

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0004721</u></p> <p>Facility Name: <u>Good Sam Soc Geneseo Village</u></p> <p>Address: <u>704 S Illinois St</u> <u>Geneseo</u> <u>61254</u> <small>Number City Zip Code</small></p> <p>County: <u>Henry</u></p> <p>Telephone Number: <u>309-994-6424</u> Fax # <u>309-944-6605</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/01/1970</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kim Kouri</u> Telephone Number: <u>605-362-3178</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2014</u> to <u>12/31/2014</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>JOE HERDINA</u> (Title) <u>VICE PRESIDENT OF FINANCE</u> (Date) _____ </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JOE HERDINA</u> (Title) <u>VICE PRESIDENT OF FINANCE</u> (Date) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JOE HERDINA</u> (Title) <u>VICE PRESIDENT OF FINANCE</u> (Date) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Good Sam Soc Geneseo Village

0004721 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,356	9,786	2,971	21,113	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,356	9,786	2,971	21,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.34%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES 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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 01/01/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Good Sam Soc Geneseo Village

0004721

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	192,061	17,080	4,830	213,971		213,971	(41,870)	172,101		1
2	Food Purchase		177,627		177,627		177,627	(3,542)	174,085		2
3	Housekeeping	93,457	20,600		114,057		114,057	(269)	113,788		3
4	Laundry	23,259	16,674		39,933		39,933	(237)	39,696		4
5	Heat and Other Utilities			84,005	84,005		84,005		84,005		5
6	Maintenance	90,659	9,058	87,746	187,463		187,463	(16,428)	171,035		6
7	Other (specify):*			10,402	10,402		10,402	(23)	10,379		7
8	TOTAL General Services	399,436	241,039	186,983	827,458		827,458	(62,369)	765,089		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	1,269,490	202,554	204,169	1,676,213		1,676,213	(124,691)	1,551,522		10
10a	Therapy		10,934	350,688	361,622		361,622	(88,540)	273,082		10a
11	Activities	64,525	4,746	12,219	81,490		81,490	(274)	81,216		11
12	Social Services	37,010	395	1,685	39,090		39,090	(6)	39,084		12
13	CNA Training										13
14	Program Transportation			7,268	7,268		7,268		7,268		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,371,025	218,629	577,229	2,166,883		2,166,883	(213,511)	1,953,372		16
	C. General Administration										
17	Administrative	88,840		219,400	308,240		308,240	81,641	389,881		17
18	Directors Fees										18
19	Professional Services			941	941		941		941		19
20	Dues, Fees, Subscriptions & Promotions			19,855	19,855		19,855	(13,968)	5,887		20
21	Clerical & General Office Expenses	77,760	88,137	45,627	211,524		211,524	(3,256)	208,268		21
22	Employee Benefits & Payroll Taxes			465,941	465,941		465,941	(50,418)	415,523		22
23	Inservice Training & Education			13,333	13,333		13,333	(2,745)	10,588		23
24	Travel and Seminar			1,545	1,545		1,545	(1,106)	439		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,063	29,063		29,063	36,753	65,816		26
27	Other (specify):*	14,886		1,334	16,220		16,220	(16,246)	(26)		27
28	TOTAL General Administration	181,486	88,137	797,039	1,066,662		1,066,662	30,655	1,097,317		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,951,947	547,805	1,561,251	4,061,003		4,061,003	(245,225)	3,815,778		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:

01/01/2014

Ending:

12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			220,822	220,822		220,822	(18,952)	201,870			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			10,085	10,085		10,085	(10,085)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,258	1,258		1,258	(570)	688			35
36	Other (specify):*											36
37	TOTAL Ownership			232,165	232,165		232,165	(29,607)	202,558			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			154,682	154,682		154,682		154,682			42
43	Other (specify):*	5,407		12,948	18,355		18,355	(18,355)				43
44	TOTAL Special Cost Centers	5,407		167,630	173,037		173,037	(18,355)	154,682			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,957,354	547,805	1,961,046	4,466,205		4,466,205	(293,187)	4,173,018			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: 01/01/2014

Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,542)	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	2,010	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	(365,266)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (366,798)		\$	30

