

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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		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			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	8,640	15,755	1,320	25,715	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,640	15,755	1,320	25,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.85%

D. How many bed-hold days during this year were paid by Public Aid? 54 (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)
Meals on /Wheels, Outpatient Therapy

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

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

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

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

STATE OF ILLINOIS

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Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2001 Ending: 12/31/2001**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	191,264	10,809	6,355	208,428		208,428		208,428		1
2	Food Purchase		134,921		134,921		134,921	(3,024)	131,897		2
3	Housekeeping	88,880	13,038		101,918		101,918		101,918		3
4	Laundry	65,351	11,779		77,130		77,130		77,130		4
5	Heat and Other Utilities			61,304	61,304		61,304	(455)	60,849		5
6	Maintenance	74,624	13,764	66,577	154,965		154,965	2,514	157,479		6
7	Other (specify):* SCHD ATTCHD			2,284	2,284		2,284		2,284		7
8	TOTAL General Services	420,119	184,311	136,520	740,950		740,950	(965)	739,985		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	982,133	81,982	11,590	1,075,705	(22,771)	1,052,934	(29,721)	1,023,213		10
10a	Therapy	70,798	569	63,369	134,736		134,736	(39,219)	95,517		10a
11	Activities	55,135	11,613	4,179	70,927		70,927	(66)	70,861		11
12	Social Services	35,213	830	944	36,987		36,987		36,987		12
13	Nurse Aide Training					22,771	22,771		22,771		13
14	Program Transportation			2,244	2,244		2,244		2,244		14
15	Other (specify):* SCHEDULE ATTAC	32,954			32,954		32,954		32,954		15
16	TOTAL Health Care and Programs	1,176,233	94,994	82,326	1,353,553		1,353,553	(69,006)	1,284,547		16
	C. General Administration										
17	Administrative	47,803		116,639	164,442		164,442	26,396	190,838		17
18	Directors Fees										18
19	Professional Services			11,401	11,401		11,401		11,401		19
20	Dues, Fees, Subscriptions & Promotions			22,170	22,170		22,170	(20,066)	2,104		20
21	Clerical & General Office Expenses	46,380	16,206	32,890	95,476		95,476	(6,364)	89,112		21
22	Employee Benefits & Payroll Taxes			308,296	308,296		308,296	7,867	316,163		22
23	Inservice Training & Education			22,016	22,016		22,016	(860)	21,156		23
24	Travel and Seminar			2,350	2,350		2,350	(222)	2,128		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			19,858	19,858		19,858	4,703	24,561		26
27	Other (specify):* SCHEDULE ATTAC	18,406		2,622	21,028		21,028	(18,632)	2,396		27
28	TOTAL General Administration	112,589	16,206	538,242	667,037		667,037	(7,178)	659,859		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,708,941	295,511	757,088	2,761,540		2,761,540	(77,149)	2,684,391		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

GENESEO GOOD SAMARITAN VILLAGE

#0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			164,377	164,377		164,377	(13,575)	150,802			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,874	3,874		3,874	(3,874)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,599	2,599		2,599		2,599			35
36	Other (specify):*											36
37	TOTAL Ownership			170,850	170,850		170,850	(17,449)	153,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			510	510		510	(510)				39
40	Barber and Beauty Shops		324		324		324	(324)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,529	39,529		39,529		39,529			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		324	40,039	40,363		40,363	(834)	39,529			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,708,941	295,835	967,977	2,972,753		2,972,753	(95,432)	2,877,321			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 **GENESEO GOOD SAMARITAN VILLAGE**

0004721

Report Period Beginning: **1/1/2001**

Ending: **12/31/2001**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,024)	2		4
5	Telephone, TV & Radio in Resident Rooms	(455)	5		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	(3,874)	32		10
11	Discounts, Allowances, Rebates & Refunds				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)	(15)	6		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	(20,066)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SCHED ATTCHD	(109,281)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,715)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	41,283	SCHD AT	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 41,283		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (95,432)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

