FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0004721

Facility Name: GOOD SAMARITAN SOC - GENESEO VILLAGE

Address: 704 SOUTH ILLINOIS STREET (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: 309-994-6424 **Fax #** 309-944-6605

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1970

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kim Kouri **Telephone Number:** 605-362-3178
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 01/01/2010 to 12/31/2010 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) RAYE NAE NYLANDER
(Title) Chief Financial Officer, Treasurer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	72	Skilled (SNF)	72	26,280	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	72	TOTALS	72	26,280	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	10,769	10,958	1,790	23,517	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,769	10,958	1,790	23,517	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.49%

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)
OUTPATIENT THERAPY

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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/01/1971

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 _____ and days of care provided _____

Medicare Intermediary NORIDIAN

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VIL # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	195,518	21,997	7,424	224,939		224,939	(224)	224,715			1
2	Food Purchase		193,871		193,871		193,871	(1,697)	192,174			2
3	Housekeeping	98,637	23,351		121,988		121,988	(246)	121,742			3
4	Laundry	55,867	18,841		74,708		74,708	(207)	74,501			4
5	Heat and Other Utilities			86,786	86,786		86,786		86,786			5
6	Maintenance	49,945	9,842	130,386	190,173		190,173	(6,922)	183,251			6
7	Other (specify):*			7,999	7,999		7,999	(243)	7,756			7
8	**TOTAL General Services**	399,967	267,902	232,595	900,464		900,464	(9,539)	890,925			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,224,638	136,984	15,631	1,377,253		1,377,253	(54,050)	1,323,203			10
10a	Therapy		15,715	225,815	241,530		241,530	(76,310)	165,220			10a
11	Activities	81,061	9,042	8,693	98,796		98,796	(857)	97,939			11
12	Social Services	51,232	234	1,477	52,943		52,943	(3)	52,940			12
13	CNA Training											13
14	Program Transportation			6,427	6,427		6,427		6,427			14
15	Other (specify):*	393			393		393		393			15
16	**TOTAL Health Care and Programs**	1,357,324	161,975	258,043	1,777,342		1,777,342	(131,220)	1,646,122			16
	C. General Administration											
17	Administrative	78,326		157,053	235,379		235,379	36,242	271,621			17
18	Directors Fees											18
19	Professional Services			6,853	6,853		6,853		6,853			19
20	Dues, Fees, Subscriptions & Promotions			45,481	45,481		45,481	(37,814)	7,667			20
21	Clerical & General Office Expenses	80,868	26,720	84,354	191,942		191,942	(3,895)	188,047			21
22	Employee Benefits & Payroll Taxes			451,703	451,703		451,703	(58,238)	393,465			22
23	Inservice Training & Education			23,764	23,764		23,764	(1,057)	22,707			23
24	Travel and Seminar			8,044	8,044		8,044	(3,843)	4,201			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,953	26,953		26,953	18,839	45,792			26
27	Other (specify):*	15,383		15,885	31,268		31,268	(31,268)				27
28	**TOTAL General Administration**	174,577	26,720	820,090	1,021,387		1,021,387	(81,034)	940,353			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,931,868	456,597	1,310,728	3,699,193		3,699,193	(221,793)	3,477,400			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 Number GOOD SAMARITAN SOC - GENESEO VILLAGE #0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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			255,725	255,725		255,725	(18,894)	236,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,565	1,565		1,565	(1,565)				32
33	Real Estate Taxes			11,765	11,765		11,765	(11,765)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,509	6,509		6,509	(2,380)	4,129			35
36	Other (specify):*											36
37	**TOTAL Ownership**			275,564	275,564		275,564	(34,604)	240,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,420	39,420		39,420		39,420			42
43	Other (specify):*			10,002	10,002		10,002	(10,002)				43
44	**TOTAL Special Cost Centers**			49,422	49,422		49,422	(10,002)	39,420			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,931,868	456,597	1,635,714	4,024,179		4,024,179	(266,399)	3,757,780			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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	(1,697)	2		4
5	Telephone, TV & Radio in Resident Rooms	(767)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	1,882	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(264,160)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (264,742)		$	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)	(1,657)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,657)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (266,399)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GOOD SAMARITAN SOC - GENESEO VILLAGE

