FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: BRIA OF GENEVA

Address: 1101 EAST 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 01/01/2014 to 12/31/2014 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) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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 BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	39,055	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,940	4,940	8
9	SNF/PED					9
10	ICF	20,974	4,188	774	25,936	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,974	4,188	5,714	30,876	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.06%

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 07/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/01 NO [ ]

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 4,940

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	37,265	10,864	428,030	476,159		476,159	1,646	477,805			1
2	Food Purchase		38,718		38,718		38,718	(169)	38,549			2
3	Housekeeping	23,092	26,561	196,703	246,356		246,356		246,356			3
4	Laundry		1,460	118,128	119,588		119,588		119,588			4
5	Heat and Other Utilities			114,973	114,973		114,973	97	115,070			5
6	Maintenance	40,663	83,337	44,510	168,510		168,510	229	168,739			6
7	Other (specify):*			24,993	24,993		24,993		24,993			7
8	TOTAL General Services	101,020	160,940	927,337	1,189,297		1,189,297	1,803	1,191,100			8
	B. Health Care and Programs											
9	Medical Director			31,070	31,070		31,070		31,070			9
10	Nursing and Medical Records	2,284,431	187,403	4,705	2,476,539		2,476,539	31,155	2,507,694			10
10a	Therapy			17,173	17,173		17,173		17,173			10a
11	Activities	105,172	5,718	5,216	116,106		116,106		116,106			11
12	Social Services	47,267	1,265	2,272	50,804		50,804		50,804			12
13	CNA Training											13
14	Program Transportation			8,247	8,247		8,247		8,247			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,436,870	194,386	68,683	2,699,939		2,699,939	31,155	2,731,094			16
	C. General Administration											
17	Administrative	96,275		397,922	494,197		494,197	(397,922)	96,275			17
18	Directors Fees											18
19	Professional Services			262,050	262,050		262,050	(128,847)	133,203			19
20	Dues, Fees, Subscriptions & Promotions			49,666	49,666		49,666	(29,690)	19,976			20
21	Clerical & General Office Expenses	189,185	29,901	86,162	305,248		305,248	(46,493)	258,755			21
22	Employee Benefits & Payroll Taxes			402,091	402,091		402,091		402,091			22
23	Inservice Training & Education			3,448	3,448		3,448	354	3,802			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,404	10,404		10,404	2,342	12,746			25
26	Insurance-Prop.Liab.Malpractice			97,704	97,704		97,704	236	97,940			26
27	Other (specify):*			156,000	156,000		156,000	(147,747)	8,253			27
28	TOTAL General Administration	285,460	29,901	1,465,447	1,780,808		1,780,808	(747,767)	1,033,041			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,823,350	385,227	2,461,467	5,670,044		5,670,044	(714,809)	4,955,235			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#: BRIA OF GENEVA **#0051540** **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	345	
	REPAIRS & MAINTENANCE		556	
	DIETARY-SERVICE CONTRACTS		427,129	428,030
3	**HOUSEKEEPING**			
	HOUSEKEEPING SERVICE CONTRACTS		196,703	
				196,703
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		118,128	118,128
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,713	
	ELECTRICITY		53,327	
	WATER		25,531	
	CABLE TV - LOBBY		3,402	
				114,973
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		25,196	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		380	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		18,934	
				44,510
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		24,993	
	SECURITY SERVICE		0	
				24,993
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	31,070	31,070

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	630	
	PHARMACY CONSULTANT	XVIII B 39-2	4,075	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				4,705
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	6,656	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,158	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	5,437	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,922	
				17,173
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	5,216	
				5,216
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,272	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,272
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIA OF GENEVA **#0051540** **Report Period Beginning: 01/01/2014** **Ending: 12/31/2014**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		8,247	
				8,247
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	397,922	397,922
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,831	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	53,249	
	BOOKKEEPING/ADMINISTRATIVE SERVICE		201,970	262,050
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	27,732	
	EMPLOYEE WANT ADS	XIX F	2,509	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,097	
	LICENSES & PERMITS	XIX F	2,328	
	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	5,652	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	2,348	
				49,666
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,162	
	EQUIPMENT REPAIR & MAINTENANCE		50,961	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	21	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		25,499	
	MESSENGER SERVICE		2,519	
				86,162

