FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0004721

Facility Name: GOOD SAM SOC - GENESEO VILLAGE

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

County: HENRY

Telephone Number: 309-994-6424 **Fax #** 609-944-6605

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

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) 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 GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	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	26,352	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	11,204	9,735	2,128	23,067	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,204	9,735	2,128	23,067	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.53%

D. How many bed-hold days during this year were paid by the Department?
76 (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 1,971

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,725	20,901	5,596	230,222		230,222	(39,806)	190,416			1
2	Food Purchase		193,393		193,393		193,393	(2,568)	190,825			2
3	Housekeeping	100,970	22,081		123,051		123,051	(271)	122,780			3
4	Laundry	51,341	14,974		66,315		66,315	(191)	66,124			4
5	Heat and Other Utilities			82,903	82,903		82,903		82,903			5
6	Maintenance	73,459	22,530	113,151	209,140		209,140	(7,054)	202,086			6
7	Other (specify):*			6,774	6,774		6,774	(30)	6,744			7
8	TOTAL General Services	429,495	273,879	208,424	911,798		911,798	(49,920)	861,878			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,324,636	175,612	200,974	1,701,222		1,701,222	(84,121)	1,617,101			10
10a	Therapy		18,320	197,102	215,422		215,422	(42,126)	173,296			10a
11	Activities	75,356	8,167	10,388	93,911		93,911	(207)	93,704			11
12	Social Services	26,236	314	5,157	31,707		31,707	(4)	31,703			12
13	CNA Training											13
14	Program Transportation			7,655	7,655		7,655		7,655			14
15	Other (specify):*	88			88		88		88			15
16	TOTAL Health Care and Programs	1,426,316	202,413	422,476	2,051,205		2,051,205	(126,458)	1,924,747			16
	C. General Administration											
17	Administrative	80,383		157,782	238,165		238,165	91,066	329,231			17
18	Directors Fees											18
19	Professional Services			3,448	3,448		3,448		3,448			19
20	Dues, Fees, Subscriptions & Promotions			44,236	44,236		44,236	(38,215)	6,021			20
21	Clerical & General Office Expenses	72,554	67,533	58,230	198,317		198,317	(6,346)	191,971			21
22	Employee Benefits & Payroll Taxes			467,043	467,043		467,043	(68,538)	398,505			22
23	Inservice Training & Education			10,735	10,735		10,735	(925)	9,810			23
24	Travel and Seminar			844	844		844	(28)	816			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,337	37,337		37,337	(7,941)	29,396			26
27	Other (specify):*	15,147		2,507	17,654		17,654	(17,654)				27
28	TOTAL General Administration	168,084	67,533	782,162	1,017,779		1,017,779	(48,581)	969,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,023,895	543,825	1,413,062	3,980,782		3,980,782	(224,959)	3,755,823			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 SAM SOC - GENESEO VILLAGE #0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			239,945	239,945		239,945	(18,988)	220,957			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,519	1,519		1,519	(1,519)				32
33	Real Estate Taxes			10,632	10,632		10,632	(10,632)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,978	4,978		4,978	(1,519)	3,459			35
36	Other (specify):*											36
37	**TOTAL Ownership**			257,074	257,074		257,074	(32,658)	224,416			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			170,349	170,349		170,349		170,349			42
43	Other (specify):*			5,685	5,685		5,685	(5,685)				43
44	**TOTAL Special Cost Centers**			176,034	176,034		176,034	(5,685)	170,349			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,023,895	543,825	1,846,170	4,413,890		4,413,890	(263,302)	4,150,588			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 SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,568)	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	2,216	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	(279,162)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (279,514)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (279,514)		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 SAM SOC - GENESEO VILLAGE

