FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0004721

Facility Name: GOOD SAM SOC - GENESEO VILLAGE

Address: 704 S. Illinois (Number) Geneseo (City) 61254 (Zip Code)

County: Henry

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

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 01/01/2018 to 12/31/2018 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: 01/01/2018 Ending: 12/31/2018

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 None

	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	7,207	8,332	1,248	16,787	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,207	8,332	1,248	16,787	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.88%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 and days of care provided 928

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: 01/01/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	159,017	10,024	7,933	176,974		176,974	(173)	176,801			1
2	Food Purchase		109,939		109,939		109,939	(3,502)	106,437			2
3	Housekeeping	65,375	12,484		77,859		77,859	(243)	77,616			3
4	Laundry	31,077	10,014		41,091		41,091	(196)	40,895			4
5	Heat and Other Utilities			78,150	78,150		78,150		78,150			5
6	Maintenance	72,579	2,909	61,206	136,694		136,694	(5,928)	130,766			6
7	Other (specify):*			344	344		344	(58)	286			7
8	**TOTAL General Services**	328,048	145,370	147,633	621,051		621,051	(10,100)	610,951			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,239,407	110,840	38,250	1,388,497		1,388,497	(68,724)	1,319,773			10
10a	Therapy		701	298,243	298,944		298,944	(103,449)	195,495			10a
11	Activities	51,139	4,804	6,076	62,019		62,019	(680)	61,339			11
12	Social Services	33,063		1,068	34,131		34,131		34,131			12
13	CNA Training											13
14	Program Transportation			1,758	1,758		1,758		1,758			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,323,609	116,345	346,595	1,786,549		1,786,549	(172,853)	1,613,696			16
	C. General Administration											
17	Administrative	110,888		180,116	291,004		291,004	38,356	329,360			17
18	Directors Fees											18
19	Professional Services			3,950	3,950		3,950		3,950			19
20	Dues, Fees, Subscriptions & Promotions			20,972	20,972		20,972	(13,497)	7,475			20
21	Clerical & General Office Expenses	25,125	68,385	34,857	128,367		128,367	(8,825)	119,542			21
22	Employee Benefits & Payroll Taxes			452,841	452,841		452,841	(56,794)	396,047			22
23	Inservice Training & Education			9,439	9,439		9,439	(1,112)	8,327			23
24	Travel and Seminar			700	700		700	(631)	69			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			33,860	33,860		33,860	50,653	84,513			26
27	Other (specify):*	11,546		655	12,201		12,201	(12,223)	(22)			27
28	**TOTAL General Administration**	147,559	68,385	737,390	953,334		953,334	(4,073)	949,261			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,799,216	330,100	1,231,618	3,360,934		3,360,934	(187,026)	3,173,908			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: 01/01/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			228,982	228,982		228,982	(25,959)	203,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			6,907	6,907		6,907	(6,907)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,082	19,082		19,082	(510)	18,572			35
36	Other (specify):*											36
37	**TOTAL Ownership**			254,971	254,971		254,971	(33,376)	221,595			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			140,231	140,231		140,231		140,231			42
43	Other (specify):*			5,470	5,470		5,470	(5,470)				43
44	**TOTAL Special Cost Centers**			145,701	145,701		145,701	(5,470)	140,231			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,799,216	330,100	1,632,290	3,761,606		3,761,606	(225,872)	3,535,734			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: 01/01/2018 Ending: 12/31/2018

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	(3,502)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	1,489	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	(257,521)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (259,534)		$	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)	33,662		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 33,662		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (225,872)		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