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	215,987	
	UNEMPLOYMENT COMPENSATION	XIX D	63,484	
	WORKERS COMPENSATION INSURANC	XIX D	84,785	
	HOSPITALIZATION INSURANCE	XIX D	21,696	
	EMPLOYEE BENEFITS - OTHER	XIX D	16,139	
	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	
				402,091
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,448	
				3,448
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,404	
				10,404
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		97,704	
				97,704
27	**OTHER**			
	BAD DEBTS	VI 24	156,000	
				156,000

GRAND TOTAL COLUMN 3 OTHER **2,461,467**

BRIA OF GENEVA
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	38,718
LESS SALES TAX	(169)
NET FOOD	38,549
TOTAL PATIENT CENSUS	30,876
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	92,628
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	92,628
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	92,628
NET FOOD	38,549
DIVIDE TOTAL MEALS/YEAR	92,628
COST PER MEAL	0.42
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number BRIA OF GENEVA #0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			88,923	88,923		88,923	233,887	322,810			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,628	18,628		18,628	450,938	469,566			32
33	Real Estate Taxes							100,493	100,493			33
34	Rent-Facility & Grounds			736,500	736,500		736,500	(736,256)	244			34
35	Rent-Equipment & Vehicles			32,152	32,152		32,152	1,263	33,415			35
36	Other (specify):*											36
37	**TOTAL Ownership**			876,203	876,203		876,203	50,325	926,528			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,653	891,476	1,075,129		1,075,129		1,075,129			39
40	Barber and Beauty Shops			9,795	9,795		9,795		9,795			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,721	210,721		210,721		210,721			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		183,653	1,111,992	1,295,645		1,295,645		1,295,645			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,823,350	568,880	4,449,662	7,841,892		7,841,892	(664,484)	7,177,408			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 BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(19,333)	30		9
10	Interest and Other Investment Income	(5,591)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	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)	21		18
19	Entertainment		20		19
20	Contributions	(5,652)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,000)	27		24
25	Fund Raising, Advertising and Promotional	(27,732)	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	(57,789)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (274,787)		$	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)	(389,697)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (389,697)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (664,484)		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

BRIA OF GENEVA

ID# 0051540

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (57,789)	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**	(57,789)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIA OF GENEVA **#** 0051540 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	1,646	0	0	0	0	0	0	0	0	1,646	1
2	Food Purchase	(169)	0	0	0	0	0	0	0	0	0	0	(169)	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	97	0	0	0	0	0	0	0	0	97	5
6	Maintenance	0	0	229	0	0	0	0	0	0	0	0	229	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(169)	0	1,972	0	0	0	0	0	0	0	0	1,803	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	31,155	0	0	0	0	0	0	0	0	31,155	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	31,155	0	0	0	0	0	0	0	0	31,155	16
	C. General Administration													
17	Administrative	0	0	(397,922)	0	0	0	0	0	0	0	0	(397,922)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,500)	0	(126,347)	0	0	0	0	0	0	0	0	(128,847)	19
20	Fees, Subscriptions & Promotions	(33,384)	0	3,694	0	0	0	0	0	0	0	0	(29,690)	20
21	Clerical & General Office Expenses	(57,810)	0	11,317	0	0	0	0	0	0	0	0	(46,493)	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	354	0	0	0	0	0	0	0	0	354	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	2,342	0	0	0	0	0	0	0	0	2,342	25
26	Insurance-Prop.Liab.Malpractice	0	0	236	0	0	0	0	0	0	0	0	236	26
27	Other (specify):*	(156,000)	0	8,253	0	0	0	0	0	0	0	0	(147,747)	27
28	**TOTAL General Administration**	(249,694)	0	(498,073)	0	0	0	0	0	0	0	0	(747,767)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(249,863)	0	(464,946)	0	0	0	0	0	0	0	0	(714,809)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF GENEVA # 0051540 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(19,333)	252,683	537	0	0	0	0	0	0	0	0	233,887	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,591)	456,325	204	0	0	0	0	0	0	0	0	450,938	32
33	Real Estate Taxes	0	99,964	529	0	0	0	0	0	0	0	0	100,493	33
34	Rent-Facility & Grounds	0	(736,500)	244	0	0	0	0	0	0	0	0	(736,256)	34
35	Rent-Equipment & Vehicles	0	0	1,263	0	0	0	0	0	0	0	0	1,263	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,924)	72,472	2,777	0	0	0	0	0	0	0	0	50,325	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)	(274,787)	72,472	(462,169)	0	0	0	0	0	0	0	0	(664,484)	45