STATE OF ILLINOIS
 GENESEO GOOD SAMARITAN VILLAGE

ID# 0004721
 Report Period Beginning: 1/1/2001
 Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	UNIFORM INC	\$ (1,804)	21	1
2	ACTIVITY INC	(66)	11	2
3	Deferred Maint Costs - 2000	779	6	3
4	Res Dev - Supplies, Fdraisers	(4,067)	21	4
5	Deferred Maint Costs - 2001	(1,158)	6	5
6	Deferred Maint Costs - 1996-1999	3,323	6	6
7	Depreciation Exp - Apt/Duplex	(13,575)	30	7
8	P/Serv-Laboratory-MDCR	(510)	39	8
9	Prescr Drugs - Reimb	(26,030)	10	9
10	Barber & Beauty Expenses	(324)	40	10
11	Res Dev - Salaries & Vac Acc	(9,234)	27	11
12	Res Dev - FICA	(2,317)	22	12
13	Res Dev - Travel	(222)	24	13
14	Res Dev - Staff Devel	(860)	23	14
15	Therapy Offset - PT, OT, ST	(39,219)	10a	15
16	Marketing Salaries	(9,277)	27	16
17	Supplies - PT B	(831)	10	17
18	Glucose Strip Expense	(2,860)	10	18
19				19
20	Admin	(3)	21	20
21	Uncl Pyroll Checks	(339)	21	21
22	Telephone	(151)	21	22
23	Res Dev - Newsletters	(184)	27	23
24	Res Dev - Equipment Repairs	(415)	6	24
25	Res Dev - Salary Reimb	105	27	25
26	Res Dev - Staff Pension	(42)	22	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	(109,281)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721 Report Period Beginning:1/1/2001Ending: 12/31/2001**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,024)	0	0	0	0	0	0	0	0	0	0	(3,024)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(455)	0	0	0	0	0	0	0	0	0	0	(455)	5
6	Maintenance	2,514	0	0	0	0	0	0	0	0	0	0	2,514	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(965)	0	0	0	0	0	0	0	0	0	0	(965)	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	(29,721)	0	0	0	0	0	0	0	0	0	0	(29,721)	10
10a	Therapy	(39,219)	0	0	0	0	0	0	0	0	0	0	(39,219)	10a
11	Activities	(66)	0	0	0	0	0	0	0	0	0	0	(66)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	(69,006)	0	0	0	0	0	0	0	0	0	0	(69,006)	16
	C. General Administration													
17	Administrative	0	26,396	0	0	0	0	0	0	0	0	0	26,396	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	(20,066)	0	0	0	0	0	0	0	0	0	0	(20,066)	20
21	Clerical & General Office Expenses	(6,364)	0	0	0	0	0	0	0	0	0	0	(6,364)	21
22	Employee Benefits & Payroll Taxes	(2,359)	10,184	0	0	0	0	0	0	0	0	0	7,825	22
23	Inservice Training & Education	(860)	0	0	0	0	0	0	0	0	0	0	(860)	23
24	Travel and Seminar	(222)	0	0	0	0	0	0	0	0	0	0	(222)	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	4,703	0	0	0	0	0	0	0	0	0	4,703	26
27	Other (specify):*	(18,590)	0	0	0	0	0	0	0	0	0	0	(18,590)	27
28	TOTAL General Administration	(48,461)	41,283	0	(7,178)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,432)	41,283	0	(77,149)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(13,575)	0	0	0	0	0	0	0	0	0	0	(13,575) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(3,874)	0	0	0	0	0	0	0	0	0	0	(3,874) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(17,449)	0	0	0	0	0	0	0	0	0	0	(17,449) 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	(510)	0	0	0	0	0	0	0	0	0	0	(510) 39
40	Barber and Beauty Shops	(324)	0	0	0	0	0	0	0	0	0	0	(324) 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(834)	0	0	0	0	0	0	0	0	0	0	(834) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(136,715)	41,283	0	(95,432) 45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Ev. Lutheran Good Samaritan Society	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Admin/Acctg	\$ 116,639	The Ev Lutheran Good Samaritan Society	100.00%	\$ 143,035	\$ 26,396
2	V						
3	V	22 Unemployment				(433)	(433)
4	V						
5	V	22 Workers Comp	31,478			42,095	10,617
6	V						
7	V	26 Prop&Liab Ins	19,859			24,562	4,703
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 167,976			\$ 209,259	\$ * 41,283

