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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 #** 309-944-6605

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kim Kouri **Telephone Number:** 605-362-3178
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2015 to 12/31/2015 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) JOSEPH 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: 01/01/2015 Ending: 12/31/2015

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	9,634	8,557	2,271	20,462	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,634	8,557	2,271	20,462	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.86%

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 2,073

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,112	16,868	3,623	220,603		220,603	(251)	220,352			1
2	Food Purchase		167,598		167,598		167,598	(4,996)	162,602			2
3	Housekeeping	93,466	16,524		109,990		109,990	(255)	109,735			3
4	Laundry	30,300	13,519		43,819		43,819	(231)	43,588			4
5	Heat and Other Utilities			90,131	90,131		90,131		90,131			5
6	Maintenance	92,842	11,299	85,975	190,116		190,116	(21,465)	168,651			6
7	Other (specify):*			1,699	1,699		1,699	(5)	1,694			7
8	TOTAL General Services	416,720	225,808	181,428	823,956		823,956	(27,203)	796,753			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,330,749	197,739	313,336	1,841,824		1,841,824	(102,187)	1,739,637			10
10a	Therapy		15,830	334,663	350,493		350,493	(92,015)	258,478			10a
11	Activities	62,727	4,489	12,600	79,816		79,816	(312)	79,504			11
12	Social Services	36,321	326	1,866	38,513		38,513	(6)	38,507			12
13	CNA Training											13
14	Program Transportation			4,811	4,811		4,811		4,811			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,429,797	218,384	668,476	2,316,657		2,316,657	(194,520)	2,122,137			16
	C. General Administration											
17	Administrative	93,532		213,587	307,119		307,119	46,885	354,004			17
18	Directors Fees											18
19	Professional Services			345	345		345		345			19
20	Dues, Fees, Subscriptions & Promotions			21,232	21,232		21,232	(14,398)	6,834			20
21	Clerical & General Office Expenses	78,161	122,976	48,552	249,689		249,689	(1,463)	248,226			21
22	Employee Benefits & Payroll Taxes			477,441	477,441		477,441	(8,954)	468,487			22
23	Inservice Training & Education			26,541	26,541		26,541	(4,428)	22,113			23
24	Travel and Seminar			3,022	3,022		3,022	(2,130)	892			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,565	26,565		26,565	112	26,677			26
27	Other (specify):*	16,972		1,619	18,591		18,591	(18,594)	(3)			27
28	TOTAL General Administration	188,665	122,976	818,904	1,130,545		1,130,545	(2,970)	1,127,575			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,035,182	567,168	1,668,808	4,271,158		4,271,158	(224,693)	4,046,465			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: 01/01/2015 Ending: 12/31/2015

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			212,341	212,341		212,341	(18,788)	193,553			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			9,043	9,043		9,043	(9,043)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,655	6,655		6,655	(544)	6,111			35
36	Other (specify):*											36
37	**TOTAL Ownership**			228,039	228,039		228,039	(28,375)	199,664			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			164,465	164,465		164,465		164,465			42
43	Other (specify):*	8,625		10,292	18,917		18,917	(10,292)	8,625			43
44	**TOTAL Special Cost Centers**	8,625		174,757	183,382		183,382	(10,292)	173,090			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,043,807	567,168	2,071,604	4,682,579		4,682,579	(263,360)	4,419,219			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: 01/01/2015 Ending: 12/31/2015

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	(4,996)	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	2,312	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	(309,047)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (311,731)		$	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)	48,371		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 48,371		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (263,360)		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