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	2	
		Amount	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)	73,611		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 73,611		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (293,187)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Good Sam Soc Geneseo VillageID# 0004721Report Period Beginning: 01/01/2014Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	See Attached Schedule	\$ (41,870)	1	1
2	See Attached Schedule	(88,540)	10A	2
3	See Attached Schedule	(269)	3	3
4	See Attached Schedule	(237)	4	4
5	See Attached Schedule	0	5	5
6	See Attached Schedule	(16,428)	6	6
7	See Attached Schedule	(23)	7	7
8	See Attached Schedule	0	8	8
9	See Attached Schedule	0	9	9
10	See Attached Schedule	(124,691)	10	10
11	See Attached Schedule	(274)	11	11
12	See Attached Schedule	(6)	12	12
13	See Attached Schedule	0	13	13
14	See Attached Schedule	0	14	14
15	See Attached Schedule	0	15	15
16	See Attached Schedule	0	16	16
17	See Attached Schedule	(4,000)	17	17
18	See Attached Schedule	0	18	18
19	See Attached Schedule	0	19	19
20	See Attached Schedule	(13,968)	20	20
21	See Attached Schedule	(5,266)	21	21
22	See Attached Schedule	(1,634)	22	22
23	See Attached Schedule	(2,745)	23	23
24	See Attached Schedule	(1,106)	24	24
25	See Attached Schedule	0	25	25
26	See Attached Schedule	0	26	26
27	See Attached Schedule	(16,247)	27	27
28	See Attached Schedule	0	28	28
29	See Attached Schedule	0	29	29
30	See Attached Schedule	(18,952)	30	30
31	See Attached Schedule	0	31	31
32	See Attached Schedule	0	32	32

33	See Attached Schedule	(10,085)	33	33
34	See Attached Schedule	0	34	34
35	See Attached Schedule	(570)	35	35
36	See Attached Schedule	0	36	36
37	See Attached Schedule	0	37	37
38	See Attached Schedule	0	38	38
39	See Attached Schedule	0	39	39
40	See Attached Schedule	0	40	40
41	See Attached Schedule	0	41	41
42	See Attached Schedule	0	42	42
43	See Attached Schedule	(18,355)	43	43
44				44
45				45
46				46
47				47
48				48
49	Total	(365,266)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Sam Soc Geneseo Village# 0004721

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	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	(41,870)	0	0	0	0	0	0	0	0	0	0	(41,870)	1
2	Food Purchase	(3,542)	0	0	0	0	0	0	0	0	0	0	(3,542)	2
3	Housekeeping	(269)	0	0	0	0	0	0	0	0	0	0	(269)	3
4	Laundry	(237)	0	0	0	0	0	0	0	0	0	0	(237)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(16,428)	0	0	0	0	0	0	0	0	0	0	(16,428)	6
7	Other (specify):*	(23)	0	0	0	0	0	0	0	0	0	0	(23)	7
8	TOTAL General Services	(62,369)	0	0	0	0	0	0	0	0	0	0	(62,369)	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	(124,691)	0	0	0	0	0	0	0	0	0	0	(124,691)	10
10a	Therapy	(88,540)	0	0	0	0	0	0	0	0	0	0	(88,540)	10a
11	Activities	(274)	0	0	0	0	0	0	0	0	0	0	(274)	11
12	Social Services	(6)	0	0	0	0	0	0	0	0	0	0	(6)	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	(213,511)	0	0	0	0	0	0	0	0	0	0	(213,511)	16
	C. General Administration													
17	Administrative	(4,000)	85,641	0	0	0	0	0	0	0	0	0	81,641	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	(13,968)	0	0	0	0	0	0	0	0	0	0	(13,968)	20
21	Clerical & General Office Expenses	(3,256)	0	0	0	0	0	0	0	0	0	0	(3,256)	21
22	Employee Benefits & Payroll Taxes	(1,634)	(48,783)	0	0	0	0	0	0	0	0	0	(50,417)	22
23	Inservice Training & Education	(2,745)	0	0	0	0	0	0	0	0	0	0	(2,745)	23
24	Travel and Seminar	(1,106)	0	0	0	0	0	0	0	0	0	0	(1,106)	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	36,753	0	0	0	0	0	0	0	0	0	36,753	26
27	Other (specify):*	(16,247)	0	0	0	0	0	0	0	0	0	0	(16,247)	27
28	TOTAL General Administration	(42,956)	73,611	0	0	0	0	0	0	0	0	0	30,655	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(318,836)	73,611	0	0	0	0	0	0	0	0	0	(245,225)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Sam Soc Geneseo Village# 0004721

