FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 4721

Facility Name: GSS - GENESEO VILLAGE

Address: 704 S ILLINOIS (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 01/01/2011 to 12/31/2011 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) JOE HERDINA
(Title) Vice President of Finance

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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	11,243	9,769	1,997	23,009	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,243	9,769	1,997	23,009	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.55%

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 72 and days of care provided 1,861

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	198,020	18,994	5,230	222,244		222,244	(36,176)	186,068			1
2	Food Purchase		190,353		190,353		190,353	(1,720)	188,633			2
3	Housekeeping	103,074	24,222		127,296		127,296	(258)	127,038			3
4	Laundry	49,565	19,380		68,945		68,945	(230)	68,715			4
5	Heat and Other Utilities			84,269	84,269		84,269		84,269			5
6	Maintenance	49,519	15,890	142,064	207,473		207,473	(9,824)	197,649			6
7	Other (specify):*			11,777	11,777		11,777	(104)	11,673			7
8	**TOTAL General Services**	400,178	268,839	243,340	912,357		912,357	(48,312)	864,045			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,187,650	145,741	225,473	1,558,864		1,558,864	(62,783)	1,496,081			10
10a	Therapy		14,397	248,343	262,740		262,740	(79,082)	183,658			10a
11	Activities	75,280	7,949	12,329	95,558		95,558	(89)	95,469			11
12	Social Services	36,817	937	1,959	39,713		39,713	(11)	39,702			12
13	CNA Training											13
14	Program Transportation			10,376	10,376		10,376		10,376			14
15	Other (specify):*	135			135		135		135			15
16	**TOTAL Health Care and Programs**	1,299,882	169,024	499,680	1,968,586		1,968,586	(141,965)	1,826,621			16
	C. General Administration											
17	Administrative	76,609		158,395	235,004		235,004	52,165	287,169			17
18	Directors Fees											18
19	Professional Services			4,062	4,062		4,062		4,062			19
20	Dues, Fees, Subscriptions & Promotions			52,661	52,661		52,661	(46,512)	6,149			20
21	Clerical & General Office Expenses	75,571	29,204	93,652	198,427		198,427	(3,040)	195,387			21
22	Employee Benefits & Payroll Taxes			489,851	489,851		489,851	(94,338)	395,513			22
23	Inservice Training & Education			21,162	21,162		21,162	(1,475)	19,687			23
24	Travel and Seminar			3,582	3,582		3,582	(428)	3,154			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			23,062	23,062		23,062	19,196	42,258			26
27	Other (specify):*	16,627		2,353	18,980		18,980	(18,980)				27
28	**TOTAL General Administration**	168,807	29,204	848,780	1,046,791		1,046,791	(93,412)	953,379			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,868,867	467,067	1,591,800	3,927,734		3,927,734	(283,689)	3,644,045			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 GSS - GENESEO VILLAGE #4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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			250,406	250,406		250,406	(18,894)	231,512			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,726	1,726		1,726	(1,726)				32
33	Real Estate Taxes			10,719	10,719		10,719	(10,719)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,757	7,757		7,757	(2,338)	5,419			35
36	Other (specify):*											36
37	**TOTAL Ownership**			270,608	270,608		270,608	(33,677)	236,931			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):*			8,972	8,972		8,972	(8,972)				43
44	**TOTAL Special Cost Centers**			48,392	48,392		48,392	(8,972)	39,420			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,868,867	467,067	1,910,800	4,246,734		4,246,734	(326,338)	3,920,396			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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(1,720)	2		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	1,915	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	(305,245)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (305,050)		$	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)	(21,288)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (21,288)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (326,338)		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