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5	NOT APPLICABLE									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 GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization The Ev Lutheran Good Samaritan Society
 Street Address 4800 W 57th St PO Box 5038
 City / State / Zip Code Sioux Falls, SD 57117-5038
 Phone Number (605)362-3100
 Fax Number (605)362-3265

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

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	See under separate cover the				\$	\$			1
2	Report on Allowable Central								2
3	Office Expenses for the Year								3
4	ended December 31, 2001"								4
5									5
6									6
7	*The allocated expenses in this report related directly to each centers								7
8	nursing home facility and no additional re-allocation of these expenses								8
9	between healthcare facilities and non healthcare facilities/apartments								9
10	should be necessary								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 GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

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	AETNA		x	Bldg & Equip	(1)	5/20/1987	\$ 275,941	\$ 0	11/1/2001	0.0897	\$ 3,874	1								
2	Bank of America					12/1999	248,709	0				2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 524,650	\$			\$ 3,874	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 524,650	\$			\$ 3,874	15								

* 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 **GENESEO GOOD SAMARITAN VILLAGE**# **0004721** Report Period Beginning: **1/1/2001** Ending: **12/31/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2000 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 2001 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 19 _____ 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:		1996	5,158	8	
		1997	7,296	9	
		1998	4,066	10	
		1999		11	
		2000		12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2000		\$		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.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721 Report Period Beginning:1/1/2001 Ending: 12/31/2001**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 22,848 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____C. Does the Operating Entity? (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? (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 8 UNITSDUPLEXES - 12 UNITSF. 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1969	\$ 26,000	1
2					2
3	TOTALS			\$ 26,000	3

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	72		1971	1971	\$ 494,740	\$ 12,369	40	\$ 12,369	\$	\$ 380,331	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING										9
10			1977		1,100		VARIES			1,100	10
11			1978		7,629		20			7,629	11
12			1981		169,320	5,451	VARIES	5,451		117,531	12
13			1982		2,299	65	VARIES	65		2,272	13
14			1986		3,335	15	VARIES	15		3,274	14
15			1987		15,313	520	VARIES	520		12,452	15
16			1988		132,771	5,313	VARIES	5,313		97,610	16
17			1989		32,054	977	VARIES	977		27,381	17
18			1990		148,304	5,488	VARIES	5,488		101,901	18
19			1991		5,106	87	VARIES	87		4,851	19
20			1992		99,897	2,573	VARIES	2,573		88,885	20
21			1993		80,357	4,864	VARIES	4,864		44,718	21
22			1994		73,192	4,491	VARIES	4,491		39,925	22
23			1995		76,365	4,715	VARIES	4,715		31,203	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