STATE OF ILLINOIS **Page 5A**

Good Sam Soc Geneseo Village

ID# **0004721**

Report Period Beginning: **01/01/2015**

Ending: **12/31/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See Attached Schedule	$ (251)	1	1
2	See Attached Schedule	(255)	3	2
3	See Attached Schedule	(231)	4	3
4	See Attached Schedule	(21,465)	6	4
5	See Attached Schedule	(5)	7	5
6	See Attached Schedule	(102,187)	10	6
7	See Attached Schedule	(92,015)	10a	7
8	See Attached Schedule	(312)	11	8
9	See Attached Schedule	(6)	12	9
10	See Attached Schedule	(8,625)	17	10
11	See Attached Schedule	(14,398)	20	11
12	See Attached Schedule	(3,775)	21	12
13	See Attached Schedule	(1,703)	22	13
14	See Attached Schedule	(4,428)	23	14
15	See Attached Schedule	(2,130)	24	15
16	See Attached Schedule	(18,594)	27	16
17	See Attached Schedule	(18,788)	30	17
18	See Attached Schedule	(9,043)	33	18
19	See Attached Schedule	(544)	35	19
20	See Attached Schedule	(10,292)	43	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(309,047)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Sam Soc Geneseo Village **#** 0004721 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	(251)	0	0	0	0	0	0	0	0	0	0	(251)	1
2	Food Purchase	(4,996)	0	0	0	0	0	0	0	0	0	0	(4,996)	2
3	Housekeeping	(255)	0	0	0	0	0	0	0	0	0	0	(255)	3
4	Laundry	(231)	0	0	0	0	0	0	0	0	0	0	(231)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(21,465)	0	0	0	0	0	0	0	0	0	0	(21,465)	6
7	Other (specify):*	(5)	0	0	0	0	0	0	0	0	0	0	(5)	7
8	**TOTAL General Services**	(27,203)	0	0	0	0	0	0	0	0	0	0	(27,203)	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	(102,187)	0	0	0	0	0	0	0	0	0	0	(102,187)	10
10a	Therapy	(92,015)	0	0	0	0	0	0	0	0	0	0	(92,015)	10a
11	Activities	(312)	0	0	0	0	0	0	0	0	0	0	(312)	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**	(194,520)	0	0	0	0	0	0	0	0	0	0	(194,520)	16
	C. General Administration													
17	Administrative	(8,625)	55,510	0	0	0	0	0	0	0	0	0	46,885	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	(14,398)	0	0	0	0	0	0	0	0	0	0	(14,398)	20
21	Clerical & General Office Expenses	(1,463)	0	0	0	0	0	0	0	0	0	0	(1,463)	21
22	Employee Benefits & Payroll Taxes	(1,703)	(7,251)	0	0	0	0	0	0	0	0	0	(8,954)	22
23	Inservice Training & Education	(4,428)	0	0	0	0	0	0	0	0	0	0	(4,428)	23
24	Travel and Seminar	(2,130)	0	0	0	0	0	0	0	0	0	0	(2,130)	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	112	0	0	0	0	0	0	0	0	0	112	26
27	Other (specify):*	(18,594)	0	0	0	0	0	0	0	0	0	0	(18,594)	27
28	**TOTAL General Administration**	(51,341)	48,371	0	0	0	0	0	0	0	0	0	(2,970)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(273,064)	48,371	0	0	0	0	0	0	0	0	0	(224,693)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Sam Soc Geneseo Village **#** 0004721 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(18,788)	0	0	0	0	0	0	0	0	0	0	(18,788)	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	(9,043)	0	0	0	0	0	0	0	0	0	0	(9,043)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(544)	0	0	0	0	0	0	0	0	0	0	(544)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,375)	0	0	0	0	0	0	0	0	0	0	(28,375)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,292)	0	0	0	0	0	0	0	0	0	0	(10,292)	43
44	**TOTAL Special Cost Centers**	(10,292)	0	0	0	0	0	0	0	0	0	0	(10,292)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(311,731)	48,371	0	0	0	0	0	0	0	0	0	(263,360)	45

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 213,587	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 269,097	$ 55,510	1
2	V	22	Workers Compensation	94,308	The Evangelical Lutheran Good Samaritan Society	100.00%	82,408	(11,900)	2
3	V	22	Unemployment	(1,015)	The Evangelical Lutheran Good Samaritan Society	100.00%		1,015	3
4	V	26	Insurance	26,565	The Evangelical Lutheran Good Samaritan Society	100.00%	26,677	112	4
5	V	22	Group Health Insurance	194,371	The Evangelical Lutheran Good Samaritan Society	100.00%	198,005	3,634	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			$ 527,816			$ 576,187	$ * 48,371	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: 01/01/2015 Ending: 12/31/2015

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	John Holt	BOD President						2
3	H. Theodore Grindal	BOD V-P						3
4	Gwen Wagstrom Halaas	BOD						4
5	Alan Gard	BOD						5
6	David Horazdovsky	BOD						6
7	Benjamin Anderson	BOD						7
8	Patricia Camero	BOD						8
9	Michael Deuth	BOD						9
10	Heather Krzmarsick	BOD						10
11	Connie March-Curtis	BOD						11
12	Guy Matson	BOD						12
13	John Racek	BOD						13
14	Jill Schumann	BOD						14
15	Dennis Stene	BOD						15
16	Sharon St. Mary	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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**		Purpose of Loan	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							$	$			$	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	22,866				10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 38,000	$ 22,866			$	14
15	TOTALS (line 9+line14)						$ 38,000	$ 22,866			$	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: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	54,094	1,547		1,547		49,711	23
24				1994	52,616					52,616	24
25				1995	69,803	751		751		69,803	25
26				1996	98,643	382		382		98,394	26
27				1997	105,978	4,379		4,379		98,754	27
28				1998	137,907	4,674		4,674		123,275	28
29				1999	122,051	3,355		3,355		64,872	29
30				2000	27,260	896		896		19,586	30
31				2001	93,264	5,693		5,693		88,673	31
32				2002	153,986	5,461		5,461		91,973	32
33				2003	111,792	4,292		4,292		61,135	33
34				2004	112,398	4,333		4,333		56,287	34
35				2005	351,952	17,168		17,168		193,326	35
36				2006	452,274	29,236		29,236		284,307	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: 01/01/2015 Ending: 12/31/2015

