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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0004721

Facility Name: GOOD SAM SOC-GENESEO VILLAGE

Address: 704 S ILLINOIS ST (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 01/01/2013 to 12/31/2013 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: 01/01/2013 Ending: 12/31/2013

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	8,318	10,347	1,819	20,484	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,318	10,347	1,819	20,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.95%

D. How many bed-hold days during this year were paid by the Department? _____ (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 _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	189,175	16,367	4,421	209,963		209,963	(51,581)	158,382			1
2	Food Purchase		175,400		175,400		175,400	(2,432)	172,968			2
3	Housekeeping	103,933	20,562		124,495		124,495	(252)	124,243			3
4	Laundry	28,190	27,370		55,560		55,560	(367)	55,193			4
5	Heat and Other Utilities			79,706	79,706		79,706		79,706			5
6	Maintenance	74,465	9,312	89,000	172,777		172,777	(10,337)	162,440			6
7	Other (specify):*			7,133	7,133		7,133	(15)	7,118			7
8	TOTAL General Services	395,763	249,011	180,260	825,034		825,034	(64,984)	760,050			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,318,896	136,709	26,640	1,482,245		1,482,245	(58,414)	1,423,831			10
10a	Therapy		8,995	214,659	223,654		223,654	(50,411)	173,243			10a
11	Activities	62,884	6,947	10,106	79,937		79,937	(940)	78,997			11
12	Social Services	36,148	796	1,717	38,661		38,661	(11)	38,650			12
13	CNA Training											13
14	Program Transportation			6,773	6,773		6,773		6,773			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,417,928	153,447	261,095	1,832,470		1,832,470	(109,776)	1,722,694			16
	C. General Administration											
17	Administrative	83,763		189,329	273,092		273,092	90,129	363,221			17
18	Directors Fees											18
19	Professional Services			1,619	1,619		1,619		1,619			19
20	Dues, Fees, Subscriptions & Promotions			24,209	24,209		24,209	(18,664)	5,545			20
21	Clerical & General Office Expenses	69,260	51,680	34,554	155,494		155,494	73	155,567			21
22	Employee Benefits & Payroll Taxes			460,973	460,973		460,973	2,619	463,592			22
23	Inservice Training & Education			13,249	13,249		13,249	(2,111)	11,138			23
24	Travel and Seminar			2,601	2,601		2,601	(2,044)	557			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,610	40,610		40,610	(10,674)	29,936			26
27	Other (specify):*	18,746		3,510	22,256		22,256	(22,256)				27
28	TOTAL General Administration	171,769	51,680	770,654	994,103		994,103	37,072	1,031,175			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,985,460	454,138	1,212,009	3,651,607		3,651,607	(137,688)	3,513,919			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: 01/01/2013 Ending: 12/31/2013

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			229,935	229,935		229,935	(19,050)	210,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			10,638	10,638		10,638	(10,638)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			967	967		967	(671)	296			35
36	Other (specify):*											36
37	**TOTAL Ownership**			241,540	241,540		241,540	(30,359)	211,181			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			194,272	194,272		194,272		194,272			42
43	Other (specify):*			5,351	5,351		5,351	(5,351)				43
44	**TOTAL Special Cost Centers**			199,623	199,623		199,623	(5,351)	194,272			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,985,460	454,138	1,653,172	4,092,770		4,092,770	(173,398)	3,919,372			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: 01/01/2013 Ending: 12/31/2013

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	(2,432)	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	2,012	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	(256,824)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (257,244)		$	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)	83,846		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 83,846		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (173,398)		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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SEE ATTACHED SCHEDULE	$ (51,581)	1	1
2	SEE ATTACHED SCHEDULE	(50,411)	10A	2
3	SEE ATTACHED SCHEDULE	(252)	3	3
4	SEE ATTACHED SCHEDULE	(367)	4	4
5	SEE ATTACHED SCHEDULE		5	5
6	SEE ATTACHED SCHEDULE	(10,337)	6	6
7	SEE ATTACHED SCHEDULE	(15)	7	7
8	SEE ATTACHED SCHEDULE		8	8
9	SEE ATTACHED SCHEDULE		9	9
10	SEE ATTACHED SCHEDULE	(58,414)	10	10
11	SEE ATTACHED SCHEDULE	(940)	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	(18,664)	20	20
21	SEE ATTACHED SCHEDULE	(1,939)	21	21
22	SEE ATTACHED SCHEDULE	(1,772)	22	22
23	SEE ATTACHED SCHEDULE	(2,111)	23	23
24	SEE ATTACHED SCHEDULE	(2,044)	24	24
25	SEE ATTACHED SCHEDULE		25	25
26	SEE ATTACHED SCHEDULE		26	26
27	SEE ATTACHED SCHEDULE	(22,256)	27	27
28	SEE ATTACHED SCHEDULE		28	28
29	SEE ATTACHED SCHEDULE		29	29
30	SEE ATTACHED SCHEDULE	(19,050)	30	30
31	SEE ATTACHED SCHEDULE		31	31
32	SEE ATTACHED SCHEDULE		32	32