GSS - GENESEO VILLAGE

ID# 4721

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See attached schedule	$ (36,176)	1	1
2	See attached schedule	(79,082)	10a	2
3	See attached schedule	(258)	3	3
4	See attached schedule	(230)	4	4
5	See attached schedule		5	5
6	See attached schedule	(9,824)	6	6
7	See attached schedule	(104)	7	7
8	See attached schedule		8	8
9	See attached schedule		9	9
10	See attached schedule	(62,783)	10	10
11	See attached schedule	(89)	11	11
12	See attached schedule	(11)	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	(46,512)	20	20
21	See attached schedule	(4,955)	21	21
22	See attached schedule	(1,689)	22	22
23	See attached schedule	(1,475)	23	23
24	See attached schedule	(428)	24	24
25	See attached schedule		25	25
26	See attached schedule		26	26
27	See attached schedule	(18,980)	27	27
28	See attached schedule		28	28
29	See attached schedule		29	29
30	See attached schedule	(18,894)	30	30
31	See attached schedule		31	31
32	See attached schedule	(1,726)	32	32
33	See attached schedule	(10,719)	33	33
34	See attached schedule		34	34
35	See attached schedule	(2,338)	35	35
36	See attached schedule		36	36
37	See attached schedule		37	37
38	See attached schedule		38	38
39	See attached schedule		39	39
40	See attached schedule		40	40
41	See attached schedule		41	41
42	See attached schedule		42	42
43	See attached schedule	(8,972)	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**	(305,245)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(36,176)	0	0	0	0	0	0	0	0	0	0	(36,176)	1
2	Food Purchase	(1,720)	0	0	0	0	0	0	0	0	0	0	(1,720)	2
3	Housekeeping	(258)	0	0	0	0	0	0	0	0	0	0	(258)	3
4	Laundry	(230)	0	0	0	0	0	0	0	0	0	0	(230)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(9,824)	0	0	0	0	0	0	0	0	0	0	(9,824)	6
7	Other (specify):*	(104)	0	0	0	0	0	0	0	0	0	0	(104)	7
8	**TOTAL General Services**	(48,312)	0	0	0	0	0	0	0	0	0	0	(48,312)	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	(62,783)	0	0	0	0	0	0	0	0	0	0	(62,783)	10
10a	Therapy	(79,082)	0	0	0	0	0	0	0	0	0	0	(79,082)	10a
11	Activities	(89)	0	0	0	0	0	0	0	0	0	0	(89)	11
12	Social Services	(11)	0	0	0	0	0	0	0	0	0	0	(11)	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**	(141,965)	0	0	0	0	0	0	0	0	0	0	(141,965)	16
	C. General Administration													
17	Administrative	0	52,165	0	0	0	0	0	0	0	0	0	52,165	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	(46,512)	0	0	0	0	0	0	0	0	0	0	(46,512)	20
21	Clerical & General Office Expenses	(3,040)	0	0	0	0	0	0	0	0	0	0	(3,040)	21
22	Employee Benefits & Payroll Taxes	(1,689)	(92,649)	0	0	0	0	0	0	0	0	0	(94,338)	22
23	Inservice Training & Education	(1,475)	0	0	0	0	0	0	0	0	0	0	(1,475)	23
24	Travel and Seminar	(428)	0	0	0	0	0	0	0	0	0	0	(428)	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	19,196	0	0	0	0	0	0	0	0	0	19,196	26
27	Other (specify):*	(18,980)	0	0	0	0	0	0	0	0	0	0	(18,980)	27
28	**TOTAL General Administration**	(72,124)	(21,288)	0	0	0	0	0	0	0	0	0	(93,412)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(262,401)	(21,288)	0	0	0	0	0	0	0	0	0	(283,689)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(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	(1,726)	0	0	0	0	0	0	0	0	0	0	(1,726)	32
33	Real Estate Taxes	(10,719)	0	0	0	0	0	0	0	0	0	0	(10,719)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(2,338)	0	0	0	0	0	0	0	0	0	0	(2,338)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,677)	0	0	0	0	0	0	0	0	0	0	(33,677)	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):*	(8,972)	0	0	0	0	0	0	0	0	0	0	(8,972)	43
44	**TOTAL Special Cost Centers**	(8,972)	0	0	0	0	0	0	0	0	0	0	(8,972)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(305,050)	(21,288)	0	0	0	0	0	0	0	0	0	(326,338)	45

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
GOOD SAMARITAN 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. ☐ 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/ACCOUNTING	$ 158,395	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 210,560	$ 52,165	1
2	V	22	WORKERS COMP	124,105	The Evangelical Lutheran Good Samaritan Society	100.00%	77,321	(46,784)	2
3	V	22	UNEMPLOYMENT	13,379	The Evangelical Lutheran Good Samaritan Society	100.00%	13,809	430	3
4	V	26	INSURANCE	23,062	The Evangelical Lutheran Good Samaritan Society	100.00%	42,258	19,196	4
5	V	22	GROUP HEALTH INSURANCE	172,441	The Evangelical Lutheran Good Samaritan Society	100.00%	126,146	(46,295)	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			$ 491,382			$ 470,094	$ * (21,288)	14