*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

STATE OF ILLINOIS

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Building		\$		\$	\$	\$		37
38	Ceramic Flooring	1996	107	5	20	5		32	38
39	Laundry Wall Protection	1996	1,109		5			1,109	39
40	Activity Room Remodel/Sink	1996	2,132		5			2,132	40
41	Laundry Doors	1996	1,874	125	15	125		729	41
42	Bathroom Sink	1996	678	34	20	34		201	42
43	Awning for Rehab Clinic	1996	983	98	10	98		565	43
44	Nurse Call System-Duplex	1996	770	77	10	77	0	443	44
45	Kemlite in Closets	1996	653	65	10	65		370	45
46	Power Access Door Operator	1996	1,009	101	10	101		572	46
47	Generator/Move to GSS	1996	3,431	343	10	343		1,944	47
48	Carpet for Parlor	1996	2,627	91	5	91		2,500	48
49	A/C-Roor Top on 200 Wing	1996	229	15	15	15		84	49
50	Electric-Remodel Parlor	1996	186	9	20	9		51	50
51	Building-Remodel Parlor	1996	1,132	57	20	57		311	51
52	Plumbing-Remodel Parlor	1996	599	30	20	30		165	52
53	Carpet-Remodel Parlor	1996	1,164	40	5	40		1,107	53
54	Wallpaper-Remodel Parlor	1996	2,645	92	5	92		2,517	54
55	Shower Remodel-Grab Bars	1996	1,321	132	10	132		694	55
56	Carpet for Resident Room	1996	768	141	5	141		768	56
57	Replace Fixtures/Floor/Wall	1996	3,955	198	20	198		1,022	57
58	Windows	1996	25,212	1,681	15	1,681		8,684	58
59	Building-Remodel	1996	1,692	85	20	85		458	59
60	Wallpaper for Resident Room	1997	2,976	595	5	595		2,926	60
61	Window for Dining Room	1997	1,650	110	15	110		541	61
62	300 Wing Ceiling Tile Work	1997	2,584	517	5	517		2,541	62
63	Wall Built in Laundry Room	1997	1,013	101	10	101		498	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,404,281	\$ 51,670		\$ 51,670	\$ 0	\$ 994,027	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,404,281	\$ 51,670		\$ 51,670	\$ 0	\$ 994,027	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,404,281	\$ 51,670		\$ 51,670	\$ 0	\$ 994,027	34

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

STATE OF ILLINOIS

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,404,281	\$ 51,670		\$ 51,670	\$ 0	\$ 994,027	1
2	Building continued								2
3	Wallpaper in Resident's Room	1997	3,838	768	6	768		3,774	3
4	Windows	1997	5,100	340	15	340		1,672	4
5	Carpet & Padding	1997	1,401	280	6	280		1,377	5
6	Wallpaper for Jack Andrews	1997	2,221	444	5	444		2,183	6
7	Carpet for Conference Room	1997	2,192	438	5	438		2,118	7
8	Conference Work Room	1997	1,350	135	10	135		664	8
9	Wall Protection	1997	739	148	5	148		714	9
10	New Sprinklers for Office	1997	909	91	10	91		424	10
11	Carpet	1997	768	154	6	154		704	11
12	Wallpaper-Resident Room #308	1997	2,667	533	5	533		2,445	12
13	Floorcovering and Labor	1997	975	195	5	195		893	13
14	Wallpaper for Offices	1997	782	156	5	156		716	14
15	Carpet for Resident Room	1997	506	101	5	101		464	15
16	Environmental Assessment of 61	1997	1,739	174	10	174		783	16
17	Roof-Front Entry	1997	21,178	1,059	20	1,059		5,206	17
18	Social Service & Conference Room	1997	1,392	93	15	93		417	18
19	D.O.N. & Staff Development Office	1997	1,236	82	15	82		371	19
20	Wallpaper-Room 308	1997	1,440	288	5	288		1,296	20
21	Drain/Sewer Work	1997	389	26	15	26		115	21
22	House 618 S Illinois Geneseo	1997	50,938	2,547	20	2,547		11,037	22
23	Floor Covering-Offices & Resid	1997	564	113	6	113		489	23
24	Ceiling Tiles	1997	1,390	278	6	278		1,158	24
25	Remodel Work in Room 309	1997	1,464	98	15	98		407	25
26	Siderail 1/2 Deluxe	1997	958	64	15	64		266	26
27	Siderails	1997	556	37	15	37		151	27
28	Drywall-Nurse Station	1997	625	125	5	125		510	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,511,598	\$ 60,437		\$ 60,437	\$ 0	\$ 1,034,381	34