33	SEE ATTACHED SCHEDULE	**(10,638)**	**33**	**33**
34	SEE ATTACHED SCHEDULE		**34**	**34**
35	SEE ATTACHED SCHEDULE	**(671)**	**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	**(5,351)**	**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**	(256,824)		**49**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(51,581)	0	0	0	0	0	0	0	0	0	0	(51,581)	1
2	Food Purchase	(2,432)	0	0	0	0	0	0	0	0	0	0	(2,432)	2
3	Housekeeping	(252)	0	0	0	0	0	0	0	0	0	0	(252)	3
4	Laundry	(367)	0	0	0	0	0	0	0	0	0	0	(367)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(10,337)	0	0	0	0	0	0	0	0	0	0	(10,337)	6
7	Other (specify):*	(15)	0	0	0	0	0	0	0	0	0	0	(15)	7
8	**TOTAL General Services**	(64,984)	0	0	0	0	0	0	0	0	0	0	(64,984)	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	(58,414)	0	0	0	0	0	0	0	0	0	0	(58,414)	10
10a	Therapy	(50,411)	0	0	0	0	0	0	0	0	0	0	(50,411)	10a
11	Activities	(940)	0	0	0	0	0	0	0	0	0	0	(940)	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**	(109,776)	0	0	0	0	0	0	0	0	0	0	(109,776)	16
	C. General Administration													
17	Administrative	0	90,129	0	0	0	0	0	0	0	0	0	90,129	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	(18,664)	0	0	0	0	0	0	0	0	0	0	(18,664)	20
21	Clerical & General Office Expenses	73	0	0	0	0	0	0	0	0	0	0	73	21
22	Employee Benefits & Payroll Taxes	(1,772)	4,391	0	0	0	0	0	0	0	0	0	2,619	22
23	Inservice Training & Education	(2,111)	0	0	0	0	0	0	0	0	0	0	(2,111)	23
24	Travel and Seminar	(2,044)	0	0	0	0	0	0	0	0	0	0	(2,044)	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	(10,674)	0	0	0	0	0	0	0	0	0	(10,674)	26
27	Other (specify):*	(22,256)	0	0	0	0	0	0	0	0	0	0	(22,256)	27
28	**TOTAL General Administration**	(46,774)	83,846	0	0	0	0	0	0	0	0	0	37,072	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(221,534)	83,846	0	0	0	0	0	0	0	0	0	(137,688)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(19,050)	0	0	0	0	0	0	0	0	0	0	(19,050)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(10,638)	0	0	0	0	0	0	0	0	0	0	(10,638)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(671)	0	0	0	0	0	0	0	0	0	0	(671)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(30,359)	0	0	0	0	0	0	0	0	0	0	(30,359)	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):*	(5,351)	0	0	0	0	0	0	0	0	0	0	(5,351)	43
44	TOTAL Special Cost Centers	(5,351)	0	0	0	0	0	0	0	0	0	0	(5,351)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(257,244)	83,846	0	0	0	0	0	0	0	0	0	(173,398)	45

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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	$ 189,329	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	$ 279,458	$ 90,129	1
2	V	22	WORKERS COMP	103,025	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	118,918	15,893	2
3	V	22	UNEMPLOYMENT	9,485	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	10,170	685	3
4	V	26	INSURANCE	40,610	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	29,936	(10,674)	4
5	V	22	GROUP HEALTH INSURANCE	163,835	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	151,648	(12,187)	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			$ 506,284			$ 590,130	$ * 83,846	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: 01/01/2013 Ending: 12/31/2013