Report Period Beginning:

01/01/2014 Ending:12/31/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(18,952)	0	0	0	0	0	0	0	0	0	0	(18,952)	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	(10,085)	0	0	0	0	0	0	0	0	0	0	(10,085)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(570)	0	0	0	0	0	0	0	0	0	0	(570)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(29,607)	0	0	0	0	0	0	0	0	0	0	(29,607)	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):*	(18,355)	0	0	0	0	0	0	0	0	0	0	(18,355)	43
44	TOTAL Special Cost Centers	(18,355)	0	0	0	0	0	0	0	0	0	0	(18,355)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(366,798)	73,611	0	0	0	0	0	0	0	0	0	(293,187)	45

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Admin/Accounting	\$ 219,400	The Evangelical Lutheran Good Samaritan Society	100.00%	\$ 305,041	\$ 85,641	1
2	V	22 Workers Compensation	88,994	The Evangelical Lutheran Good Samaritan Society	100.00%	86,589	(2,405)	2
3	V	22 Unemployment	29,063	The Evangelical Lutheran Good Samaritan Society	100.00%	2,258	(26,805)	3
4	V	26 Insurance	1,930	The Evangelical Lutheran Good Samaritan Society	100.00%	38,683	36,753	4
5	V	22 Group Health Insurance	194,599	The Evangelical Lutheran Good Samaritan Society	100.00%	175,026	(19,573)	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		\$ 533,986			\$ 607,597	\$ * 73,611	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:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Neil Gulsvig	BOD Chair						2
3	John Holt	BOD Vice Chair						3
4	Theodore Grindal	BOD						4
5	Liane Connelly	BOD						5
6	David Horazdovsky	CEO						6
7	Michael Deuth	BOD						7
8	Alan Gard	BOD						8
9	Gwen Halaas	BOD						9
10	Teresa Hildebrandt	BOD						10
11	Connie March-Curtis	BOD						11
12	Guy Matson	BOD						12
13	John Racek	BOD						13
14	Philip Samuelson	BOD						14
15	Dennis Stene	BOD						15
16	Sharon St. Mary	BOD						16
17	Carla Trout	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: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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: 01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10	Annuities						38,000	14,371								
11																
12																
13																
14	TOTAL Non-Facility Related						\$ 38,000	\$ 14,371			\$					
15	TOTALS (line 9+line14)						\$ 38,000	\$ 14,371			\$					

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2013 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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2009	_____	8	
		2010	_____	9	
		2011	_____	10	
		2012	_____	11	
		2013	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2013 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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	54,094	1,547		1,547		48,164	23
24			1994	52,616	427		427		52,616	24
25			1995	69,803	1,980		1,980		69,052	25
26			1996	98,643	382		382		98,011	26
27			1997	105,978	4,379		4,379		94,375	27
28			1998	137,907	4,674		4,674		118,601	28
29			1999	135,848	4,055		4,055		71,979	29
30			2000	27,260	1,047		1,047		18,690	30
31			2001	93,264	5,693		5,693		82,980	31
32			2002	153,986	5,461		5,461		86,512	32
33			2003	119,570	4,292		4,292		64,621	33
34			2004	112,398	4,454		4,454		51,954	34
35			2005	351,952	18,077		18,077		176,157	35
36			2006	452,274	29,236		29,236		255,070	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:

01/01/2014

Ending:

12/31/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38		2007	215,353	10,368		10,368		77,266	38
39		2008	147,252	7,172		7,172		72,665	39
40		2009	313,558	20,529		20,529		175,681	40
41	3'X6'8" HOLLOW METAL DOOR	2010	2,211	111		111		544	41
42	VINYL WINDOW - ROOM #209	2010	881	59		59		289	42
43	MARQUEE/2-TRANSMITTRS/3-PAGERS	2010	1,226	245		245		1,226	43
44	VINYL - 2 ROOMS	2010	2,700	270		270		1,283	44
45	WANDERGUARD MAGLOCKS/KEYPADS	2010	1,235	123		123		576	45
46	HANDRAILS & CAPS - HALLWAYS	2010	627	42		42		199	46
47	VINYL - ROOM #206 & 208	2010	1,414	141		141		648	47
48	REPAIR PENDANT SYS/6-TRANSMTR	2010	2,065	413		413		1,892	48
49	WATERPROOF BASEMENT-631 S CONG	2010	4,690	469		469		2,267	49
50	622 S. ILLINOIS FLOORING	2010	771	77		77		334	50
51	NURSE STATION CABINETS	2010	3,050	203		203		898	51
52	Building-Rmdl Resident Lounge	2010	5,176	207		207		897	52
53	Cabinets-Rmdl Resident Lounge	2010	4,614	308		308		1,333	53
54	Elect Fix-Rmdl Resident Lounge	2010	296	30		30		128	54
55	HOT WATER STORAGE TANKS	2010	14,720	1,472		1,472		6,133	55
56	NEW PHONE SYSTEM	2010	30,095	3,010		3,010		13,794	56
57	RMDL SOILED UTILITY RM WING200	2011	3,537	236		236		865	57
58	PLEATED SHADES/BLINDS	2010	1,158	232		232		946	58
59	STAIN GLASS WINDOWS	2011	2,080	208		208		797	59
60	DOOR FOR DUPLEX	2011	659	66		66		236	60
61	Blinds-Remodel 2010	2011	1,828	366		366		1,462	61
62	Building-Remodel 2010	2011	15,945	638		638		2,551	62
63	Cabinets-Remodel 2010	2011	1,603	80		80		321	63
64	Electric-Remodel 2010	2011	3,869	258		258		1,032	64
65	REPAIRS/PARTS DOOR ALARM SYSTE	2011	2,863	573		573		1,956	65
66	SHUTTERS FOR FRONT OF BLDG	2011	1,833	367		367		1,283	66
67	HVAC UNIT 631 S CONGRESS	2011	4,890	326		326		1,087	67
68	PLEATED WINDOW SHADE (2)	2011	500	100		100		333	68
69	STEEL DOOR FRONT ENTRANCE	2011	1,850	123		123		421	69
70	TOTAL (lines 4 thru 69)		\$ 3,766,456	\$ 134,523		\$ 134,523	\$	\$ 2,666,392	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:

01/01/2014 Ending: 12/31/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,766,456	\$ 134,523		\$ 134,523	\$	\$ 2,666,392	1
2	STAINED GLASS WINDOWS (4)	2011	3,595	360		360		1,228	2
3	MARQUEE ALPHA215 CALL ALARM SY	2011	572	114		114		381	3
4	FIRE ALARM REPAIR LIGHTNING ST	2011	6,597	1,319		1,319		4,618	4
5	GARAGE DOOR 725 S CONGRESS ST	2011	3,075	308		308		999	5
6	GENERATOR REPAIRS	2012	4,795	480		480		1,159	6
7	TRANE COMPRESSOR	2012	3,750	250		250		646	7
8	MAGIC FORCE DOOR-MAIN ENTRANCE	2012	4,275	428		428		926	8
9	FIN TUBE CABINET	2012	2,002	133		133		367	9
10	PRIVACY CURTAIN NURSE STATION	2012	579	116		116		280	10
11	GENERATOR REPAIRS	2012	1,208	121		121		292	11
12	HUMIDIFIER REPAIRS	2013	2,685	537		537		984	12
13	AC UNIT REPAIRS	2013	1,502	300		300		551	13
14	FURNACE - 721 S CONGRESS ST	2013	1,490	99		99		199	14
15	AIR TEMP SENSOR FOR KITCHEN	2013	3,018	302		302		578	15
16	ADA DOOR SYSTEM	2013	2,496	250		250		458	16
17	WATER HEATER	2013	1,412	141		141		188	17
18	CHAIR RAIL/HARDWARE/VINYL	2013	630	63		63		68	18
19	HANDRAILS/HARDWARE/WALL COVER	2014	802	36		36		36	19
20	GENERATOR RPAIR SWITCH/BATTERY	2014	556	51		51		51	20
21	TANKLESS WATER HEATER	2013	12,527	1,253		1,253		1,357	21
22	Signs-Remodel 2010	2010	363	36		36		145	22
23	CONCRETE FOR ENTRY WAY	2013	2,625	175		175		204	23
24	LANDSCAPING-HOUSE DEMOLITION	2013	6,100	610		610		712	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)		\$ 3,833,110	\$ 142,004		\$ 142,004	\$	\$ 2,682,820	34