GOOD SAM SOC - GENESEO VILLAGE

ID# 0004721

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	See Attached Schedule	(173)	1	2
3	See Attached Schedule	(243)	3	3
4	See Attached Schedule	(196)	4	4
5	See Attached Schedule	(5,928)	6	5
6	See Attached Schedule	(58)	7	6
7	See Attached Schedule	(68,724)	10	7
8	See Attached Schedule	(103,449)	10a	8
9	See Attached Schedule	(680)	11	9
10	See Attached Schedule	(13,497)	20	10
11	See Attached Schedule	(10,314)	21	11
12	See Attached Schedule	(1,447)	22	12
13	See Attached Schedule	(1,112)	23	13
14	See Attached Schedule	(631)	24	14
15	See Attached Schedule	(12,223)	27	15
16	See Attached Schedule	(25,959)	30	16
17	See Attached Schedule	(6,907)	33	17
18	See Attached Schedule	(510)	35	18
19	See Attached Schedule	(5,470)	43	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(257,521)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(173)	0	0	0	0	0	0	0	0	0	0	(173)	1
2	Food Purchase	(3,502)	0	0	0	0	0	0	0	0	0	0	(3,502)	2
3	Housekeeping	(243)	0	0	0	0	0	0	0	0	0	0	(243)	3
4	Laundry	(196)	0	0	0	0	0	0	0	0	0	0	(196)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,928)	0	0	0	0	0	0	0	0	0	0	(5,928)	6
7	Other (specify):*	(58)	0	0	0	0	0	0	0	0	0	0	(58)	7
8	TOTAL General Services	(10,100)	0	0	0	0	0	0	0	0	0	0	(10,100)	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	(68,724)	0	0	0	0	0	0	0	0	0	0	(68,724)	10
10a	Therapy	(103,449)	0	0	0	0	0	0	0	0	0	0	(103,449)	10a
11	Activities	(680)	0	0	0	0	0	0	0	0	0	0	(680)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	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	(172,853)	0	0	0	0	0	0	0	0	0	0	(172,853)	16
	C. General Administration													
17	Administrative	0	38,356	0	0	0	0	0	0	0	0	0	38,356	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	(13,497)	0	0	0	0	0	0	0	0	0	0	(13,497)	20
21	Clerical & General Office Expenses	(8,825)	0	0	0	0	0	0	0	0	0	0	(8,825)	21
22	Employee Benefits & Payroll Taxes	(1,447)	(21,128)	0	0	0	0	0	0	0	0	0	(22,575)	22
23	Inservice Training & Education	(1,112)	0	0	0	0	0	0	0	0	0	0	(1,112)	23
24	Travel and Seminar	(631)	0	0	0	0	0	0	0	0	0	0	(631)	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	16,434	0	0	0	0	0	0	0	0	0	16,434	26
27	Other (specify):*	(12,223)	0	0	0	0	0	0	0	0	0	0	(12,223)	27
28	TOTAL General Administration	(37,735)	33,662	0	0	0	0	0	0	0	0	0	(4,073)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(220,688)	33,662	0	0	0	0	0	0	0	0	0	(187,026)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(25,959)	0	0	0	0	0	0	0	0	0	0	(25,959)	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	(6,907)	0	0	0	0	0	0	0	0	0	0	(6,907)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(510)	0	0	0	0	0	0	0	0	0	0	(510)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,376)	0	0	0	0	0	0	0	0	0	0	(33,376)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,470)	0	0	0	0	0	0	0	0	0	0	(5,470)	43
44	**TOTAL Special Cost Centers**	(5,470)	0	0	0	0	0	0	0	0	0	0	(5,470)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(259,534)	33,662	0	0	0	0	0	0	0	0	0	(225,872)	45

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 180,116	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 218,472	$ 38,356	1
2	V	22	Workers Compensation	93,932	The Evangelical Lutheran Good Samaritan Society	100.00%	59,769	(34,163)	2
3	V	22	Unemployment	(359)	The Evangelical Lutheran Good Samaritan Society	100.00%		359	3
4	V	26	Insurance	33,860	The Evangelical Lutheran Good Samaritan Society	100.00%	50,294	16,434	4
5	V	22	Group Health Insurance	176,128	The Evangelical Lutheran Good Samaritan Society	100.00%	188,804	12,676	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			$ 483,677			$ 517,339	$ * 33,662	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: 01/01/2018 Ending: 12/31/2018