ID# 0004721

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See attached schedule	$ (224)	1	1
2	See attached schedule	(76,310)	10a	2
3	See attached schedule	(246)	3	3
4	See attached schedule	(207)	4	4
5	See attached schedule	0	5	5
6	See attached schedule	(6,922)	6	6
7	See attached schedule	(243)	7	7
8	See attached schedule	0	8	8
9	See attached schedule	0	9	9
10	See attached schedule	(54,050)	10	10
11	See attached schedule	(90)	11	11
12	See attached schedule	(3)	12	12
13	See attached schedule		13	13
14	See attached schedule		14	14
15	See attached schedule		15	15
16	See attached schedule		16	16
17	See attached schedule		17	17
18	See attached schedule		18	18
19	See attached schedule		19	19
20	See attached schedule	(37,814)	20	20
21	See attached schedule	(5,777)	21	21
22	See attached schedule	(1,500)	22	22
23	See attached schedule	(1,057)	23	23
24	See attached schedule	(3,843)	24	24
25	See attached schedule	0	25	25
26	See attached schedule	0	26	26
27	See attached schedule	(31,268)	27	27
28	See attached schedule	0	28	28
29	See attached schedule	0	29	29
30	See attached schedule	(11,765)	33	30
31	See attached schedule	0	31	31
32	See attached schedule	(1,565)	32	32
33	See attached schedule	(18,894)	30	33
34	See attached schedule	0	34	34
35	See attached schedule	(2,380)	35	35
36	See attached schedule	0	36	36
37	See attached schedule	0	37	37
38	See attached schedule	0	38	38
39	See attached schedule	0	39	39
40	See attached schedule	0	40	40
41	See attached schedule	0	41	41
42	See attached schedule	0	42	42
43	See attached schedule	(10,002)	43	43
44	See attached schedule		44	44
45	See attached schedule		45	45
46	See attached schedule		46	46
47	See attached schedule		47	47
48	See attached schedule		48	48
49	**Total**	(264,160)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(224)	0	0	0	0	0	0	0	0	0	0	(224)	1
2	Food Purchase	(1,697)	0	0	0	0	0	0	0	0	0	0	(1,697)	2
3	Housekeeping	(246)	0	0	0	0	0	0	0	0	0	0	(246)	3
4	Laundry	(207)	0	0	0	0	0	0	0	0	0	0	(207)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,922)	0	0	0	0	0	0	0	0	0	0	(6,922)	6
7	Other (specify):*	(243)	0	0	0	0	0	0	0	0	0	0	(243)	7
8	**TOTAL General Services**	(9,539)	0	0	0	0	0	0	0	0	0	0	(9,539)	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	(54,050)	0	0	0	0	0	0	0	0	0	0	(54,050)	10
10a	Therapy	(76,310)	0	0	0	0	0	0	0	0	0	0	(76,310)	10a
11	Activities	(857)	0	0	0	0	0	0	0	0	0	0	(857)	11
12	Social Services	(3)	0	0	0	0	0	0	0	0	0	0	(3)	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**	(131,220)	0	0	0	0	0	0	0	0	0	0	(131,220)	16
	C. General Administration													
17	Administrative	0	36,242	0	0	0	0	0	0	0	0	0	36,242	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(37,814)	0	0	0	0	0	0	0	0	0	0	(37,814)	20
21	Clerical & General Office Expenses	(3,895)	0	0	0	0	0	0	0	0	0	0	(3,895)	21
22	Employee Benefits & Payroll Taxes	(1,500)	(56,738)	0	0	0	0	0	0	0	0	0	(58,238)	22
23	Inservice Training & Education	(1,057)	0	0	0	0	0	0	0	0	0	0	(1,057)	23
24	Travel and Seminar	(3,843)	0	0	0	0	0	0	0	0	0	0	(3,843)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	18,839	0	0	0	0	0	0	0	0	0	18,839	26
27	Other (specify):*	(31,268)	0	0	0	0	0	0	0	0	0	0	(31,268)	27
28	**TOTAL General Administration**	(79,377)	(1,657)	0	0	0	0	0	0	0	0	0	(81,034)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(220,136)	(1,657)	0	0	0	0	0	0	0	0	0	(221,793)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(18,894)	0	0	0	0	0	0	0	0	0	0	(18,894)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,565)	0	0	0	0	0	0	0	0	0	0	(1,565)	32
33	Real Estate Taxes	(11,765)	0	0	0	0	0	0	0	0	0	0	(11,765)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(2,380)	0	0	0	0	0	0	0	0	0	0	(2,380)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(34,604)	0	0	0	0	0	0	0	0	0	0	(34,604)	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):*	(10,002)	0	0	0	0	0	0	0	0	0	0	(10,002)	43
44	TOTAL Special Cost Centers	(10,002)	0	0	0	0	0	0	0	0	0	0	(10,002)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(264,742)	(1,657)	0	0	0	0	0	0	0	0	0	(266,399)	45

