE/CONTRIB/ETC

(3,163)

Less: Public Relations Expense

(0)

Non-allowable advertising

(34,549)

Yellow page advertising

(0)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 32,180

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

0

Seminar Expense

0

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$6,820

(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? _____ 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. \$ 36,383 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. \$ 293,789
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 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.