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	$ 215,353	$ 10,258		$ 10,258	$	$ 87,524	37
38		2008	147,252	6,793		6,793		79,458	38
39		2009	313,558	17,383		17,383		193,063	39
40		2010	77,291	6,942		6,942		40,473	40
41		2011	45,623	3,813		3,813		15,368	41
42	FIRE ALARM REPAIR LIGHTNING ST	2012	6,597	1,319	60	1,319		5,937	42
43	GARAGE DOOR 725 S CONGRESS ST	2012	3,075	308	120	308		1,307	43
44	GENERATOR REPAIRS	2012	4,795	480	120	480		1,638	44
45	TRANE COMPRESSOR	2012	3,750	250	180	250		896	45
46	MAGIC FORCE DOOR-MAIN ENTRANCE	2012	4,275	428	120	428		1,354	46
47	FIN TUBE CABINET	2012	2,002	133	180	133		501	47
48	PRIVACY CURTAIN NURSE STATION	2012	579	116	60	116		396	48
49	GENERATOR REPAIRS	2012	1,208	121	120	121		413	49
50	HUMIDIFIER REPAIRS	2013	2,685	537	60	537		1,521	50
51	AC UNIT REPAIRS	2013	1,502	300	60	300		851	51
52	FURNACE - 721 S CONGRESS ST	2013	1,490	99	180	99		298	52
53	AIR TEMP SENSOR FOR KITCHEN	2013	3,018	302	120	302		880	53
54	ADA DOOR SYSTEM	2013	2,496	250	120	250		707	54
55	WATER HEATER	2013	1,412	141	120	141		329	55
56	CHAIR RAIL/HARDWARE/VINYL	2013	630	63	120	63		131	56
57	HANDRAILS/HARDWARE/WALL COVER	2014	802	53	180	53		89	57
58	GENERATOR RPAIR SWITCH/BATTERY	2014	556	56	120	56		107	58
59	TANKLESS WATER HEATER	2013	12,527	1,253	120	1,253		2,610	59
60	CONCRETE FOR ENTRY WAY	2013	2,625	175	180	175		379	60
61	LANDSCAPING-HOUSE DEMOLITION	2013	6,100	610	120	610		1,322	61
62	LANDSCAPING-SIDEWALKS/TRAIL	2015	38,168	1,908	240	1,908		3,817	62
63	SIDEWALKS/WALKING TRAIL	2015	9,801	490	240	490		980	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,859,503	$ 136,747		$ 136,747	$	$ 2,801,326	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: 01/01/2015 Ending: 12/31/2015

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	$ 440,450	$ 42,549	$ 42,549	$		$ 266,809	71
72	Current Year Purchases	35,205	5,573	5,573			5,573	72
73	Fully Depreciated Assets	746,226	11,785	11,785			746,226	73
74								74
75	TOTALS	$ 1,221,881	$ 59,907	$ 59,907	$		$ 1,018,608	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	Fully Depreciated	Many	$ 90,579	$	$	$		$ 90,579	76
77	Nursing Home	Golf Cart	2013	1,500	500	500		3	1,125	77
78	Nursing Home	2014 Ford Van	2014	59,890	14,973	14,973		4	27,450	78
79										79
80	TOTALS			$ 151,969	$ 15,473	$ 15,473	$		$ 119,154	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)	$ 5,259,353	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,127	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,127	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)	$ 3,939,088	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 and Land Improvements	3,229,744	89,191	1,758,606	87
88	FFE	104,532	2,531	91,364	88
89					89
90					90
91	TOTALS	$ 3,468,969	$ 91,722	$ 1,849,970	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 13,333	92
93			93
94			94
95		$ 13,333	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,655 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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$	9,777	$	146,661	$ 11	9,777	$ 146,672	1
2	Licensed Speech and Language Development Therapist	Line 10A, col 3	hrs		1,871		28,066		1,871	28,066	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	Line 10A, col 3	hrs		10,662		159,936		10,662	159,936	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			$	22,310	$	334,663	$ 11	22,310	$ 334,674	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: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 169,165	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,387)	430,815		3
4	Supply Inventory (priced at)	5,160		4
5	Short-Term Investments	289,300		5
6	Prepaid Insurance	33,118		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,623		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 934,181	$	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	6,584,407		14
15	Leasehold Improvements, at Historical Cost	504,841		15
16	Equipment, at Historical Cost	1,478,381		16
17	Accumulated Depreciation (book methods)	(5,791,845)		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 (specify):	365,825		22
23	Other(specify):	97,645		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,399,947	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,334,128	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 131,259	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,913		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,809		30
31	Accrued Taxes Payable (excluding real estate taxes)	(543)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,063		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	53,705		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 472,206	$	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	1,382,697		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,382,697	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,854,903	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,478,225	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,333,128	$	48