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	Dr Gwen Halaas	0	BOD					1
2	Dale Thompson	0	BOD					2
3	Alan Gard	0	BOD					3
4	Jill Schumann	0	BOD					4
5	Randy Bury	0	BOD					5
6	Kelby Krabbenhoft	0	BOD					6
7	Patricia Camero	0	BOD					7
8	Heather Krzmarzick	0	BOD					8
9	Lee Laaveg	0	BOD					9
10	John Racek	0	BOD					10
11	Dina Robinson	0	BOD					11
12	Lisa Melby	0	BOD					12
13	Timothy Phillippe	0	BOD					13
14	Norval Beckneberg	0	BOD					14
15	Rebecca Bollig	0	BOD					15
16	Scott Petersen	0	BOD					16
17	Javier Espinosa	0	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: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	33,191				10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 38,000	$ 33,191			$	14
15	TOTALS (line 9+line14)						$ 38,000	$ 33,191			$	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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:		
2013		8
2014		9
2015		10
2016		11
2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

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	Nursing Home		1969	$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	1,018					1,018	10
11				1977	508					508	11
12				1978	11,445					11,445	12
13				1981	167,386					167,340	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	111,310					111,310	20
21				1991	953					953	21
22				1992	26,546					26,546	22
23				1993	47,726	1,289		1,289		47,726	23
24				1994	50,561					50,561	24
25				1995	69,053					69,053	25
26				1996	98,643					98,643	26
27				1997	105,978					105,978	27
28				1998	133,107	2,322		2,322		130,145	28
29				1999	116,554	3,355		3,355		69,441	29
30				2000	26,187	846		846		21,050	30
31				2001	93,264	379		379		90,695	31
32				2002	153,986	5,263		5,263		107,999	32
33				2003	111,792	4,172		4,172		73,891	33
34				2004	112,398	4,333		4,333		69,285	34
35				2005	351,952	14,498		14,498		236,821	35
36				2006	450,397	28,961		28,961		369,408	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: 01/01/2018 Ending: 12/31/2018

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	$ 9,371		$ 9,371	$	$ 117,031	37
38		2008	145,038	5,781		5,781		96,629	38
39		2009	316,408	17,586		17,586		246,723	39
40		2010	130,957	7,722		7,722		70,708	40
41		2011	48,489	2,638		2,638		27,259	41
42		2012	12,860	1,161		1,161		7,969	42
43		2013	138,200	8,218		8,218		47,179	43
44		2014	34,773	3,186		3,186		13,516	44
45	ELEC - RECEPTACLES	2015	10,425	1,043	120	1,043		3,475	45
46	FIRE ALARM - MODULE/SOUNDER	2015	3,279	328	120	328		1,093	46
47	RTU - LAUNDRY	2016	11,880	792	180	792		2,310	47
48	WIRELESS INOVONICS # RECEIVER	2016	2,201	440	60	440		1,174	48
49	I-BEAM WALL BRACING	2016	3,000	300	120	300		800	49
50	MOTOR - 300 WING RTU	2016	1,568	209	90	209		540	50
51	FIRE ALARM EXPANDER	2016	485	49	120	49		137	51
52	PLMB-BACKFLOW PREVENT-RPZ (2)	2016	1,961	98	240	98		286	52
53	THERAPY RM CEILING TILE	2016	6,880	860	96	860		2,365	53
54	WTR SOFTENER - CONTROL MOD	2016	1,349	270	60	270		742	54
55	445 E CHESTNUT HOUSE	2016	95,948	4,797	240	4,797		11,194	55
56	WATER HEATERS	2016	44,188	4,419	120	4,419		10,310	56
57	CASCADE SPA/TUB	2015	22,963	2,296	120	2,296		7,080	57
58	COLONIAL RUBBER WALL BASE	2016	898	90	120	90		187	58
59	EMERGENCY PANEL	2016	828	83	120	83		235	59
60	AIR CONDITIONER-ACTIVITY ROOM	2016	5,365	537	120	537		1,162	60
61	REPAIRS TO AC UNIT	2016	2,038	408	60	408		849	61
62	AIR CONDITIONER-THERAPY ROOM	2016	10,780	1,078	120	1,078		2,246	62
63	Levolor blinds, acute wing	2016	740	148	60	148		333	63
64	SECURITY CAMERA	2017	1,819	364	60	364		576	64
65	FIRE ALARM DEVICE FOR SYSTEM	2017	798	160	60	160		253	65
66	CARPET	2017	2,676	535	60	535		1,026	66
67	DOORS	2016	1,107	74	180	74		215	67
68	MIXING VALVE	2017	8,979	898	120	898		1,272	68
69	A.O. SMITH WATER HEATER	2017	1,108	111	120	111		148	69
70	TOTAL (lines 4 thru 69)		$ 4,210,851	$ 141,469		$ 141,469	$	$ 3,221,581	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,210,851	$ 141,469		$ 141,469	$	$ 3,221,581	1
2	SECURITY CAMERA	2017	932	186	60	186		280	2
3	FIRE ALARM SYSTEM	2015	19,718	1,972	120	1,972		7,723	3
4	GREASE TRAP	2018	3,931	360	120	360		360	4
5	SECURITY CAMERA	2017	621	124	60	124		124	5
6	LIGHT FIXTURE (20)	2016	1,816	182	120	182		378	6
7	PERGOLA, 16X12 POSTS	2016	5,700	570	120	570		1,425	7
8	CONCRETE REPAIRS	2016	15,126	1,513	120	1,513		3,277	8
9	CROSS W/ BASE PRAYER GARDEN	2015	545	55	120	55		186	9
10	LANDSCAPING-SIDEWALKS/TRAIL	2015	38,168	1,908	240	1,908		7,634	10
11	SIDEWALKS/WALKING TRAIL	2015	9,801	490	240	490		1,961	11
12									12
13									13
14	Depreciation Adjustments						(21,162)		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,307,209	$ 148,829		$ 148,829	$ (21,162)	$ 3,244,928	34