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Good Samartain Society	100					

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	17	Admin/Accting	$ 157,053	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 193,295	$ 36,242	1
2	V	22	Workers Comp	83,660			74,180	(9,480)	2
3	V	22	Unemployment	24,228			24,905	677	3
4	V	26	Insurance	26,954			45,793	18,839	4
5	V	22	Group Health Insurance	169,587			121,652	(47,935)	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			$ 461,482			$ 459,825	$ * (1,657)	14

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VIL # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
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	TOTALS					$	$		$	25

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VIL # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Annuities						38,000	38,000			1,518	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 38,000	$ 38,000			$ 1,518	14
15	TOTALS (line 9+line14)						$ 38,000	$ 38,000			$ 1,518	15

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

*** 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 GOOD SAMARITAN SOC - GENESEO VILLAGE **#** 0004721 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		**8**
	2006		**9**
	2007		**10**
	2008		**11**
	2009		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	**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.**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN SOC - GENESEO VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0004721

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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? [x] (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).

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			1969	$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			1971	1971	$ 493,090	$ 12,346		$ 12,346	$	$ 490,065	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1974	3,499					3,499	9
10				1975	1,100					1,100	10
11				1977	508					508	11
12				1978	11,445					11,445	12
13				1981	168,836	5,451		5,451		166,064	13
14				1982	2,299					2,299	14
15				1985	6,089					6,089	15
16				1986	2,249					2,249	16
17				1987	265					265	17
18				1988	156,911	597		597		155,716	18
19				1989	20,342					20,342	19
20				1990	112,181	4,575		4,575		112,181	20
21				1991	12,176	561		561		11,755	21
22				1992	27,180	724		724		26,215	22
23				1993	65,664	1,682		1,682		53,178	23
24				1994	54,107	1,507		1,507		49,160	24
25				1995	85,663	3,268		3,268		76,993	25
26				1996	98,643	2,193		2,193		95,061	26
27				1997	115,138	5,485		5,485		83,833	27
28				1998	143,224	6,754		6,754		99,260	28
29				1999	108,581	2,781		2,781		40,364	29
30				2000	27,260	1,284		1,284		14,503	30
31				2001	93,678	6,171		6,171		60,191	31
32				2002	153,986	6,363		6,363		63,523	32
33				2003	113,067	5,146		5,146		38,671	33
34				2004	112,398	4,735		4,735		33,293	34
35				2005	351,952	18,077		18,077		103,848	35
36				2006	452,270	29,589		29,589		137,912	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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Paint Remodel Resident Rooms	2007	$ 2,975	$ 595	5	$ 595	$	$ 2,380	37
38	Drapes Remodel Resident Rooms	2007	120	12	10	12		48	38
39	Building Remodel Resident Rooms	2007	14,749	590	25	590		2,360	39
40	Door	2007	1,729	115	15	115		423	40
41	signs with New Logo	2007	2,071	207	10	207		725	41
42	Entry Sign	2007	2,545	255	10	255		891	42
43	100 Gal/75k BTU Gas Heater	2007	1,645	165	10	165		548	43
44	Upgrade Fire Detection Ssytem	2007	4,128	413	10	413		1,376	44
45	Cabinets - Dining Room	2007	19,676	984	20	984		3,115	45
46	Drive Thru Canopy	2007	68,562	2,742	25	2,742		8,684	46
47	Front Parking Lot rEplacement	2007	98,229	4,911	20	4,911		15,553	47
48	Sink in Dining Room	2007	570	28	20	28		85	48
49	Blinds Residents Room Remodel	2008	382	76	5	76		229	49
50	Drapes - Resident Remodel room	2008	773	155	5	155		464	50
51	Paint - Resident Room Remodel	2008	11,007	2,201	5	2,201		6,604	51
52	Wallpaper - Resident Room Remodel	2008	3,235	647	5	647		1,941	52
53	Asbestos - Resident Room Remodel	2008	3,456	346	10	346		1,037	53
54	Corner Buar-Resident Room Remodel	2008	582	29	20	29		87	54
55	Doors - Resident Room Remodel	2008	1,028	51	20	51		154	55
56	Building - Resident Room Remodel	2008	31,295	1,252	25	1,252		3,755	56
57	100 Gallon Gas Water Heater	2008	1,645	165	10	165		494	57
58	Light Poles & Bases	2008	546	27	20	27		82	58
59	Carpert Apt 10B	2008	752	150	5	150		451	59
60	Carpet	2008	2,826	565	5	565		1,649	60
61	Door & Parts	2008	988	66	15	66		187	61
62	Doors - Resident Room Remodel	2008	750	50	15	50		142	62
63	A.O Smith EC 52 D water Heater	2008	569	57	10	57		152	63
64	Carpet - House Unit 1	2008	1,471	293	5	293		787	64
65	Garage Door 721 S. Congress	2008	521	35	15	35		87	65
66	Partial Roof Replacement	2008	54,104	2,705	20	2,705		6,763	66
67	N. Street Parking Lot Patch	2008	5,247	1,049	5	1,049		2,624	67
68	Pond Improvements	2008	8,457	849	10	849		1,951	68
69	Vinly Floor Rooms	2008	4,550	455	10	455		1,062	69
70	TOTAL (lines 4 thru 69)		$ 3,344,984	$ 141,529		$ 141,529	$	$ 2,026,472	70