ID# 0004721

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SEE ATTACHED SCHEDULE	$ (39,806)	1	1
2	SEE ATTACHED SCHEDULE	(42,126)	10A	2
3	SEE ATTACHED SCHEDULE	(271)	3	3
4	SEE ATTACHED SCHEDULE	(191)	4	4
5	SEE ATTACHED SCHEDULE		5	5
6	SEE ATTACHED SCHEDULE	(7,054)	6	6
7	SEE ATTACHED SCHEDULE	(30)	7	7
8	SEE ATTACHED SCHEDULE		8	8
9	SEE ATTACHED SCHEDULE		9	9
10	SEE ATTACHED SCHEDULE	(84,121)	10	10
11	SEE ATTACHED SCHEDULE	(207)	11	11
12	SEE ATTACHED SCHEDULE	(4)	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	(38,215)	20	20
21	SEE ATTACHED SCHEDULE	(8,562)	21	21
22	SEE ATTACHED SCHEDULE	(1,625)	22	22
23	SEE ATTACHED SCHEDULE	(925)	23	23
24	SEE ATTACHED SCHEDULE	(28)	24	24
25	SEE ATTACHED SCHEDULE		25	25
26	SEE ATTACHED SCHEDULE		26	26
27	SEE ATTACHED SCHEDULE	(17,654)	27	27
28	SEE ATTACHED SCHEDULE		28	28
29	SEE ATTACHED SCHEDULE		29	29
30	SEE ATTACHED SCHEDULE	(18,988)	30	30
31	SEE ATTACHED SCHEDULE		31	31
32	SEE ATTACHED SCHEDULE	(1,519)	32	32

33	SEE ATTACHED SCHEDULE	**(10,632)**	**33**	**33**
34	SEE ATTACHED SCHEDULE		**34**	**34**
35	SEE ATTACHED SCHEDULE	**(1,519)**	**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	**(5,685)**	**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**	(279,162)		**49**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(39,806)	0	0	0	0	0	0	0	0	0	0	(39,806)	1
2	Food Purchase	(2,568)	0	0	0	0	0	0	0	0	0	0	(2,568)	2
3	Housekeeping	(271)	0	0	0	0	0	0	0	0	0	0	(271)	3
4	Laundry	(191)	0	0	0	0	0	0	0	0	0	0	(191)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,054)	0	0	0	0	0	0	0	0	0	0	(7,054)	6
7	Other (specify):*	(30)	0	0	0	0	0	0	0	0	0	0	(30)	7
8	**TOTAL General Services**	(49,920)	0	0	0	0	0	0	0	0	0	0	(49,920)	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	(84,121)	0	0	0	0	0	0	0	0	0	0	(84,121)	10
10a	Therapy	(42,126)	0	0	0	0	0	0	0	0	0	0	(42,126)	10a
11	Activities	(207)	0	0	0	0	0	0	0	0	0	0	(207)	11
12	Social Services	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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**	(126,458)	0	0	0	0	0	0	0	0	0	0	(126,458)	16
	C. General Administration													
17	Administrative	0	91,066	0	0	0	0	0	0	0	0	0	91,066	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	(38,215)	0	0	0	0	0	0	0	0	0	0	(38,215)	20
21	Clerical & General Office Expenses	(6,346)	0	0	0	0	0	0	0	0	0	0	(6,346)	21
22	Employee Benefits & Payroll Taxes	(1,625)	(66,913)	0	0	0	0	0	0	0	0	0	(68,538)	22
23	Inservice Training & Education	(925)	0	0	0	0	0	0	0	0	0	0	(925)	23
24	Travel and Seminar	(28)	0	0	0	0	0	0	0	0	0	0	(28)	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	(7,941)	0	0	0	0	0	0	0	0	0	(7,941)	26
27	Other (specify):*	(17,654)	0	0	0	0	0	0	0	0	0	0	(17,654)	27
28	**TOTAL General Administration**	(64,793)	16,212	0	0	0	0	0	0	0	0	0	(48,581)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,171)	16,212	0	0	0	0	0	0	0	0	0	(224,959)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	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	(18,988)	0	0	0	0	0	0	0	0	0	0	(18,988)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,519)	0	0	0	0	0	0	0	0	0	0	(1,519)	32
33	Real Estate Taxes	(10,632)	0	0	0	0	0	0	0	0	0	0	(10,632)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,519)	0	0	0	0	0	0	0	0	0	0	(1,519)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(32,658)	0	0	0	0	0	0	0	0	0	0	(32,658)	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):*	(5,685)	0	0	0	0	0	0	0	0	0	0	(5,685)	43
44	TOTAL Special Cost Centers	(5,685)	0	0	0	0	0	0	0	0	0	0	(5,685)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(279,514)	16,212	0	0	0	0	0	0	0	0	0	(263,302)	45