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
SEE PAGE 6-SUPPLEMENTAL		SEE PAGE 6-SUPPLEMENTAL		SEE PAGE 6-SUPPLEMENTAL		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	34	RENT	$ 736,500	GENEVA STATE STREET, LLC		$	$ (736,500)	1
2	V	32	INTEREST				433,767	433,767	2
3	V	32	AMORT LOAN COST				22,558	22,558	3
4	V	33	REAL ESTATE TAXES				99,964	99,964	4
5	V	30	DEPRECIATION (SL)				252,683	252,683	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 736,500			$ 808,972	$ * 72,472	14

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	17	MANAGEMENT FEES	$ 397,922	BRIA HEALTH SERVICES, LLC		$	$ (397,922)	15
16	V	19	BKKPNG/ADMIN SERVICES	178,000				(178,000)	16
17	V								17
18	V	1	DIETARY SALARIES				1,646	1,646	18
19	V	5	UTILITIES				97	97	19
20	V	6	REPAIR/MAINT				229	229	20
21	V	10	NURSING CONSULTING FEE				1,008	1,008	21
22	V	10	NURSING SALARIES				30,147	30,147	22
23	V	19	PROFESSIONAL FEES				51,653	51,653	23
24	V	20	WANT ADS, LICENSES				3,694	3,694	24
25	V	21	TOTAL OFFICE				11,317	11,317	25
26	V	23	SEMINARS				354	354	26
27	V	25	TRANSPORTATION				2,342	2,342	27
28	V	26	INSURANCE				236	236	28
29	V	27	EMPLOYEE BENEFITS				8,253	8,253	29
30	V	30	DEPRECIATION (SL)				537	537	30
31	V	32	INTEREST				204	204	31
32	V	33	RE TAX				529	529	32
33	V	34	OFFICE RENT				244	244	33
34	V	35	PUBLIC STORAGE				266	266	34
35	V	35	AUTO LEASE				997	997	35
36	V								36
37	V								37
38	V								38
39	Total			$ 575,922			$ 113,753	$ * (462,169)	39

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	BRIA OF BELLEVILLE	BELLEVILLE	WEISS MGMT	LINCOLNWOOD	MANAGEMENT/	2
3					GROUP, INC		CLERICAL	3
4	NATAN WEISS	33.4	BRIA OF PALOS HILLS	PALOS HILLS				4
5					BRIA HEALTH	LINCOLNWOOD	MANAGEMENT	5
6	AVRUM WEINFELD	33.3	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO	SERVICES, LLC		SERVICES	6
7				HEIGHTS				7
8					GENEVA STATE	LINCOLNWOOD	REAL ESTATE	8
9			LAKE PARK CENTER	WAUKEGAN	STREET, LLC			9
10								10
11								11
12			BRIA OF WESTMONT	WESTMONT				12
13								13
14								14
15			BRIA OF FOREST EDGE	CHICAGO				15
16								16
17								17
18			BRIA OF RIVER OAKS	BURNHAM				18
19								19
20								20
21			BRIA OF CAHOKIA	CAHOKIA				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	AVRUM WEINFELD	SHAREHOLDER	ADMINISTRATIV	33.30		15	13.76		$ 0		1
2					SEE						2
3	NATAN WEISS	CFO	FINANCE/MGMT	33.40	ATTACHED	2	2.70		0		3
4					SCHEDULE						4
5	DANIEL WEISS	SHAREHOLDER	ADMINISTRATIV	33.30		15	13.04		0		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	421,649	8	$ 22,482	$ 22,482	30,876	$ 1,646	1
2	5	UTILITIES	PATIENT CENSUS	421,649	8	1,327		30,876	97	2
3	6	REPAIR/MAINT	PATIENT CENSUS	421,649	8	3,134		30,876	229	3
4	10	NURSING CONSULTING FEE	PATIENT CENSUS	421,649	8	13,770		30,876	1,008	4
5	10	NURSING SALARIES	PATIENT CENSUS	421,649	8	411,700	411,700	30,876	30,147	5
6	19	PROFESSIONAL FEES	PATIENT CENSUS	421,649	8	705,381	100,000	30,876	51,653	6
7	20	WANT ADS, LICENSES	PATIENT CENSUS	421,649	8	50,442		30,876	3,694	7
8	21	TOTAL OFFICE	PATIENT CENSUS	421,649	8	154,551	71,971	30,876	11,317	8
9	23	SEMINARS	PATIENT CENSUS	421,649	8	4,839		30,876	354	9
10	25	TRANSPORTATION	PATIENT CENSUS	421,649	8	31,980		30,876	2,342	10
11	26	INSURANCE	PATIENT CENSUS	421,649	8	3,220		30,876	236	11
12	27	EMPLOYEE BENEFITS	PATIENT CENSUS	421,649	8	112,698		30,876	8,253	12
13	30	DEPRECIATION (SL)	PATIENT CENSUS	421,649	8	7,337		30,876	537	13
14	32	INTEREST	PATIENT CENSUS	421,649	8	2,787		30,876	204	14
15	33	RE TAX	PATIENT CENSUS	421,649	8	7,222		30,876	529	15
16	34	OFFICE RENT	PATIENT CENSUS	421,649	8	3,338		30,876	244	16
17	35	PUBLIC STORAGE	PATIENT CENSUS	421,649	8	3,634		30,876	266	17
18	35	AUTO LEASE	PATIENT CENSUS	421,649	8	13,620		30,876	997	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,553,462	$ 606,153		$ 113,753	25