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	Neil Gulsveg	BOD CHAIR						2
3	Christopher Johnson	BOD VICE CHAIR						3
4	John Holt	BOD						4
5	David Horazdovsky	CEO						5
6	Elwin Brown	BOD						6
7	Liane Connelly	BOD						7
8	Gwen Halaas	BOD						8
9	Michael Deuth	BOD						9
10	Theodore Gindal	BOD						10
11	Kari Berit Ramlo Gustafson	BOD						11
12	Teresa Hildebrandt	BOD						12
13	Michelle Juffer	BOD						13
14	Guy Matson	BOD						14
15	John Racek	BOD						15
16	Philip Samuelson	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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	15,244				10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 38,000	$ 15,244			$	14
15	TOTALS (line 9+line14)						$ 38,000	$ 15,244			$	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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 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:		
2008		8
2009		9
2010		10
2011		11
2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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					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					26,546	22
23				1993	26,985	97		97		26,985	23
24				1994	54,107	1,507		1,507		53,680	24
25				1995	76,045	1,980		1,980		73,314	25
26				1996	98,643	382		382		97,629	26
27				1997	105,978	4,379		4,379		89,996	27
28				1998	138,997	6,466		6,466		115,017	28
29				1999	108,254	2,781		2,781		48,379	29
30				2000	23,783	989		989		14,538	30
31				2001	93,678	5,693		5,693		77,701	31
32				2002	153,986	5,461		5,461		81,050	32
33				2003	99,483	4,096		4,096		43,720	33
34				2004	107,113	4,333		4,333		42,336	34
35				2005	244,006	12,680		12,680		109,504	35
36				2006	451,258	29,135		29,135		225,072	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: 01/01/2013 Ending: 12/31/2013

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	$	$ 68,051	37
38		2008	94,108	5,323		5,323		51,486	38
39		2009	305,040	32,399		32,399		153,517	39
40	3'X6'8" HOLLOW METAL DOOR	2010	2,211	111		111		433	40
41	VINYL WINDOW - ROOM #209	2010	881	59		59		230	41
42	MARQUEE/2-TRANSMITTRS/3-PAGERS	2010	1,226	245		245		981	42
43	TUB & INSTALL - 631 S CONGRESS	2010	2,899	145		145		652	43
44	REPLACE CAST IRON SEWER PIPES	2010	2,821	141		141		576	44
45	VINYL - 2 ROOMS	2010	2,700	270		270		1,013	45
46	WANDERGUARD MAGOLOCKS/KEYPADS	2010	1,235	124		124		453	46
47	VINYL SLIDING WINDOW	2010	720	48		48		192	47
48	HANDRAILS & CAPS - HALLWAYS	2010	627	42		42		157	48
49	VINYL - ROOM #206 & 208	2010	1,414	141		141		507	49
50	REPAIR PENDANT SYS/6-TRANSMTTR	2010	2,065	413		413		1,480	50
51	WATERPROOF BASEMENT-631 S CONG	2010	4,690	469		469		1,798	51
52	622 S. ILLINOIS FLOORING	2010	771	77		77		257	52
53	NURSE STATION CABINETS	2010	3,050	203		203		695	53
54	Building-Rmdl Resident Lounge	2010	5,176	207		207		690	54
55	Cabinets-Rmdl Resident Lounge	2010	4,614	308		308		1,025	55
56	Elect Fix-Rmdl Resident Lounge	2010	296	30		30		99	56
57	HOT WATER STORAGE TANKS	2010	14,720	1,472		1,472		4,661	57
58	NEW PHONE SYSTEM	2010	30,095	3,010		3,010		10,784	58
59	RMDL SOILED UTILITY RM WING200	2011	3,537	236		236		629	59
60	PLEATED SHADES/BLINDS	2010	1,158	232		232		714	60
61	STAIN GLASS WINDOWS	2011	2,080	208		208		589	61
62	DOOR FOR DUPLEX	2011	659	66		66		170	62
63	Blinds-Remodel 2010	2011	1,828	366		366		1,097	63
64	Building-Remodel 2010	2011	15,945	638		638		1,913	64
65	Cabinets-Remodel 2010	2011	1,603	80		80		240	65
66	Electric-Remodel 2010	2011	3,869	258		258		774	66
67	REPAIRS/PARTS DOOR ALARM SYSTE	2011	2,863	573		573		1,384	67
68	SHUTTERS FOR FRONT OF BLDG	2011	1,833	367		367		917	68
69	HVAC UNIT 631 S CONGRESS	2011	4,890	326		326		761	69
70	TOTAL (lines 4 thru 69)		$ 3,527,249	$ 138,984		$ 138,984	$	$ 2,414,111	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: 01/01/2013 Ending: 12/31/2013