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	$ 157,782	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	$ 248,848	$ 91,066	1
2	V	22	WORKERS COMP	123,068	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	79,171	(43,897)	2
3	V	22	UNEMPLOYMENT	916	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	942	26	3
4	V	26	INSURANCE	37,337	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	29,396	(7,941)	4
5	V	22	GROUP HEALTH INSURANCE	161,818	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	138,776	(23,042)	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			$ 480,921			$ 497,133	$ * 16,212	14

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Patricia Haugen	BOD						2
3	Neil Gulsveg	BOD						3
4	Christopher Johnson	BOD						4
5	John Holt	BOD						5
6	David Horazdovsky	BOD						6
7	Elwin Brown	BOD						7
8	Lori Bussler	BOD						8
9	Andrea DeGroot-Nesdahl	BOD						9
10	Michael Deuth	BOD						10
11	theodore Gindal	BOD						11
12	Kari Berit Ramlo Gustafson	BOD						12
13	Teresa Hildebrandt	BOD						13
14	Michelle Juffer	BOD						14
15	Jack Moorman	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 GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	ANNUITIES						38,000	38,000				10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 38,000	$ 38,000			$	14
15	TOTALS (line 9+line14)						$ 38,000	$ 38,000			$	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 SAM SOC - GENESEO VILLAGE **#** 0004721 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAM 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1971	$ 493,090	$		$	$	$ 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					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		156,911	18
19				1989	20,342					20,342	19
20				1990	112,181					112,181	20
21				1991	953					953	21
22				1992	26,546	241		241		26,546	22
23				1993	26,985	135		135		26,888	23
24				1994	54,107	1,507		1,507		52,173	24
25				1995	76,045	1,980		1,980		71,334	25
26				1996	98,643	382		382		97,247	26
27				1997	105,978	4,619		4,619		85,618	27
28				1998	138,997	6,738		6,738		108,551	28
29				1999	49,448	1,992		1,992		35,363	29
30				2000	6,093	165		165		5,423	30
31				2001	93,678	5,693		5,693		72,008	31
32				2002	67,433	2,240		2,240		40,680	32
33				2003	25,639	2,115		2,115		19,720	33
34				2004	30,355	1,410		1,410		13,061	34
35				2005	288,320	14,896		14,896		114,815	35
36				2006	451,644	29,194		29,194		196,328	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 SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2007	$ 216,998	$ 10,422		$ 10,422	$	$ 57,628	37
38		2008	148,622	12,101		12,101		56,398	38
39	Absestos - Floor Coverings	2009	53,580	5,358	10	5,358		20,539	39
40	Building - Floor Coverings	2009	7,210	288	25	288		1,106	40
41	Carpet-Floor Coverings	2009	46,839	9,368	5	9,368		35,910	41
42	Ceramic Tile-Floor Coverings	2009	500	25	12	25		96	42
43	Vinyl Floor-Floor Coverings	2009	13,980	1,398	10	1,398		5,359	43
44	Wallpaper-Floor Coverings	2009	200	40	5	40		153	44
45	Windows-Floor Coverings	2009	1,320	88	15	88		337	45
46	Business Office Carpet	2009	2,384	477	5	477		1,947	46
47	Handrail/Parking Lot	2009	1,700	113	15	113		425	47
48	Building-Remodel 2008	2009	18,153	726	25	726		2,783	48
49	Carpet-Remodel 2008	2009	25,508	5,102	5	5,102		19,556	49
50	Ceramic Tile - Remodel 2008	2009	57,028	2,851	12	2,851		10,930	50
51	Vinyl Floor -Remodel 2008	2009	3,279	328	10	328		1,257	51
52	10 gallon water heater	2009	1,697	170	10	170		551	52
53	CCTV System Installation	2009	37,049	3,705	10	3,705		12,658	53
54	Blinds-Remodel 2009	2009	365	36	10	36		119	54
55	Building - Remodel 2009	2009	19,434	777	25	777		2,526	55
56	Cabinets - Remodel 2009	2009	736	37	12	37		120	56
57	Ceramic Tile - Remodel 2009	2009	1,160	58	12	58		189	57
58	Electric-Remodel 2009	2009	372	25	15	25		81	58
59	Millwork - Remodel 2009	2009	318	21	15	21		69	59
60	Vinyl Flooring	2009	2,960	296	10	296		1,011	60
61	NFPA Safety Upgrade	2009	5,885	588	10	588		2,011	61
62	Wireless Pendants	2009	4,614	923	5	923		3,076	62
63	100 Wing RTU - Compressor	2009	1,154	77	15	77		257	63
64	Hollow Metal Door	2010	2,211	111	12	111		322	64
65	Vinyl Window	2010	881	59	15	59		171	65
66	Margee Transmitters Pagers	2010	1,226	245	5	245		736	66
67	Tub & Install	2009	2,899	145	12	145		507	67
68	Replace Cast Iron Sewer Pipe	2009	2,821	141	12	141		435	68
69	Vinyl flooring	2010	2,700	270	10	270		743	69
70	TOTAL (lines 4 thru 69)		$ 3,205,459	$ 130,273		$ 130,273	$	$ 2,185,481	70