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 487,955	$ 49,030	$ 49,030	$		$ 283,030	71
72	Current Year Purchases	39,660	4,618	4,618			4,618	72
73	Fully Depreciated Assets	714,694	990	990			714,694	73
74								74
75	TOTALS	$ 1,242,309	$ 54,638	$ 54,638	$		$ 1,002,342	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	$ 39,367	$	$	$	Many	$ 39,367	76
77	Nursing Home	2014 Ford Van	2014	73,102	6,810	6,810		4	70,023	77
78	Nursing Home	2009 Chrylser	2014	12,630	2,368	2,368		4	12,630	78
79	Nursing Home	2017 Toyota Minivan	2107	53,650	13,413	13,413		4	17,883	79
80	TOTALS			$ 178,749	$ 22,591	$ 22,591	$		$ 139,903	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)	$ 5,754,267	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,058	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 226,058	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (21,162)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,387,173	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	3,385,518	92,403	2,006,008	87
88	FFE	114,870	3,087	95,946	88
89					89
90					90
91	TOTALS	$ 3,635,081	$ 95,490	$ 2,101,954	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 42,755	92
93			93
94			94
95		$ 42,755	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: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 19,082 Description: General & Admin/Nursing Equipment Rental Lease
(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: 01/01/2018 Ending: 12/31/2018

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 10A, Col 3	hrs	$	7,340	$ 110,099	$ 179	7,340	$ 110,278	1
2	Licensed Speech and Language Development Therapist	Line 10A, Col 3	hrs		2,799	41,991		2,799	41,991	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10A, Col 3	hrs		9,662	144,930	278	9,662	145,208	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			$	19,801	$ 297,020	$ 457	19,801	$ 297,477	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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 140,807	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 225,944)	121,259		3
4	Supply Inventory (priced at)	11,720		4
5	Short-Term Investments	82,502		5
6	Prepaid Insurance	2,653		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,813		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 363,754	$	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	7,123,276		14
15	Leasehold Improvements, at Historical Cost	569,453		15
16	Equipment, at Historical Cost	1,535,928		16
17	Accumulated Depreciation (book methods)	(6,489,128)		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):	42,737		22
23	Other(specify):	84,545		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,027,504	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,391,258	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 114,809	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,572		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,752		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,355		31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,136		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	62,956		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 442,580	$	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	1,089,451		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,089,451	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,532,031	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,859,227	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,391,258	$	48

***(See instructions.)**

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,327,828	1
2	Restatements (describe):		2
3	Senior Living	58,134	3
4	Apartments	(8,759)	4
5	Duplexes	9,207	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,386,410	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(132,269)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (132,269)	17
	B. Transfers (Itemize):		
18	Dnor Restricted Gifts	3,757	18
19	SOA Accounts	(398,671)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (394,914)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,859,227	24 *

