FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0051540

Facility Name: GENEVA NURSING & REHAB CTR

Address: 1101 E STATE ST (Number) GENEVA (City) 60134 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,162	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	39,162	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,288	6,288	8
9	SNF/PED					9
10	ICF	21,708	3,794	386	25,888	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,708	3,794	6,674	32,176	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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
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.

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

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**			
	GROUNDS 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 SERVIC		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 CONSULTAN	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 CONSULTA	XVIII B 41-2	8,680	
	RESPIRATORY THERAPY CONSULTAN	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 CONSULTAN	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

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

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**

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

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
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.**

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

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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (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

STATE OF ILLINOIS

GENEVA NURSING & REHAB CTR

ID# 0051540

Report Period Beginning: 01/01/2012

Ending: 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

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(11,250)	8,000	2,908	0	0	0	0	0	0	0	(342)	1
2	Food Purchase	(66)	0	0	0	0	0	0	0	0	0	0	(66)	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	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(66)	(11,250)	8,000	2,908	0	0	0	0	0	0	0	(408)	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	(42,000)	11,815	10,308	0	0	0	0	0	0	0	(19,877)	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	(42,000)	11,815	10,308	0	0	0	0	0	0	0	(19,877)	16
	C. General Administration													
17	Administrative	0	(390,767)	231,253	0	0	0	0	0	0	0	0	(159,514)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(77,500)	548	3,296	0	0	0	0	0	0	0	(73,656)	19
20	Fees, Subscriptions & Promotions	(37,712)	0	2,638	837	0	0	0	0	0	0	0	(34,237)	20
21	Clerical & General Office Expenses	(51,639)	0	36,427	3,377	0	0	0	0	0	0	0	(11,835)	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	136	159	0	0	0	0	0	0	0	295	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	2,178	759	0	0	0	0	0	0	0	2,937	25
26	Insurance-Prop.Liab.Malpractice	0	0	258	203	0	0	0	0	0	0	0	461	26
27	Other (specify):*	(172,600)	0	15,300	3,338	0	0	0	0	0	0	0	(153,962)	27
28	**TOTAL General Administration**	(261,951)	(468,267)	288,738	11,969	0	0	0	0	0	0	0	(429,511)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(262,017)	(521,517)	308,553	25,185	0	0	0	0	0	0	0	(449,796)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(65,226)	0	903	0	0	0	0	0	0	0	0	(64,323)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(143)	0	0	0	0	0	0	0	0	0	0	(143)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,843	1,994	0	0	0	0	0	0	0	7,837	34
35	Rent-Equipment & Vehicles	0	0	274	199	0	0	0	0	0	0	0	473	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(65,369)	0	7,020	2,193	0	0	0	0	0	0	0	(56,156)	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)**	(327,386)	(521,517)	315,573	27,378	0	0	0	0	0	0	0	(505,952)	45

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

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

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	
						Hours	Percent	Description	Amount		
1	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIC	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 [X] 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 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	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 [X] 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	1	DIETARY SALARIES	PATIENT CENSUS	322,729	8	$ 29,170	$ 29,170	32,176	$ 2,908	1
2	10	NURSING SALARIES	PATIENT CENSUS	322,729	8	103,388	103,388	32,176	10,308	2
3	19	PROFESSIONAL FEES	PATIENT CENSUS	322,729	8	33,054	32,765	32,176	3,296	3
4	20	WANT ADS	PATIENT CENSUS	322,729	8	8,400		32,176	837	4
5	21	TOTAL OFFICE	PATIENT CENSUS	322,729	8	23,931		32,176	2,386	5
6	21	CLERICAL SALARIES	PATIENT CENSUS	322,729	8	9,940	9,940	32,176	991	6
7	23	SEMINARS	PATIENT CENSUS	322,729	8	1,599		32,176	159	7
8	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	322,729	8	7,616		32,176	759	8
9	26	INSURANCE	PATIENT CENSUS	322,729	8	2,036		32,176	203	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	322,729	8	33,481		32,176	3,338	10
11	34	OFFICE RENT	PATIENT CENSUS	322,729	8	20,000		32,176	1,994	11
12	35	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

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)**

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

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

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GENEVA NURSING & REHAB CTR COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0051540

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-02-429-009	NURSING HOME	$ 22,461.52	$ 22,461.52
2.	12-02-429-005	NURSING HOME	$ 825.74	$ 825.74
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,287.26	$ 23,287.26

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	9
10	REPLACE THE 3 RTU'S			2011	11,900	433	27.5	433		487	10
11	INSTALL TRACO NX SERIES DOUBLE HUNG WINDOWS			2012	109,415	2,155	27.5	2,155		2,155	11
12	INSTALL 29 EACH SLEEVE UNITS			2012	34,000	567	27.5	567		567	12
13	NORTH/SOUTH, EAST/WEST RESIDENT ROOMS; FRONT			2012	209,990	2,864	27.5	2,864		2,864	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	1,476	5	1,476		1,476	18
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	20
21	INTERIOR SIGNAGE			2012	2,717	45	15	45		45	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

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.

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

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.

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

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. [X] 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: [X] YES [ ] NO Terms: *

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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

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

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

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

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
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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

	1	2	3	4	5	6	7	8	
	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
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		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.

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

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.)

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

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.**

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

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	1 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	2 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) MANAGED CARE	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.**

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number GENEVA NURSING & REHAB CTR # 0051540 Report Period Beginning: 01/01/2012 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)		$ 390,767
(Attach a copy of any management service agreement)		

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

* Attach copy of IMRF notifications

**See instructions.

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

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

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

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

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 COUNSIL 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 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.