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

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	\$ 575,231	\$ 60,132	\$ 60,132	\$		\$ 361,365	71
72	Current Year Purchases	15,750	1,331	1,331			1,331	72
73	Fully Depreciated Assets	596,169	4,943	4,943			596,169	73
74								74
75	TOTALS	\$ 1,187,150	\$ 66,406	\$ 66,406	\$		\$ 958,865	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 Passenger Van	1998 2003	\$ 52,713	\$	\$	\$		\$ 52,713	76
77	Nursing Home	Snow Plan 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 2014 Ford Van	2013 2014	61,390	12,977	12,977			13,102	79
80	TOTALS			\$ 151,969	\$ 12,977	\$ 12,977	\$		\$ 103,681	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)	\$ 5,198,229	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 221,387	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,387	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)	\$ 3,745,366	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	3,148,435	91,319	1,650,995	87
88	FFE	102,073	2,302	88,502	88
89					89
90					90
91	TOTALS	\$ 3,385,201	\$ 93,621	\$ 1,739,497	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: 01/01/2014

Ending: 12/31/2014

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: _____ *

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: \$ 1,258 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: 01/01/2014 Ending: 12/31/2014
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	Line 10A, Col 3	hrs	\$	9,345	\$ 140,182	\$ 25	9,345	\$ 140,207	1	
2	Licensed Speech and Language Development Therapist	Line 10A, Col 3	hrs		1,776	26,636		1,776	26,636	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	Line 10A, Col 3	hrs		12,258	183,870		12,258	183,870	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							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			\$	23,379	\$ 350,688	\$ 25	23,379	\$ 350,713	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# 0004721Report Period Beginning: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 62,458	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>24,074</u>)	668,287		3
4	Supply Inventory (priced at)	7,206		4
5	Short-Term Investments	339,447		5
6	Prepaid Insurance	2,653		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,080,051	\$	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	6,572,642		14
15	Leasehold Improvements, at Historical Cost	408,902		15
16	Equipment, at Historical Cost	1,441,192		16
17	Accumulated Depreciation (book methods)	(5,487,651)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	294,112		21
22	Other Long-Term Assets (specify):	110,933		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,500,823	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,580,874	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,926	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,579		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,377		30
31	Accrued Taxes Payable (excluding real estate taxes)	(3,833)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,408		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Security Deposits</u>	55,953		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 427,410	\$	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	<u>Deferred Liabilities</u>	1,282,244		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,282,244	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,709,654	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,871,220	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,580,874	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,064,023	1
2	Restatements (describe):	(79,508)	2
3	SENIOR LIVING	2,833	3
4	APARTMENTS	1,820	4
5	DUPLEXES	85,332	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,074,500	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	37,346	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)	\$ 37,346	17
B. Transfers (Itemize):			
18	FOUNDATION TRANSFER	(10,340)	18
19	TECHNOLOGY USER ASSESSMENT NC	(14,773)	19
20	DONOR FUNDS	8,352	20
21	SOA ENTRY, SECURITY & PRIORITY PAYMENTS	(222,582)	21
22	INTRA-CO N/A-NC	(1,283)	22
23	TOTAL Transfers (sum of lines 18-22)	\$ (240,626)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,871,220	24 *

* This must agree with page 17, line 47.