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

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,744,941	1
2	Discounts and Allowances for all Levels	(1,462,269)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,282,672	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	28,834	5
6	Therapy	1,085,237	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,114,071	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	3,502	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	24,510	16
17	Sale of Drugs	264,287	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,435	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 293,734	23
	D. Non-Operating Revenue		
24	Contributions	50,858	24
25	Interest and Other Investment Income***	6,511	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 57,369	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical & Nursing Supplies	45,432	28
28a	Misc Income PY settlements	(163,942)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (118,510)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,629,336	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	621,051	31
32	Health Care	1,786,548	32
33	General Administration	953,334	33
	B. Capital Expense		
34	Ownership	254,971	34
	C. Ancillary Expense		
35	Special Cost Centers	5,470	35
36	Provider Participation Fee	140,231	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,761,605	40
41	**Income before Income Taxes (line 30 minus line 40)****	(132,269)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (132,269)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 832,898	44
45	Private Pay - Net Inpatient Revenue	1,516,767	45
46	Medicare - Net Inpatient Revenue	476,834	46
47	Other-(specify)	497,509	47
48	Other-(specify)	(1,041,336)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,282,672	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: 01/01/2018 Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,835	2,080	$ 66,340	$ 31.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,305	7,222	199,642	27.64	3
4	Licensed Practical Nurses	10,668	11,463	259,034	22.60	4
5	CNAs & Orderlies	40,040	44,626	699,311	15.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,397	1,515	25,787	17.02	9
10	Activity Assistants	1,578	1,716	23,179	13.51	10
11	Social Service Workers	1,404	1,602	33,168	20.70	11
12	Dietician					12
13	Food Service Supervisor	1,180	1,525	28,102	18.43	13
14	Head Cook	3,901	4,527	55,685	12.30	14
15	Cook Helpers/Assistants	7,038	8,136	82,572	10.15	15
16	Dishwashers					16
17	Maintenance Workers	2,588	2,889	68,413	23.68	17
18	Housekeepers	5,442	6,482	67,962	10.48	18
19	Laundry	1,617	2,103	35,490	16.88	19
20	Administrator	1,325	1,714	80,253	46.82	20
21	Assistant Administrator					21
22	Other Administrative	448	626	10,550	16.85	22
23	Office Manager	1,841	2,236	40,133	17.95	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	1,228	1,423	26,078	18.33	31
32	Other Health Care(specify)					32
33	Other(specify) Res Dev/Mktg	484	583	13,364	22.92	33
34	TOTAL (lines 1 - 33)	90,319	102,468	$ 1,815,063 *	$ 17.71	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	170	$ 7,181	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	139	1,497	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	17	495	Ln 11, Col 3	44
45	Social Service Consultant	34	1,007	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	360	$ 11,380		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	537	$ 26,839	Ln 10, Col 3	50
51	Licensed Practical Nurses			Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	28	847	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	565	$ 27,686		53

Facility Name & ID Number GOOD SAM SOC - GENESEO VILLAGE # 0004721 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Gary	Administrator	100	$ 93,718
Jennifer Dunk	Administrator	100	17,170
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,888

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 180,116
TOTAL (agree to Schedule V, line 17, col. 3)	$ 180,116
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gallup	Survery Services	$ 3,950
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 3,950

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,932
Unemployment Compensation Insurance	(253)
FICA Taxes	133,325
Employee Health Insurance	176,128
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	32,530
Taxable Gifts	16,276
Other	903
Offset (Page 5a)	(56,794)
TOTAL (agree to Schedule V, line 22, col.8)	$ 396,047

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,854
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues	6,776
Publications	3,342
Less: Public Relations Expense	( )
Non-allowable advertising	(13,497)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,475

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (710)
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ (710)

* Attach copy of IMRF notifications

**See instructions.

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, $3,064**

(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? **Yes**

(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? **8.33**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,263** 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. $ **140,231**
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. $ **3,502** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,502**

(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? **64%**
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?
Firm Name: **CLIFTON LARSEN 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