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$ 3,344,984	$ 141,529		$ 141,529	$	$ 2,026,472	37
38	Laundry Room pipes	2008	2,663	133	20	133		311	38
39	Business office carpet	2008	2,387	477	5	477		993	39
40	Rooftop Unit A/C work	2008	1,157	116	10	116		241	40
41	Kitchen Water Heater	2008	6,498	650	10	650		1,354	41
42	Cabnites & Install Activities room	2008	6,865	458	15	458		915	42
43	Carpet - Floor coverings	2008	46,839	9,368	5	9,368		17,174	43
44	Wallpaper - floor coverings	2009	200	40	5	40		73	44
45	Carpet - Remodel 2008	2009	25,508	5,102	5	5,102		9,353	45
46	Vinyl Floor - Remodel 2008	2009	3,279	328	10	328		601	46
47	Vinyl Floor - Floor Coverings	2009	13,980	1,398	10	1,398		2,563	47
48	Asbestos - Floor Covering	2009	53,580	5,358	10	5,358		9,823	48
49	Windows - Floor Coverings	2009	1,320	88	15	88		161	49
50	Ceramic Tile - Remodel 2008	2009	57,028	2,851	20	2,851		5,228	50
51	Ceramic Tile - Floor Coverings	2009	500	25	20	25		46	51
52	Building - Floor Covering	2009	7,210	288	25	288		529	52
53	Building - Remodel 2008	2009	18,153	726	25	726		1,331	53
54	Handrail/parking Lot Handicap	2009	1,700	113	15	113		198	54
55	Tub & Install	2009	2,899	145	20	145		217	55
56	Vinly Flooring Rooms 201 & 309	2009	2,960	296	10	296		419	56
57	NFPA Safety Upgrade Per Survey	2009	5,885	588	10	588		834	57
58	CCTV System Installation	2009	37,049	3,705	10	3,705		5,249	58
59	Wireless Pendants	2009	4,614	923	5	923		1,230	59
60	100 Wing RTU Compressor	2009	1,154	77	15	77		103	60
61	10 Gal Water Heater	2009	1,697	170	10	170		212	61
62	Blinds - Remodel 2009	2009	365	36	10	36		46	62
63	Electric - Remodel 2009	2009	372	25	15	25		31	63
64	Millwork - Remodel 2009	2009	318	21	15	21		27	64
65	Ceramic Tile - Remodel 2009	2009	1,160	58	20	58		73	65
66	Cabinets - Remodel 2009	2009	736	37	20	37		46	66
67	Building Remodel 2009	2009	19,434	777	25	777		972	67
68	Porch & Patio Concrete replacement	2009	3,775	252	15	252		294	68
69	Replace Cast Iron Sewer Pipes	2009	2,821	141	20	141		153	69
70	TOTAL (lines 4 thru 69)		$ 3,679,090	$ 176,299		$ 176,299	$	$ 2,087,272	70