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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Susan Nickerson	BOD						2
3	Patricia K. Haugen	BOD						3
4	Neil Gulsvig	BOD						4
5	Chrstopher Johnson	BOD						5
6	David Horazdovsky	BOD						6
7	Elwin Brown	BOD						7
8	Lori Bussler	BOD						8
9	Andrea DeGroot-Nesdahl	BOD						9
10	Kari Gustafson	BOD						10
11	Teresa Hildebrant	BOD						11
12	John Holt	BOD						12
13	Michele Juffer	BOD						13
14	Bruce Kallis	BOD						14
15	Scott Peters	BOD						15
16	Joanna Randall	BOD						16
17	Sharon St. Mary	BOD						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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [x]

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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			1,519	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 38,000	$ 38,000			$ 1,519	14
15	TOTALS (line 9+line14)						$ 38,000	$ 38,000			$ 1,519	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 GSS - GENESEO VILLAGE # 4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GSS - GENESEO VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 4721

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 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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				1971	$ 493,090	$ 3,024		$ 3,024	$	$ 493,090	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	2,726		2,726		168,790	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		156,313	18
19				1989	20,342					20,342	19
20				1990	112,181					112,181	20
21				1991	953	374		374		953	21
22				1992	26,712	724		724		26,471	22
23				1993	26,985	135		135		26,753	23
24				1994	54,107	1,507		1,507		50,666	24
25				1995	76,045	1,980		1,980		69,355	25
26				1996	98,643	1,804		1,804		96,865	26
27				1997	105,978	5,405		5,405		80,999	27
28				1998	139,696	6,754		6,754		102,485	28
29				1999	35,651	1,302		1,302		24,978	29
30				2000	6,093	165		165		5,258	30
31				2001	93,678	6,125		6,125		66,315	31
32				2002	67,433	2,901		2,901		38,439	32
33				2003	17,862	1,337		1,337		11,188	33
34				2004	30,355	1,410		1,410		11,651	34
35				2005	288,320	14,896		14,896		99,919	35
36				2006	451,644	29,405		29,405		167,134	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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		2007	$ 216,998	$ 11,017		$ 11,017	$	$ 47,206	37
38	100 Gal. Gas Water Heat	2008	1,645	165	120	165		658	38
39	CARPET APT 10B								39
40	Door & Parts	2008	988	66	180	66		253	40
41	Carpet	2008	2,826	565	60	565		2,214	41
42	Doors	2008	750	50	180	50		192	42
43	Asbestos-Resident Room Remodel	2008	3,456	346	120	346		1,382	43
44	Blinds-Resident Room Remodel	2008	382	76	60	76		306	44
45	Building-Resident Room Remodel	2008	31,295	1,252	300	1,252		5,007	45
46	Corner Guar-Resident Room Rmdl	2008	582	29	240	29		116	46
47	Drapes-Resident Room Rmdl	2008	773	155	60	155		619	47
48	Doors-Resident Room Rmdl	2008	1,028	51	240	51		206	48
49	Paint-Resident Room Rmdl	2008	11,007	2,201	60	2,201		8,805	49
50	Wallpaper-Resident Room Rmdl	2008	3,235	647	60	647		2,588	50
51	A.O.SMITH EC-52D WATER HEATER	2008	569	57	120	57		209	51
52	Carpet-Rental House Unit 01								52
53	Partial Roof Replacement	2008	54,104	2,705	240	2,705		9,468	53
54	Garage Door 721 S.Congress								54
55	Vinyl Floor Rms 202,203,204	2008	4,550	455	120	455		1,517	55
56	Laundry Room Pipes	2008	2,663	133	240	133		444	56
57	Rooftop Unit A/C Work	2008	1,157	116	120	116		357	57
58	Kitchen Water Heater	2008	6,498	650	120	650		2,003	58
59	CABINETS&INSTALL/ACTIVITY ROOM	2008	6,865	458	180	458		1,373	59
60	Asbestos-Floor Coverings	2009	53,580	5,358	120	5,358		15,181	60
61	Building-Floor Coverings	2009	7,210	288	300	288		817	61
62	Carpet-Floor Coverings	2009	46,839	9,368	60	9,368		26,542	62
63	Ceramic Tile-Floor Coverings	2009	500	25	240	25		71	63
64	Vinyl Floor-Floor Coverings	2009	13,980	1,398	120	1,398		3,961	64
65	Wallpaper-Floor Coverings	2009	200	40	60	40		113	65
66	Windows-Floor Coverings	2009	1,320	88	180	88		249	66
67	BUSINESS OFFICE CARPET	2009	2,384	477	60	477		1,470	67
68	HANDRAIL/PRKING LOT-HANDICAP	2009	1,700	113	180	113		312	68
69	Building-Remodel 2008	2009	18,153	726	300	726		2,057	69
70	**TOTAL (lines 4 thru 69)**		$ 2,996,205	$ 121,646		$ 121,646	$	$ 1,993,294	70