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,205,459	$ 130,273		$ 130,273	$	$ 2,185,481	1
2	Wanderguard	2010	1,235	123	10	123		329	2
3	Vinyl Sliding Window	2009	720	48	15	48		144	3
4	Handrails & Caps	2010	627	42	15	42		115	4
5	Vinyl flooring	2010	1,414	141	10	141		365	5
6	Repair Pendant Transmitter	2010	2,065	413	5	413		1,067	6
7	Waterproof basement floor	2010	4,690	469	10	469		1,329	7
8	Flooring	2010	771	77	10	77		180	8
9	Nurse Station Cabinets	2010	3,050	203	15	203		491	9
10	Building - Remodel Resident Lounge	2010	5,176	207	25	207		483	10
11	Cabinets - Remodel Resident Lounge	2010	4,614	308	15	308		718	11
12	Electric - Remodel Resident Lounge	2010	296	30	10	30		69	12
13	Hot water storage tanks	2010	14,720	1,472	10	1,472		3,189	13
14	New phone system	2010	30,095	3,010	10	3,010		7,775	14
15	Remodel Soiled Utility room	2011	3,537	236	15	236		393	15
16	Pleated Shades/Blinds	2010	1,158	232	5	232		483	16
17	Stain Glass window	2011	2,080	208	10	208		381	17
18	Door for Duplex	2011	659	66	10	66		104	18
19	Blinds-Remodel 2010	2011	1,828	366	5	366		731	19
20	Building-Remodel 2010	2011	15,945	638	25	638		1,276	20
21	Cabinets - Remodel 2010	2011	1,603	80	12	80		160	21
22	Electric-Remodel 2010	2011	3,869	258	15	258		516	22
23	Door alarm system	2011	2,863	573	5	573		811	23
24	Shutters	2011	1,833	367	5	367		550	24
25	HVAC Unit	2011	4,890	326	15	326		435	25
26	Pleated Window shades	2011	500	100	5	100		133	26
27	Steel Door front entrance	2011	1,850	123	15	123		175	27
28	Stained Glass Window	2011	3,595	360	10	360		509	28
29	Marguee Call alarm system	2011	572	114	5	114		153	29
30	Fire Alarm repair	2011	6,597	1,319	5	1,319		1,979	30
31	Garage Door	2011	3,075	308	10	308		384	31
32	Generator Repairs	2012	4,795	200	10	200		200	32
33	Trane Compressor	2012	3,750	146	15	146		146	33
34	TOTAL (lines 1 thru 33)		$ 3,339,930	$ 142,833		$ 142,833	$	$ 2,211,253	34