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	RELATED PARTY: GENEVA STATE STREET, LLC						$	$			$	1
2	THE PRIVATE BANK	X		MORTGAGE		04/30/13	7,800,000	7,800,000	04/30/18	5.5000	433,767	2
3	LOAN COST			AMORT OVER 5 YEARS			112,791	75,194			22,558	3
4												4
5												5
	Working Capital											
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	08/01/11	150,000	300,000		PRIME+	18,628	6
7												7
8	RELATED PARTY ALLOCATION										204	8
9	TOTAL Facility Related						$ 8,062,791	$ 8,175,194			$ 475,157	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,062,791	$ 8,175,194			$ 475,157	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 BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$ 99,964	2
3. Under or (over) accrual (line 2 minus line 1).		$ 99,964	3
4. Real Estate Tax accrual used for 2014 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.		$ 99,964	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011	23,287	10
2012	73,263	11
2013	99,964	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIA OF GENEVA COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0051540

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-02-429-009	NURSING HOME	$ 98,110.56	$ 98,110.56
2.	12-02-429-005	NURSING HOME	$ 1,853.18	$ 1,853.18
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 99,963.74	$ 99,963.74

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2013	$ 700,000	1
2					2
3	TOTALS			$ 700,000	3

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	107		2013		$ 6,117,660	$ 222,460	27.5	$ 222,460	$	$ 333,571	4
5	OFFICE		2013		135,450	3,473	39	3,473		6,749	5
6											6
7											7
8	RELATED PARTY ALLOCATION				6,575	169		169			8
	Improvement Type**										
9	REPLACE D/F SIGN INCLUDES NEW ROUND LOGO			2011	6,414	428	15	428		1,427	9
10	REPLACE THE 3 RTU'S			2011	11,900	433	27.5	433		1,353	10
11	INSTALL TRACO NX SERIES DOUBLE HUNG WINDOWS			2012	109,415	3,979	27.5	3,979		10,113	11
12	INSTALL 29 EACH SLEEVE UNITS			2012	34,000	1,236	27.5	1,236		3,039	12
13	NORTH/SOUTH, EAST/WEST RESIDENT ROOMS; FRONT			2012	209,990	7,636	27.5	7,636		18,136	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	6,732	5	6,732		19,428	18
19	LEVEL 1, HALLWAY, LEVEL 2, BATHROOMS,5 OFFICES										19
20	WINDOW TREATMENTS UPPER FLOOR ONLY			2012	29,696	6,771	5	6,771		19,540	20
21	INTERIOR SIGNAGE			2012	2,717	181	15	181		407	21