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.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 4,171,184	1	
2	Discounts and Allowances for all Levels	(1,510,389)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,660,795	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients	8,095	5	
6	Therapy	1,325,782	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,333,877	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants	4,000	10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals	3,542	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space	24,570	16	
17	Sale of Drugs	284,443	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	4,707	19	
20	Radiology and X-Ray	6,650	20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 327,912	23	
D. Non-Operating Revenue				
24	Contributions	126,518	24	
25	Interest and Other Investment Income***	4,800	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 131,318	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Nursing & Medical Supplies	80,888	28	
28a	Misc Income/PY Settlements	(31,237)	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 49,651	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,503,553	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	827,457	31	
32	Health Care	2,166,886	32	
33	General Administration	1,066,662	33	
B. Capital Expense				
34	Ownership	232,165	34	
C. Ancillary Expense				
35	Special Cost Centers	18,355	35	
36	Provider Participation Fee	154,682	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,466,207	40	
41	Income before Income Taxes (line 30 minus line 40)**	37,346	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 37,346	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 997,035	44
45	Private Pay - Net Inpatient Revenue	1,774,431	45
46	Medicare - Net Inpatient Revenue	1,270,708	46
47	Other-(specify)	145,361	47
48	Other-(specify)	(1,526,740)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,660,795	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: 01/01/2014

Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,063	1,873	\$ 50,473	\$ 26.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,387	14,059	373,702	26.58	3
4	Licensed Practical Nurses	7,388	7,022	141,716	20.18	4
5	CNAs & Orderlies	53,840	48,585	687,994	14.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,932	1,803	24,856	13.79	9
10	Activity Assistants	3,734	3,272	39,354	12.03	10
11	Social Service Workers	1,758	1,598	36,993	23.15	11
12	Dietician					12
13	Food Service Supervisor	2,137	1,985	40,827	20.57	13
14	Head Cook	5,385	4,575	65,184	14.25	14
15	Cook Helpers/Assistants	8,715	7,955	84,142	10.58	15
16	Dishwashers					16
17	Maintenance Workers	4,272	3,822	90,294	23.62	17
18	Housekeepers	7,957	7,036	92,134	13.09	18
19	Laundry	1,314	1,156	23,544	20.37	19
20	Administrator	2,217	1,915	88,840	46.39	20
21	Assistant Administrator					21
22	Other Administrative	1,758	1,558	27,838	17.87	22
23	Office Manager	2,641	2,353	47,421	20.15	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	1,019	903	18,792	20.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Medical Records</u>	977	854	20,532	24.04	33
34	TOTAL (lines 1 - 33)	124,494	112,324	\$ 1,954,636 *	\$ 17.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	114	\$ 4,830	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		4,688	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	56	1,685	Ln 11, Col 3	44
45	Social Service Consultant	56	1,685	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 14,088		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	183	\$ 9,139	Ln 10, Col 3	50
51	Licensed Practical Nurses	44	1,745	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	6,267	188,002	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	6,494	\$ 198,886		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lori Lofgren	Administrator	0	\$ 88,840	Workers' Compensation Insurance	\$ 88,994	IDPH License Fee	\$	
				Unemployment Compensation Insurance	2,063	Advertising: Employee Recruitment	12,747	
				FICA Taxes	143,156	Health Care Worker Background Check		
				Employee Health Insurance	194,599	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues	6,051	
				Pension	37,101	Publications	1,057	
				Taxable Gifts	368			
				Other	(340)			
				Marketing/Resource	(1,635)	Less: Public Relations Expense	()	
				Work Comp	(48,783)	Non-allowable advertising	(13,968)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 88,840				\$ 415,523			\$ 5,887	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Admin/Accounting			\$ 219,400				Out-of-State Travel	\$ 942
							In-State Travel	603
							Seminar Expense	
							Out of State Travel	(1,106)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 219,400				\$			\$ 439	
C. Professional Services								
Vendor/Payee	Type	Amount						
MIV Staff Survey	Employee Relations	\$ 941						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 941								

* Attach copy of IMRF notifications

**See instructions.

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	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# 0004721Report Period Beginning: 01/01/2014 Ending: 12/31/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
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. \$ 22,267 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. \$ 154,682
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. \$ 3,542
- (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 LARSON ALLEN
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.