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,339,930	$ 142,833		$ 142,833	$	$ 2,211,253	1
2	Porch & Patio	2009	3,775	252	15	252		797	2
3	Signs	2011	363	36	10	36		73	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,344,068	$ 143,121		$ 143,121	$	$ 2,212,123	34

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 625,291	$ 68,977	$ 68,977	$		$ 343,581	71
72	Current Year Purchases	38,340	3,825	3,825			3,825	72
73	Fully Depreciated Assets	529,421	3,546	3,546			529,421	73
74								74
75	TOTALS	$ 1,193,052	$ 76,348	$ 76,348	$		$ 876,827	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	Nursing home	19 PASS VAN W/CHAIR	1998 2003	$ 68,555	$	$	$		$ 68,555	76
77	Nursing home	SNOW PLOW 200 MINIVAN	2004	17,059					17,059	77
78	Nursing home	TAILGATE FOR TRUCK	2006	1,220	140	140	0		1,220	78
79	Nursing home	1998 FORD TRUCK	2010	3,745	1,248	1,248	(0)		3,745	79
80	TOTALS			$ 90,579	$ 1,388	$ 1,388	$ (0)		$ 90,579	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)	$ 4,653,698	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 220,858	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 220,857	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,179,529	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	3,570,390	118,589	1,668,760	87
88	FFE	100,047	2,019	85,033	88
89					89
90					90
91	TOTALS	$ 3,805,130	$ 120,608	$ 1,753,793	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 GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 4,978 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 SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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 SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	LINE 10A, COL 3	hrs	$	4,984	$ 74,753	$ 354	4,984	$ 75,107	1
2	Licensed Speech and Language Development Therapist	LINE 10A, COL 3	hrs		2,051	30,769	0	2,051	30,769	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	LINE 10A, COL 3	hrs		6,105	91,579	0	6,105	91,579	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			$	13,140	$ 197,101	$ 354	13,140	$ 197,455	14

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 99,003	$	1
2	Cash-Patient Deposits	7,411		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 283)	696,451		3
4	Supply Inventory (priced at)	10,314		4
5	Short-Term Investments	1,449,897		5
6	Prepaid Insurance	4,643		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)**	$ 2,267,719	$	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	6,508,015		14
15	Leasehold Improvements, at Historical Cost	406,444		15
16	Equipment, at Historical Cost	1,383,679		16
17	Accumulated Depreciation (book methods)	(4,936,110)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	146,900		22
23	Other(specify): Other Assets	148,364		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,817,985	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,085,704	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 83,686	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,411		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	166,905		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,370		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	38,058		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 379,430	$	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	Deferrred Liabilities	1,128,165		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,128,165	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,507,595	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,578,109	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,085,704	$	48

***(See instructions.)**

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,593,983	1	
2	Restatements (describe):		2	
3	SENIOR LIVING	9,716	3	
4	APARTMENTS	31,173	4	
5	DUPLEXES	154,046	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,788,918	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(164,376)	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)**	$ (164,376)	17	
	B. Transfers (Itemize):			
18			18	
19	Reserve Fund Assesment NC	(28,950)	19	
20	Technology User Assessment NC	(27,546)	20	
21	Donor funds	10,063	21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (46,433)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,578,109	24	*