22	VESTIBULE, LOBBY, LOWER LEVEL RESIDENT ROOMS:										22
23	WALL BASE INSTALLATION, FLOORING			2013	54,274	1,974	27.5	1,974		3,043	23
24	INSTALL ELEVEN NEW 20 AMPERE CIRCUITS AND OUTLETS										24
25	FOR PTEC UNITS IN ROOM #S 302-3012			2013	11,000	400	27.5	400		750	25
26	FURNISH & INSTALLED (2) PEDESTRIAN ENTRY DOORS										26
27	AND FRAME			2013	9,400	342	27.5	342		556	27
28	NORTH AND SOUTH PARKING LOT:GRAIND & PATCH,										28
29	ASPHALTING,SEALCOATING, STRIPING,CRACK FILLING			2013	10,879	725	15	725		1,148	29
30	PAINTING OUTSIDE OF THE BUILDING: SOFFITS, WOODS,										30
31	DOORS,METAL FENCES AND COLLUMS.			2013	8,100	2,592	5	2,592		4,212	31
32	LOWER LEVEL CORRIDOR HANDRAIL, DOORS HANDRAIL			2013	25,489	927	27.5	927		1,429	32
33	THE BASEMENT: INSTALL NEW RAILINGS, BAMPERS,										33
34	CONERGUARDS, DOORS KICK PLATE			2013	15,043	547	27.5	547		843	34
35	LAUNDRY ROOM:BUILD NEW WALLS WITH NEW METAL										35
36	DOORS, NEW CERAMIC TILE			2013	2,500	91	27.5	91		133	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	INSTALLED NEW MULE-HIDE TPO ROOF SYSTEM & NEW		$	$		$	$	$	37
38	JOHNS MANSVILLE MODIFIELD BITUMEN	2013	6,675	243	27.5	243		314	38
39	WIRE UP 22 ROOMS ON BASEMENT LEVEL	2013	4,950	180	27.5	180		203	39
40	PASSENGER ELEVATOR-REPLACE CONTROLLER; PROVIDE								40
41	NEW HOISTWAY WIRING, TANK, MOTOR, PUMP & VALVE	2014	59,400	2,070	27.5	2,070		2,070	41
42	LOWER LEVEL RESIDENT ROOMS, SOLARIUM, DINING								42
43	ROOM-WINDOW TREATMENTS	2014	18,771	3,754	5	3,754		3,754	43
44	REMODEL DINING ROOM IN BASEMENT-INSTALL NEW								44
45	CORNER GUARDS,OUTLETS, LIGHT FIXTURS,WALLCOVE-								45
46	RING, HANDRAILS, CELLING TILE	2014	62,892	1,811	27.5	1,811		1,811	46
47	INSTALL FIVE NEW 20 AMPERE CIRCUITS AND OUTLETS								47
48	FOR PTEC UNITS IN ROOM #201,203,205,207,204	2014	5,000	144	27.5	144		144	48
49	LOWER LEVEL DINING ROOM-WALLCOVERING,								49
50	FLOORING	2014	13,278	382	27.5	382		382	50
51	LOWER LEVEL SOLARIUM AND CORRIDOR-FLOORING	2014	6,621	131	27.5	131		131	51
52	REMODEL SHOWER ROOM IN BASEMONT-DRYWALL,								52
53	SOFFITS, COVER WITH PLASTIC 2 DOORS	2014	11,650	194	27.5	194		194	53
54	REINFORCE THE FIRE WALL ABOVE THE FIRE DOOR IN								54
55	THE NORTHWEST AND EAST SIDE OF THE BUILDING	2014	16,600	277	27.5	277		277	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)		$ 7,035,866	$ 270,282		$ 270,282	$	$ 435,157	70