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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
1	Totals from Page 12A, Carried Forward		$ 2,996,205	$ 121,646		$ 121,646	$	$ 1,993,294	1
2	Carpet-Remodel 2008	2009	25,508	5,102	60	5,102		14,454	2
3	Ceramic Tile-Remodel 2008	2009	57,028	2,851	240	2,851		8,079	3
4	Vinyl Floor-Remodel 2008	2009	3,279	328	120	328		929	4
5	RUUD/RHEEM 10GAL WATER HEATER	2009	1,697	170	120	170		382	5
6	CCTV System Installation	2009	37,049	3,705	120	3,705		8,953	6
7	Blinds-Remodel 2009	2009	365	36	120	36		82	7
8	Building-Remodel 2009	2009	19,434	777	300	777		1,749	8
9	Cabinets-Remodel 2009	2009	736	37	240	37		83	9
10	Ceramic Tile-Remodel 2009	2009	1,160	58	240	58		131	10
11	Electric-Remodel 2009	2009	372	25	180	25		56	11
12	Millwork-Remodel 2009	2009	318	21	180	21		48	12
13	VINYL FLOORING - RMS #201&309	2009	2,960	296	120	296		715	13
14	NFPA SAFETY UPGRADE,PER SURVEY	2009	5,885	588	120	588		1,422	14
15	WIRELESS PENDANTS&PROGRAMMING	2009	4,614	923	60	923		2,153	15
16	100 WING RTU - COMPRESSOR	2009	1,154	77	180	77		180	16
17	3'X6'8" HOLLOW METAL DOOR	2010	2,211	111	240	111		212	17
18	VINYL WINDOW - ROOM #209	2010	881	59	180	59		113	18
19	MARQUEE/2-TRANSMITTRS/3-PAGERS	2010	1,226	245	60	245		490	19
20	TUB & INSTALL - 631 S CONGRESS	2010	2,899	145	240	145		362	20
21	REPLACE CAST IRON SEWER PIPES	2010	2,821	141	240	141		294	21
22	VINYL - 2 ROOMS	2010	2,700	270	120	270		473	22
23	WANDERGUARD MAGOLOCKS/KEYPADS	2010	1,235	123	120	123		206	23
24	VINYL SLIDING WINDOW	2010	720	48	180	48		96	24
25	HANDRAILS & CAPS - HALLWAYS	2010	627	42	180	42		73	25
26	VINYL - ROOM #206 & 208	2010	1,414	141	120	141		224	26
27	REPAIR PENDANT SYS/6-TRANSMTTR	2010	2,065	413	60	413		654	27
28	WATERPROOF BASEMENT-631 S CONG	2010	4,690	469	120	469		860	28
29	622 S. ILLINOIS FLOORING	2010	771	77	120	77		103	29
30	NURSE STATION CABINETS	2010	3,050	203	180	203		288	30
31	Building-Rmdl Resident Lounge	2010	5,176	207	300	207		276	31
32	Cabinets-Rmdl Resident Lounge	2010	4,614	308	180	308		410	32
33	Elect Fix-Rmdl Resident Lounge	2010	296	30	120	30		39	33
34	**TOTAL (lines 1 thru 33)**		$ 3,195,157	$ 139,671		$ 139,671	$	$ 2,037,882	34