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

STATE OF ILLINOIS

Page 12D

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward								
2	Building continued		\$ 60,437			\$ 0	\$ 1,034,381		2
3	Rehab Wall Work	1997	414	83	5	83		338	3
4	Carpet	1997	1,396	279	5	279		1,138	4
5	Floorcovering & Labor-Apts	1997	1,832	366	5	366		1,496	5
6	Reroofing	1997	64,129	3,206	20	3,206		13,360	6
7	Building-Remodel Nurses Station	1998	18,510	740	25	740		2,962	7
8	Carpet-Remodel Nurses Station	1998	1,753	351	5	351		1,403	8
9	Wallcovering-Remodel Nurses Station	1998	1,794	359	5	359		1,436	9
10	Form & Pour Lamp Post Bases	1998	800	160	5	160		640	10
11	Floor Covering	1998	735	147	5	147		588	11
12	Apt Floor Covering	1998	573	115	5	115		458	12
13	Side Rails	1998	812	54	15	54		216	13
14	Kitchen Door	1998	1,242	83	15	83		310	14
15	Cabinetry & Installation	1998	3,799	190	20	190		712	15
16	Room 204 Work	1998	2,532	253	10	253		949	16
17	Vinyl Covering-Kick Plates	1998	1,367	137	10	137		513	17
18	Handrail & Installation	1998	699	47	15	47		175	18
19	Fire Alarm System Workr	1998	1,090	109	10	109		400	19
20	Bathroom Fixtures	1998	411	41	10	41		148	20
21	Root Flashing Installation	1998	753	75	10	75		270	21
22	Koroguard in Med Room and Bath	1998	1,008	101	10	101		361	22
23	Carpet	1998	554	111	5	111		397	23
24	Generator	1998	47,534	2,377	20	2,377		8,913	24
25	Boiler Tank	1998	3,803	380	10	380		1,331	25
26	Door Frame Guards	1998	593	40	15	40		138	26
27	Water Heater & Labor	1998	1,339	134	10	134		458	27
28	Floor Covering Ceiling Tile	1998	1,397	280	5	280		932	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,672,467	\$ 70,655		\$ 70,655	\$ 0	\$ 1,074,423	34

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,672,467	\$ 70,655		\$ 70,655	\$ 0	\$ 1,074,423	1
2	Building continued								2
3	Resident Room Work	1998	996	199	5	199		747	3
4	Ceiling Tile	1998	20,524	1,025	20	1,025		3,421	4
5	Project	1998	6,817	341	20	341		1,108	5
6	Bathroom Work	1998	2,120	212	10	212		689	6
7	Aluminum Entrance/Ambulance	1999	1,726	115	15	115		336	7
8	Air Conditioning	1998	24,278	1,624	15	1,624		4,926	8
9	HVAC Systems	1998	4,284	287	15	287		870	9
10	Roof Work	1999	2,800	280	10	280		723	10
11	House & Property	1999	86,726	2,168	40	2,168		4,878	11
12	Wood Sign	1999	327	33	10	33		79	12
13	HVAC	1999	2,350	234	10	234		607	13
14	Plumbing-Bathroom Remodel	1999	4,739	237	20	237		632	14
15	Building-Remodel Resident Room	1999	6,265	251	25	251		544	15
16	Drapes-Remodel Resident Room	1999	279	56	5	56		121	16
17	Electric-Remodel Resident Room	1999	197	10	20	10		21	17
18	Paint-Remodel Resident Room	1999	2,697	539	5	539		1,168	18
19	Thermostats for Apts	2000	1,412	94	15	94		165	19
20	Faucets	2000	1,159	58	20	58		92	20
21	Oak Cabinets for Kitchen	2000	1,603	107	15	107		187	21
22	Laundry Repair	2000	533	106	5	106		186	22
23	Building-Rental Prop Improvement	2000	19,696	787	25	787		1,247	23
24	Carpet-Rental Prop Improvement	2000	60	12	5	12		19	24
25	Generator Repair	2000	2,258	226	10	226		263	25
26	Water Softener	2000	541	54	10	54		59	26
27	Maintenance Garage	2001	79,709	4,428	15	4,428		4,428	27
28	Bldg-Redecorate 300 Wing Corridor	2001	8,062	161	25	161		161	28
29	Carpet-Redecorate 300 Corridor	2001	1,985	199	5	199		199	29
30	Fire Alarm Control Panel	2001	414	14	10	14		14	30
31	Work on Heat Units	2001	3,857	32	10	32		32	31
32	Depreciated Items erroneously included within Nursing		(209,904)	(8,193)		(8,193)			32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,750,977	\$ 76,351		\$ 76,351	\$ 0	\$ 1,102,345	34