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 173,641	$ 14,568	$ 22,525	$ 7,957	5-10	$ 61,423	71
72	Current Year Purchases	50,292	30,175	2,885	(27,290)	8-10	2,885	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL ALLOCATION		27,118	27,118				74
75	TOTALS	$ 223,933	$ 71,861	$ 52,528	$ (19,333)		$ 64,308	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)	$ 7,959,799	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 342,143	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 322,810	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,333)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 499,465	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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: $ 27,941 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	ADMINISTRATIVE	2014 HONDA CRV	$ 424.39	$ 4,211	17
18					18
19					19
20					20
21	TOTAL		$ 424.39	$ 4,211	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 BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 348,862	$		$ 348,862	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			118,212			118,212	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			424,402			424,402	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				146,028		146,028	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					18,916		18,916	12
13	I.V. THERAPY Other (specify): MEDICAL SUPPLY	39-2 39-2					11,520 7,189		11,520 7,189	13
14	TOTAL			$		$ 891,476	$ 183,653		$ 1,075,129	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 256,551	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 365,012)	2,346,372		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,008		6
7	Other Prepaid Expenses	42,768		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,742,699	$	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	776,181		15
16	Equipment, at Historical Cost	223,933		16
17	Accumulated Depreciation (book methods)	(276,801)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 723,313	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,466,012	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,785,105	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	356,935		29
30	Accrued Salaries Payable	29,223		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,123		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)**	$ 2,181,386	$	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)**	$ 2,181,386	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,284,626	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,466,012	$	48

***(See instructions.)**

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,146,090	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,146,088	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	138,538	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)**	$ 138,538	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)**	$ 1,284,626	24 *

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

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 7,974,677	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,974,677	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,591	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,591	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	162	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 162	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,980,430	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,189,297	31
32	Health Care	2,699,939	32
33	General Administration	1,780,808	33
	B. Capital Expense		
34	Ownership	876,203	34
	C. Ancillary Expense		
35	Special Cost Centers	1,084,924	35
36	Provider Participation Fee	210,721	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,841,892	40
41	**Income before Income Taxes (line 30 minus line 40)****	138,538	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 138,538	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,974,107	44
45	Private Pay - Net Inpatient Revenue	3,005,636	45
46	Medicare - Net Inpatient Revenue	1,068,282	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	507,352	47
48	Other-(specify) MANAGED CARE	419,300	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,974,677	49

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

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,856	2,024	$ 82,944	$ 40.98	1
2	Assistant Director of Nursing	2,071	2,254	72,241	32.05	2
3	Registered Nurses	19,995	20,656	631,438	30.57	3
4	Licensed Practical Nurses	11,284	11,725	318,952	27.20	4
5	CNAs & Orderlies	71,850	74,092	1,010,471	13.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,767	10,290	105,172	10.22	10
11	Social Service Workers	2,464	2,488	47,267	19.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,862	3,968	37,265	9.39	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,000	40,663	20.33	17
18	Housekeepers	2,798	2,878	23,092	8.02	18
19	Laundry					19
20	Administrator	1,888	2,138	96,275	45.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,667	9,998	189,185	18.92	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	1,930	2,026	23,644	11.67	31
32	Other Health C: Care Plan Coord	4,250	4,426	144,741	32.70	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,650	150,963	$ 2,823,350 *	$ 18.70	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	$ 345	1-3	35
36	Medical Director	O	31,070	9-3	36
37	Medical Records Consultant	N	630	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,075	10-3	39
40	Physical Therapy Consultant	L	6,656	10a-3	40
41	Occupational Therapy Consultant	Y	3,158	10a-3	41
42	Respiratory Therapy Consultant		5,437	10a-3	42
43	Speech Therapy Consultant	F	1,922	10a-3	43
44	Activity Consultant	E	5,216	11-3	44
45	Social Service Consultant	E	2,272	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 60,781		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		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SCOTT HOCHSTADT	ADMINISTRATOR	0	$ 36,036
HELEN SICAT	ADMINISTRATOR	0	60,239
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 96,275

B. Administrative - Other

Description	Amount
	$
BRIA HEALTH SERVICES, LLC MANAGEMENT FEES	397,922
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 397,922

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		262,050
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 262,050

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,785
Unemployment Compensation Insurance	63,484
FICA Taxes	215,987
Employee Health Insurance	21,696
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	16,139
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)	$ 402,091

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,509
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 156	2,348
TRUST/FRANCHISE/CONTRIB/ETC	5,652
MARKETING/ADV/PROMO	27,732
LICENSES/DUES/SUBSCRIPTIONS	11,425
MGMT CO ALLOC	3,694
TRUST/FRANCHISE/CONTRIB/ETC	(5,652)
Less: Public Relations Expense	(0)
Non-allowable advertising	(27,732)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,976

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)	$

**See instructions.

Facility Name & ID Number BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 BRIA OF GENEVA # 0051540 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL OF LONG TERM CARE $6,968**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,632** 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. $ **210,721**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.