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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
1	Totals from Page 12B, Carried Forward		$ 3,195,157	$ 139,671		$ 139,671	$	$ 2,037,882	1
2	HOT WATER STORAGE TANKS	2010	14,720	1,472	120	1,472		1,717	2
3	NEW PHONE SYSTEM	2010	30,095	3,010	120	3,010		4,765	3
4	CARPET IN RENTAL	2011	3,647	669	60	669		669	4
5	RMDL SOILED UTILITY RM WING200	2011	3,537	157	180	157		157	5
6	PLEATED SHADES/BLINDS	2011	1,158	232	60	232		251	6
7	STAIN GLASS WINDOWS	2011	2,080	173	120	173		173	7
8	DOOR FOR DUPLEX	2011	659	38	120	38		38	8
9	Blinds-Remodel 2010	2011	1,828	366	60	366		366	9
10	Building-Remodel 2010	2011	15,945	638	300	638		638	10
11	Cabinets-Remodel 2010	2011	1,603	80	240	80		80	11
12	Electric-Remodel 2010	2011	3,869	258	180	258		258	12
13	REPAIRS/PARTS DOOR ALARM SYSTE	2011	2,863	239	60	239		239	13
14	SHUTTERS FOR FRONT OF BLDG	2011	1,833	183	60	183		183	14
15	CARPET 616 S. ILLINOS	2011	1,862	217	60	217		217	15
16	HVAC UNIT 631 S CONGRESS	2011	4,890	109	180	109		109	16
17	PLEATED WINDOW SHADE (2)	2011	500	33	60	33		33	17
18	STEEL DOOR FRONT ENTRANCE	2011	1,850	51	180	51		51	18
19	STAINED GLASS WINDOWS (4)	2011	3,595	150	120	150		150	19
20	MARQUEE ALPHA215 CALL ALARM SY	2011	572	38	60	38		38	20
21	Light Poles & Bases	2008	546	27	240	27		109	21
22	N.STREET/PARKING LOT PATCH	2008	5,247	1,049	60	1,049		3,673	22
23	Pond Improvements	2008	8,457	849	120	849		2,799	23
24	PORCH&PATIO CONCRETE REPLACMNT	2009	3,775	252	180	252		545	24
25	Signs-Remodel 2010	2011	363	36	120	36		36	25
26	Prior Year Depreciation on Asset #234011			1,756		1,756			26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,310,650	$ 151,753		$ 151,753	$	$ 2,055,178	34

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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 641,857	$ 69,776	$ 69,776	$		$ 334,309	71
72	Current Year Purchases	39,887	4,401	4,401			4,401	72
73	Fully Depreciated Assets	460,851	3,933	3,933			460,851	73
74	Prioer Year Depr.		192	192				74
75	TOTALS	$ 1,142,595	$ 78,302	$ 78,302	$		$ 799,561	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		19 Pass Van w/chair	1998 2003	$ 68,555	$	$	$		$	76
77		SNOW PLOW 200 MIN VAN	2004	17,059						77
78		TAILGATE FOR TRUCK	2006	1,220	210	210		6	1,080	78
79		1998 FORD VAN	2010	3,745	1,248	1,248		3	2,497	79
80	TOTALS			$ 90,579	$ 1,458	$ 1,458	$		$ 3,577	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)	$ 4,569,824	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 231,513	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 231,513	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)	$ 2,858,316	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	3,587,725	120,237	1,565,141	87
88	FFE	100,072	2,268	86,745	88
89					89
90					90
91	TOTALS	$ 3,822,490	$ 122,505	$ 1,651,886	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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 7,757 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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 10a, Col 3	hrs	$	6,484	$ 97,259	$ 218	6,484	$ 97,477	1
2	Licensed Speech and Language Development Therapist	Line 10a, Col 3	hrs		2,830	42,454	0	2,830	42,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a, col 3	hrs		7,242	108,629	0	7,242	108,629	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			$	16,556	$ 248,342	$ 218	16,556	$ 248,560	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 GSS - GENESEO VILLAGE **#** 4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2011 **(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	$ 18,989	$	1
2	Cash-Patient Deposits	21,221		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (34,469))	616,000		3
4	Supply Inventory (priced at)	7,232		4
5	Short-Term Investments	1,722,465		5
6	Prepaid Insurance	2,653		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)**	$ 2,388,560	$	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	6,491,931		14
15	Leasehold Improvements, at Historical Cost	406,444		15
16	Equipment, at Historical Cost	1,363,209		16
17	Accumulated Depreciation (book methods)	(4,595,817)		17
18	Deferred Charges	147,374		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)**	$ 3,973,834	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,362,394	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 146,433	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,221		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	158,868		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,444		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	33,585		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 443,551	$	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	1,324,860		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,324,860	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,768,411	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,593,983	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,362,394	$	48