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		$ 3,527,249	$ 138,984		$ 138,984	$	$ 2,414,111	1
2	PLEATED WINDOW SHADE (2)	2011	500	100		100		233	2
3	STEEL DOOR FRONT ENTRANCE	2011	1,850	123		123		298	3
4	STAINED GLASS WINDOWS (4)	2011	3,595	360		360		869	4
5	MARQUEE ALPHA215 CALL ALARM SY	2011	572	114		114		267	5
6	FIRE ALARM REPAIR LIGHTNING ST	2011	6,597	1,319		1,319		3,298	6
7									7
8	GENERATOR REPAIRS	2012	4,795	480		480		679	8
9	TRANE COMPRESSOR	2012	3,750	250		250		396	9
10	MAGIC FORCE DOOR-MAIN ENTRANCE	2012	4,275	428		428		499	10
11	FIN TUBE CABINET	2012	2,002	133		133		234	11
12	PRIVACY CURTAIN NURSE STATION	2012	579	116		116		164	12
13	GENERATOR REPAIRS	2012	1,208	121		121		171	13
14	HUMIDIFIER REPAIRS	2013	2,685	447		447		447	14
15	AC UNIT REPAIRS	2013	1,502	250		250		250	15
16									16
17	AIR TEMP SENSOR FOR KITCHEN	2013	3,018	277		277		277	17
18	ADA DOOR SYSTEM	2013	2,496	208		208		208	18
19	WATER HEATER	2013	1,412	47		47		47	19
20	CHAIR RAIL/HARDWARE/VINYL	2013	630	5		5		5	20
21	PORCH&PATIO CONCRETE REPLACMNT	2010	3,775	252		252		1,049	21
22	Signs-Remodel 2010	2011	363	36		36		109	22
23	CONCRETE FOR ENTRY WAY	2013	2,625	29		29		29	23
24	LANDSCAPING-HOUSE DEMOLITION	2013	3,050	51		51		51	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)		$ 3,578,528	$ 144,131		$ 144,131	$	$ 2,423,691	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: 01/01/2013 Ending: 12/31/2013

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	$ 604,576	$ 65,002	$ 65,002	$		$ 345,868	71
72	Current Year Purchases	22,141	2,009	2,009			2,009	72
73	Fully Depreciated Assets	601,714	5,515	5,515			601,714	73
74								74
75	TOTALS	$ 1,228,431	$ 72,526	$ 72,526	$		$ 949,591	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	$ 52,713	$	$	$		$ 52,713	76
77	Nursing Home	SNOW PLOW 200 MINIVAN	2004	17,059					17,059	77
78	Nursing Home	2004 Dodge Truck etc.	2003	20,807					20,807	78
79	Nursing Home	Golf cart	2013	1,500	125	125			125	79
80	TOTALS			$ 92,079	$ 125	$ 125	$		$ 90,704	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)	$ 4,925,038	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,782	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 216,782	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)	$ 3,463,986	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	3,431,123	114,314	1,715,946	87
88	FFE	101,512	2,238	87,418	88
89					89
90					90
91	TOTALS	$ 3,667,328	$ 116,552	$ 1,803,364	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: 01/01/2013 Ending: 12/31/2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 967 Description: General & Admin/Nursing equipment lease rental
    (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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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	$	5,341	$ 80,120	$ 552	5,341	$ 80,672	1
2	Licensed Speech and Language Development Therapist	LINE 10A, COL 3	hrs		2,180	32,705	0	2,180	32,705	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	LINE 10A, COL 3	hrs		6,789	101,833	0	6,789	101,833	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			$	14,310	$ 214,658	$ 552	14,310	$ 215,210	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: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 166,704	$	1
2	Cash-Patient Deposits	5,678		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,037)	549,975		3
4	Supply Inventory (priced at)	7,812		4
5	Short-Term Investments	208,502		5
6	Prepaid Insurance	6,633		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)**	$ 945,304	$	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	6,594,483		14
15	Leasehold Improvements, at Historical Cost	415,169		15
16	Equipment, at Historical Cost	1,422,022		16
17	Accumulated Depreciation (book methods)	(5,270,138)		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 Assets	200,756		22
23	Other(specify): Other Assets	126,227		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,649,212	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,594,516	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 56,177	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,678		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	158,766		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,306)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,665		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	45,265		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 348,245	$	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	1,182,248		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,182,248	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,530,493	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,064,023	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,594,516	$	48