***(See instructions.)**

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,871,220	1
2	Restatements (describe):		2
3	**Senior Living**	(25,089)	3
4	**Apartments**	(20,995)	4
5	**Duplexes**	59,058	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,884,194	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(382,089)	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)**	$ (382,089)	17
	B. Transfers (Itemize):		
18	**Foundation Transfer**	(7,244)	18
19	**Dnr Restricted Accounts**	(49,092)	19
20	**SOA Accounts**	32,456	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (23,880)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,478,225	24 *

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

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,182,914	1
2	Discounts and Allowances for all Levels	(1,561,729)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,621,185	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	16,723	5
6	Therapy	1,234,660	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,251,383	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	4,996	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	24,544	16
17	Sale of Drugs	242,804	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,476	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 276,820	23
	D. Non-Operating Revenue		
24	Contributions	92,590	24
25	Interest and Other Investment Income***	5,890	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98,480	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	86,066	28
28a	Misc Oncome/PY Settlements	(33,443)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52,623	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,300,491	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	823,956	31
32	Health Care	2,316,658	32
33	General Administration	1,130,545	33
	B. Capital Expense		
34	Ownership	228,039	34
	C. Ancillary Expense		
35	Special Cost Centers	18,917	35
36	Provider Participation Fee	164,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,682,580	40
41	**Income before Income Taxes (line 30 minus line 40)****	(382,089)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (382,089)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,186,704	44
45	Private Pay - Net Inpatient Revenue	1,516,192	45
46	Medicare - Net Inpatient Revenue	1,012,496	46
47	Other-(specify)	209,146	47
48	Other-(specify)	(1,303,353)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,621,185	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: 01/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,026	$ 53,892	$ 26.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,154	11,160	306,885	27.50	3
4	Licensed Practical Nurses	10,726	10,066	219,164	21.77	4
5	CNAs & Orderlies	55,706	50,855	725,184	14.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,901	1,700	25,149	14.79	9
10	Activity Assistants	3,634	3,229	38,069	11.79	10
11	Social Service Workers	1,684	1,512	36,068	23.85	11
12	Dietician					12
13	Food Service Supervisor	2,126	1,996	40,255	20.17	13
14	Head Cook	4,901	4,415	60,662	13.74	14
15	Cook Helpers/Assistants	9,299	8,433	94,116	11.16	15
16	Dishwashers					16
17	Maintenance Workers	4,479	4,074	91,217	22.39	17
18	Housekeepers	8,001	6,894	93,005	13.49	18
19	Laundry	2,286	2,083	31,334	15.04	19
20	Administrator	2,277	1,921	93,532	48.69	20
21	Assistant Administrator					21
22	Other Administrative	1,764	1,551	27,919	18.00	22
23	Office Manager	2,676	2,388	48,956	20.50	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	1,177	1,036	20,374	19.67	31
32	Other Health Care(specify)					32
33	Other(specify)	1,171	1,057	25,274	23.91	33
34	TOTAL (lines 1 - 33)	128,050	116,396	$ 2,031,055 *	$ 17.45	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	78	$ 3,266	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	340	4,075	Ln 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	62	1,866	Ln 11, Col 3	44
45	Social Service Consultant	62	1,866	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	542	$ 12,273		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,175	$ 58,670	Ln 10, Col 3	50
51	Licensed Practical Nurses	838	33,219	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	7,210	216,294	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	9,223	$ 308,183		53

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Lofgren	Administrator		$ 93,532
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,532

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 213,587
TOTAL (agree to Schedule V, line 17, col. 3)	$ 213,587
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Central Bank	Appraisal	$ 345
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,308
Unemployment Compensation Insurance	(870)
FICA Taxes	148,756
Employee Health Insurance	194,371
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	39,824
Taxable gifts	752
Other	300
Offsets on Page 5	(8,954)
TOTAL (agree to Schedule V, line 22, col.8)	$ 468,487

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,153
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues	7,312
Publications	2,767
Less: Public Relations Expense	( )
Non-allowable advertising	(14,398)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,834

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,903
In-State Travel	1,119
Seminar Expense	
Out of State Travel	(2,130)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 892

**See instructions.

Facility Name & ID Number Good Sam Soc Geneseo Village # 0004721 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:** 01/01/2015 **Ending:** 12/31/2015

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? Yes
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? 7.25

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 21,328 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. $ 164,465
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. $ 4,993

(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? 27%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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 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.