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,237,169	1
2	Discounts and Allowances for all Levels	(1,246,029)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,991,140	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	8,584	5
6	Therapy	743,486	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 752,070	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	2,568	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	30,669	16
17	Sale of Drugs	191,032	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,913	19
20	Radiology and X-Ray	5,468	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 235,650	23
	D. Non-Operating Revenue		
24	Contributions	99,138	24
25	Interest and Other Investment Income***	3,431	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 102,569	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NURSING & MEDICAL SUPPLIES	82,989	28
28a	MISC INCOME/PY SETTLEMETNS	85,099	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 168,088	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,249,517	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	911,800	31
32	Health Care	2,051,205	32
33	General Administration	1,017,780	33
	B. Capital Expense		
34	Ownership	257,074	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	170,349	36
	D. Other Expenses (specify):		
37	OTHER	5,685	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,413,893	40
41	**Income before Income Taxes (line 30 minus line 40)****	(164,376)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (164,376)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,249,246	44
45	Private Pay - Net Inpatient Revenue	1,778,801	45
46	Medicare - Net Inpatient Revenue	800,432	46
47	Other-(specify)	58,775	47
48	Other-(specify)	(896,114)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,991,140	49

* **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 SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,011	1,963	$ 66,109	$ 33.68	1
2	Assistant Director of Nursing	1,957	1,762	55,883	31.72	2
3	Registered Nurses	9,072	8,525	221,205	25.95	3
4	Licensed Practical Nurses	11,141	10,082	208,663	20.70	4
5	CNAs & Orderlies	59,749	55,239	748,230	13.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,255	1,956	31,548	16.13	9
10	Activity Assistants	4,162	3,399	43,808	12.89	10
11	Social Service Workers	1,286	1,180	26,236	22.23	11
12	Dietician					12
13	Food Service Supervisor	2,129	1,847	35,654	19.30	13
14	Head Cook	6,840	5,864	78,642	13.41	14
15	Cook Helpers/Assistants	9,186	8,363	89,429	10.69	15
16	Dishwashers					16
17	Maintenance Workers	4,024	3,643	73,459	20.16	17
18	Housekeepers	8,642	7,603	100,970	13.28	18
19	Laundry	4,350	3,555	51,341	14.44	19
20	Administrator	2,155	1,878	80,472	42.85	20
21	Assistant Administrator					21
22	Other Administrative	4,673	4,217	72,554	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	1,528	1,359	24,546	18.06	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	781	681	15,147	22.24	33
34	TOTAL (lines 1 - 33)	135,941	123,116	$ 2,023,896 *	$ 16.44	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	133	$ 5,596	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		3,981	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	57	1,724	Ln 11, Col 3	44
45	Social Service Consultant	62	5,157	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	252	$ 17,658		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	389	$ 17,857	Ln 10, Col 3	50
51	Licensed Practical Nurses	1,569	54,906	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	5,328	123,864	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	7,286	$ 196,627		53

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Dunk	Administrator		$ 80,089
Vacation Accrual			382
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,471

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 157,782
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 157,782

C. Professional Services

Vendor/Payee	Type	Amount
Medicare cost report prep		$ 950
Medicaid cost report prep		1,000
Contract Services - Admin		1,498
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 3,448

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,068
Unemployment Compensation Insurance	916
FICA Taxes	150,819
Employee Health Insurance	161,818
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	26,335
Taxable Gifts	206
Other	3,882
NCO Adjustments	(66,913)
Resource Development exp	(1,625)
TOTAL (agree to Schedule V, line 22, col.8)	$ 398,506

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	31,556
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues	6,364
Inter Reimbursement	4,521
Newsletter	
Publications	1,795
Less: Public Relations Expense	( )
Non-allowable advertising	(37,631)
Yellow page advertising	(584)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,021

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	844
Seminar Expense	
Travel Reimb. - Resource & Marketing	(28)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 816

**See instructions.

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? _____
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? **9.6 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,340** 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. $ **170,349**
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. $ **2,568**

(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? **10**
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. $ _____

(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.