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$ 3,679,090	$ 176,299		$ 176,299	$	$ 2,087,272	37
38	Vinyl Sliding Window	2009	720	48	15	48		48	38
39	Marquee 2 Transmitter pagers	2010	1,226	245	5	245		245	39
40	Hollow Metal Door	2010	2,211	101	20	101		101	40
41	Vinyl Window Room 209	2010	881	54	15	54		54	41
42	Waterproof Basement	2010	4,690	391	10	391		391	42
43	Handrails and Caps	2010	627	31	15	31		31	43
44	Vinyl - 2 rooms	2010	2,700	203	10	203		203	44
45	Wanderguard Mago locks	2010	1,235	82	10	82		82	45
46	Repair Pendant Transmitter	2010	2,065	241	5	241		241	46
47	Vinly Room 206 & 208	2010	1,414	82	10	82		82	47
48	Nurse Station Cabinets	2010	3,050	85	15	85		85	48
49	622 S. Illinois Flooring	2010	771	26	10	26		26	49
50	Electrical Fix Remodel Resident Lounge	2010	296	10	10	10		10	50
51	Cabinets Remodel Resident Lounge	2010	4,614	103	15	103		103	51
52	Building Remodel Resident Lounge	2010	5,176	69	25	69		69	52
53	Hot Water Storage Tanks	2010	14,720	245	10	245		245	53
54									54
55	Non Nursing assets listed in Building and Land Improve.		(533,391)	(18,895)		(18,895)		(216,535)	55
56	See attached worksheet								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)		$ 3,192,095	$ 159,420		$ 159,420	$	$ 1,872,753	70

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 582,714	$ 63,100	$ 63,100	$		$ 316,446	71
72	Current Year Purchases	69,220	5,169	5,169			5,169	72
73	Fully Depreciated Assets	434,551	5,600	5,600			434,551	73
74								74
75	TOTALS	$ 1,086,485	$ 73,869	$ 73,869	$		$ 756,166	75

D. Vehicle Depreciation (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		19 Pass Van W/CHAIR 2004 DOI	1998 2003	$ 68,555	$	$	$		$ 68,555	76
77		SNOW PLOW 2000 MIN VAN	2004	17,059	761	761		6	17,059	77
78		TAILGATE FOR TRUCK	2006	1,220	210	210		6	870	78
79		1998 FORD VAN	2010	3,745	1,248	1,248		3	1,249	79
80	TOTALS			$ 90,579	$ 2,219	$ 2,219	$		$ 87,733	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)	$ 4,395,159	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 235,508	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 235,508	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,716,652	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	Land	$ 134,693	$	$	86
87	Building & Land Improvements	3,116,634	101,041	1,292,052	87
88	FFE	132,097	9,471	97,529	88
89	Non Care Assets Allocation to 01 Equip	(29,681)	(5,936)	(11,855)	89
90	Non Care Assets Allocation to 01	533,391	18,895	216,535	90
91	TOTALS	$ 3,887,134	$ 123,471	$ 1,594,261	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 27,719	92
93			93
94			94
95		$ 27,719	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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,509 Description: Computer Leasing and one time rentals
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Ln 10a, col 3	hrs	$	6,198	$ 92,976	$	6,198	$ 92,976	1
2	Licensed Speech and Language Development Therapist	Ln 10a, col 3	hrs		2,302	34,524		2,302	34,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, col 3	hrs		6,554	98,315		6,554	98,315	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	15,054	$ 225,815	$	15,054	$ 225,815	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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 30,920	$	1
2	Cash-Patient Deposits	19,468		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,827))	234,835		3
4	Supply Inventory (priced at)	7,252		4
5	Short-Term Investments	2,135,209		5
6	Prepaid Insurance	3,897		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,431,581	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,693		13
14	Buildings, at Historical Cost	6,412,347		14
15	Leasehold Improvements, at Historical Cost	429,771		15
16	Equipment, at Historical Cost	1,362,711		16
17	Accumulated Depreciation (book methods)	(4,310,913)		17
18	Deferred Charges	144,140		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): CIP	27,719		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,226,468	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,658,049	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,436	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,468		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	168,043		30
31	Accrued Taxes Payable (excluding real estate taxes)	(13,691)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,924		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Security Deposit Payable	29,929		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 453,109	$	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	Deferred Liabilities	1,505,608		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,505,608	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,958,717	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,699,332	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,658,049	$	48

*(See instructions.)