***(See instructions.)**

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,699,332	1
2	Restatements (describe):		2
3	SENIOR LIVING	16,308	3
4	APARTMENTS	19,040	4
5	DUPLIX	49,830	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,784,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(71,943)	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)**	$ (71,943)	17
	B. Transfers (Itemize):		
18	Reserve Fund Assessment NC	(7,068)	18
19	Technology User Assessment	(75,497)	19
20	Foundation Transfer	(20,826)	20
21	Dnr Rst Prop Gift Cash	(18,852)	21
22	Dnr Rest Endow-Restr	3,659	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (118,584)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,593,983	24 *

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

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 4,158,229	1
2	Discounts and Allowances for all Levels	(1,122,981)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,035,248	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	16,216	5
6	Therapy	808,574	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 824,790	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	35	13
14	Non-Patient Meals	1,720	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	42,793	16
17	Sale of Drugs	101,541	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	254	19
20	Radiology and X-Ray	1,878	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 148,221	23
	D. Non-Operating Revenue		
24	Contributions	92,714	24
25	Interest and Other Investment Income***	12,262	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 104,976	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	56,542	28
28a	Misc Income/PY Settlements/Bad debt/Gains	5,014	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,556	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,174,791	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	911,495	31
32	Health Care	1,969,447	32
33	General Administration	1,046,792	33
	B. Capital Expense		
34	Ownership	270,608	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,420	36
	D. Other Expenses (specify):		
37	Other	8,972	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,246,734	40
41	**Income before Income Taxes (line 30 minus line 40)****	(71,943)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (71,943)	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 GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2,021	1,655	$ 61,422	$ 37.11	1
2	Assistant Director of Nursing	1,983	1,932	57,547	29.79	2
3	Registered Nurses	6,076	5,669	155,675	27.46	3
4	Licensed Practical Nurses	11,277	10,446	209,317	20.04	4
5	CNAs & Orderlies	54,520	50,172	675,255	13.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,195	1,975	31,233	15.81	9
10	Activity Assistants	4,075	3,642	43,455	11.93	10
11	Social Service Workers	1,848	1,702	37,470	22.02	11
12	Dietician					12
13	Food Service Supervisor	2,243	1,960	37,445	19.10	13
14	Head Cook	5,976	5,458	67,071	12.29	14
15	Cook Helpers/Assistants	9,944	8,750	93,068	10.64	15
16	Dishwashers					16
17	Maintenance Workers	2,679	2,370	50,993	21.52	17
18	Housekeepers	8,752	7,715	102,710	13.31	18
19	Laundry	4,337	4,016	47,534	11.84	19
20	Administrator	2,090	1,859	76,203	40.99	20
21	Assistant Administrator					21
22	Other Administrative	5,855	5,307	91,359	17.21	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	1,594	1,439	25,853	17.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,465	116,067	$ 1,863,610 *	$ 16.06	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	124	$ 5,230	Ln 1, 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		3,052	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	62	1,856	Ln 11, Col 3	44
45	Social Service Consultant	62	1,856	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	248	$ 13,194		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	489	$ 22,550	Ln 10, Col 3	50
51	Licensed Practical Nurses	1,822	60,410	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	5,617	135,169	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	7,928	$ 218,129		53

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Dunk	Administrato	0	$ 76,609
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,609

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 158,395
TOTAL (agree to Schedule V, line 17, col. 3)	$ 158,395
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medicare cost report preparation		$ 950
Medicaid cost report preparation		1,000
Contract services - Admin		2,112
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,062

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 124,105
Unemployment Compensation Insurance	13,379
FICA Taxes	137,996
Employee Health Insurance	172,441
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	27,395
Taxable Gifts	10,791
Other	3,744
NCO adjustments	(92,649)
Resource Development expenses	(1,689)
TOTAL (agree to Schedule V, line 22, col.8)	$ 395,513

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	38,541
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	5,515
Inter Reimbursement	2,775
Newsletter	1,070
Publications	4,760
Less: Public Relations Expense	( )
Non-allowable advertising	(46,100)
Yellow page advertising	(412)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,149

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,582
Seminar Expense	
Travel Reimb. - Resource & Marketing	(428)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,154

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GSS - GENESEO VILLAGE # 4721 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 GSS - GENESEO VILLAGE **#** 4721 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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? **YES**
What was the average life used for new equipment added during this period? **9.5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,508** 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? **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. $ **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. $ **1,720**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **54%**
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? **YES**
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. $ **0**

(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.