***(See instructions.)**

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,578,109	1
2	Restatements (describe):		2
3	SENIOR LIVING	(16,293)	3
4	APARTMENTS	23,161	4
5	DUPLEXES	143,561	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,728,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,259)	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)**	$ (132,259)	17
	B. Transfers (Itemize):		
18	FOUNDATION TRANSFER	(9,283)	18
19	TECHNOLOGY USER ASSESSMENT NC	(20,615)	19
20	DONOR FUNDS	220	20
21	SOA ENTRY,SECURITY & PRIORITY PAYMENTS	(1,502,578)	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,532,256)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,064,023	24 *

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

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 3,847,532	1
2	Discounts and Allowances for all Levels	(1,116,759)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,730,773	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	14,049	6
7	Oxygen	829,825	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 843,874	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	2,432	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	20,921	16
17	Sale of Drugs	129,921	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,084	19
20	Radiology and X-Ray	2,963	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 160,321	23
	D. Non-Operating Revenue		
24	Contributions	132,031	24
25	Interest and Other Investment Income***	25,412	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 157,443	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NURSING & MEDICAL SUPPLIES	64,833	28
28a	MISC INCOME/PY SETTLEMENTS	3,267	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 68,100	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,960,511	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	825,033	31
32	Health Care	1,832,470	32
33	General Administration	994,103	33
	B. Capital Expense		
34	Ownership	241,541	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	194,272	36
	D. Other Expenses (specify):		
37	OTHER	5,351	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,092,770	40
41	**Income before Income Taxes (line 30 minus line 40)****	(132,259)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (132,259)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 877,994	44
45	Private Pay - Net Inpatient Revenue	1,920,025	45
46	Medicare - Net Inpatient Revenue	769,544	46
47	Other-(specify) MANAGED CARE	12,458	47
48	Other-(specify) HOSPICE/OTHER	(849,248)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,730,773	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: 01/01/2013 Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,887	1,642	$ 59,062	$ 35.97	1
2	Assistant Director of Nursing	1,019	869	29,336	33.76	2
3	Registered Nurses	13,039	11,833	311,943	26.36	3
4	Licensed Practical Nurses	9,434	8,775	175,814	20.04	4
5	CNAs & Orderlies	57,542	51,916	722,646	13.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,870	1,683	23,431	13.92	10
11	Social Service Workers	3,761	3,346	39,453	11.79	11
12	Dietician	1,754	1,597	36,148	22.63	12
13	Food Service Supervisor					13
14	Head Cook	2,033	1,597	36,284	22.72	14
15	Cook Helpers/Assistants	6,050	5,312	69,965	13.17	15
16	Dishwashers	8,751	7,835	82,926	10.58	16
17	Maintenance Workers					17
18	Housekeepers	3,646	3,242	74,465	22.97	18
19	Laundry	9,048	7,812	103,933	13.30	19
20	Administrator	2,289	2,217	28,190	12.72	20
21	Assistant Administrator	2,152	1,860	83,685	44.99	21
22	Other Administrative					22
23	Office Manager	4,178	3,621	69,339	19.15	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	1,059	902	20,095	22.28	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	925	818	18,746	22.92	33
34	TOTAL (lines 1 - 33)	130,437	116,877	$ 1,985,461 *	$ 16.99	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	105	$ 4,421	Ln , 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		3,656	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	1,717	Ln 11, Col 3	44
45	Social Service Consultant	62	1,717	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	224	$ 12,711		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	240	$ 22,067	Ln 10, Col 3	50
51	Licensed Practical Nurses			Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides			Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	240	$ 22,067		53

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Dunk	Administrator		$ 83,318
Vacation Accrual			367
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 83,685

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 189,329
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 189,329

C. Professional Services

Vendor/Payee	Type	Amount
Contract Services - Admin		$ 1,619
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,619

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,025
Unemployment Compensation Insurance	9,485
FICA Taxes	147,467
Employee Health Insurance	163,835
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	32,976
Taxable Gifts	134
Other	4,051
NCO Adjustments	4,392
Resource Development expense	(1,772)
TOTAL (agree to Schedule V, line 22, col.8)	$ 463,593

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	14,419
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues	7,468
Inter Reimbursement	
Newsletter	
Publications	2,323
Less: Public Relations Expense	( )
Non-allowable advertising	(18,664)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,546

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,891
In-State Travel	710
Seminar Expense	
Out of State Travel	(1,891)
Traevl Reimb. Marketing	(153)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 557

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAM SOC-GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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. LSN-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? 7.75

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 20,638 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. $ 194,272
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. $ 2,432

(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?
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: CLIFTON LARSONALLEN

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.