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,586,814	1
2	Restatements (describe):		2
3	SENIOR LIVING	17,913	3
4	APARTMENTS	31,974	4
5	DUPLEX	154,348	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,791,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(14,388)	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)**	$ (14,388)	17
	B. Transfers (Itemize):		
18	Reserve Fund Assessment NC/NC Foundation Transfer	(54,201)	18
19	Technology User Assessment NC	(21,924)	19
20	Dnr Rst Prop Gift Cash/Grant/Endow	(1,204)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (77,329)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,699,332	24 *

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

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,133,650	1
2	Discounts and Allowances for all Levels	(1,125,138)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,008,512	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	746,515	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 746,515	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	1,697	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	29,080	16
17	Sale of Drugs	125,515	17
18	Sale of Supplies to Non-Patients	36	18
19	Laboratory	3,883	19
20	Radiology and X-Ray	2,523	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 162,734	23
	D. Non-Operating Revenue		
24	Contributions	108,170	24
25	Interest and Other Investment Income***	9,829	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 117,999	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing Supplies	50,979	28
28a	Bad Debt/Misc Income/Settlements	(76,950)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (25,971)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,009,789	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	900,464	31
32	Health Care	1,777,341	32
33	General Administration	1,021,386	33
	B. Capital Expense		
34	Ownership	275,564	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,420	36
	D. Other Expenses (specify):		
37	Other	10,002	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,024,177	40
41	**Income before Income Taxes (line 30 minus line 40)****	(14,388)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (14,388)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2,027	1,770	$ 61,698	$ 34.86	1
2	Assistant Director of Nursing	251	251	7,010	27.93	2
3	Registered Nurses	11,584	10,809	258,533	23.92	3
4	Licensed Practical Nurses	10,142	9,439	176,733	18.72	4
5	CNAs & Orderlies	61,488	56,315	696,654	12.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,108	1,847	33,129	17.94	9
10	Activity Assistants	4,578	4,105	47,932	11.68	10
11	Social Service Workers	2,338	2,179	51,232	23.51	11
12	Dietician					12
13	Food Service Supervisor	2,124	1,959	34,645	17.69	13
14	Head Cook	6,323	5,697	70,344	12.35	14
15	Cook Helpers/Assistants	9,556	8,890	90,529	10.18	15
16	Dishwashers					16
17	Maintenance Workers	2,736	2,413	49,945	20.70	17
18	Housekeepers	8,483	7,491	98,637	13.17	18
19	Laundry	5,003	4,532	55,867	12.33	19
20	Administrator	2,333	1,991	78,326	39.34	20
21	Assistant Administrator					21
22	Other Administrative	6,405	5,840	96,251	16.48	22
23	Office Manager					23
24	Clerical					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	1,593	1,435	24,403	17.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,072	126,963	$ 1,931,868 *	$ 15.22	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	176	$ 7,424	Ln1 Col 3	35
36	Medical Director		1,200	Ln 10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,577	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,426	Ln 11 Col 3	44
45	Social Service Consultant	21	1,426	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	219	$ 14,053		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	307	$ 11,707	Ln 10 Col 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	307	$ 11,707		53

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Fisher	Administrator	0	$ 62,689
Jeniffer Dunk	Administrator	0	14,359
Vac Accrual			1,278
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,326

B. Administrative - Other

Description	Amount
Admini/Acctg Serg	$ 157,053
TOTAL (agree to Schedule V, line 17, col. 3)	$ 157,053
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
5800 National Campus	Contract Services	$
64540 National Campus	Medicare Cost Report Prep	850
64541 National Campus	Medicaid Cost Report Prep	900
64360 Professional Service	Admin Consulting	
64363 Professional Sevice	Admin Consulting	1,250
58000 Contract Services	Contract Services/Admin	2,015
Legal Services	Legal servicese	1,838
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,853

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,660
Unemployment Compensation Insurance	24,228
FICA Taxes	142,493
Employee Health Insurance	169,587
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	24,638
Taxable Gifts	5,475
Other	1,622
NCO adjustments	(56,738)
Resource Dev. Expense offsets	(1,500)
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,465

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	30,625
Health Care Worker Background Check	
(Indicate # of checks performed)	
Newsletter	3,585
Publications	4,765
Dues Reimbursable	6,506
Less Dues	(1,488)
Less: Public Relations Expense	(2,500)
Non-allowable advertising	(32,765)
Yellow page advertising	(1,061)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,667

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,111
In-State Travel	4,933
Seminar Expense	
Out of State	(3,111)
Travel Resource Development	(732)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,201

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GOOD SAMARITAN SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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?
If YES, give association name and amount. LSNI-4379

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(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?
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 15,314 Line 10

(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?
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 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. $ 39,420
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. $ Has any meal income been offset against related costs? YES Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
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. $ YES
c. What percent of all travel expense relates to transportation of nurses and patients? 27%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: LARSON ALLEN LLP

(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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.