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 1,750,977	\$ 76,351		\$ 76,351	\$ 0	\$ 1,102,345		1
2	Land Improvements								2
3		1971-1975	22,290		15		22,290		3
4		1978	4,541		15		4,541		4
5		1981	5,292	65	15	65	5,246		5
6		1985	6,089		15		6,089		6
7		1988	62,030	4,135	15	4,135	54,104		7
8		1990	3,857		10		3,857		8
9		1991	11,223	561	20	561	5,752		9
10		1992	16,042	769	varies	769	14,462		10
11		1995	15,860	1,057	varies	1,057	6,608		11
12	Bury Elect	1996	3,347	335	10	335	1,980		12
13	Site Improvements-Duplexes	1996	50,912	5,091	10	5,091	27,577		13
14	Gazebo	1997	2,850	143	20	143	665		14
15	Walk	1997	2,500	167	15	167	778		15
16	Entrance Area Landscaping	1997	2,450	245	10	245	1,082		16
17	Sprinkler System	1997	727	48	15	48	198		17
18	Parking Lot	1997	2,266	113	20	113	481		18
19	Courthouse Research For Prepari	1998	515	52	10	52	202		19
20	Patio	1998	1,314	131	10	131	449		20
21	Skylight & Flashing work	1998	1,607	161	10	161	549		21
22	Sidewalk	1999	475	48	10	48	123		22
23	Blocks/Retension Pond	2001	1,129	19	20	19	19		23
24	0101 - 50% Nrsg								24
25	Seal Coat Parking Lot	1987	790		12		790		25
26	Parking Lot Expansion	1999	13,797	690	20	690	1,495		26
27									27
28	Depreciated Items erroneously included within Nursing		(50,912)	(5,091)		(5,091)			28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,931,968	\$ 85,090		\$ 85,090	\$ 0	\$ 1,261,682		34

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 588,966	\$ 55,387	\$ 55,387	\$		\$ 347,293	71
72	Current Year Purchases	35,157	2,552	2,552			2,516	72
73	Fully Depreciated Assets	231,951					236,955	73
74	Apartment Costs	1,026						74
75	TOTALS	\$ 857,100	\$ 57,939	\$ 57,939	\$		\$ 586,764	75

D. Vehicle Depreciation (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	Truck		1994	\$ 3,000	\$	\$	\$	2	\$ 3,000	76
77	Rebuilding Truck		1996	3,596				4	3,595	77
78	19 passenger van	1998 Ford Eld	1998	46,636	7,773	7,773		6	29,148	78
79										79
80	TOTALS			\$ 53,232	\$ 7,773	\$ 7,773	\$		\$ 35,743	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)	\$ 2,868,300	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,802	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,884,189	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	Apt's & Duplex	\$	\$	\$	86
87	Land	134,693			87
88	Land Imp	25,260	1,050	21,709	88
89	Bldg	2,165,196	69,125	399,486	89
90	FFE	84,271	5,311	53,200	90
91	TOTALS	\$ 2,409,420	\$ 75,486	\$ 474,395	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 53,168	92
93			93
94			94
95		\$ 53,168	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.

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? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 2,599 Description: network computer equip lease, one time rentals
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>93.8</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>41.3</u></p>
--	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 1,000	\$ 2,500	\$	\$ 3,500
2	Books and Supplies	75	187		262
3	Classroom Wages (a)	2,782	8,494		11,276
4	Clinical Wages (b)	305	4,048		4,353
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	680	2,600		3,280
8	Nurse Aide Competency Tests		100		100
9	TOTALS	\$ 4,842	\$ 17,929	\$	\$ 22,771
10	SUM OF line 9, col. 1 and 2 (e)	\$ 22,771			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	18

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	\$	553	\$ 24,956	\$	553	\$ 24,956	1
2	Licensed Speech and Language Development Therapist	line 10a, col 3	hrs		83	4,560		83	4,560	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	line 10a, col 3	hrs		560	33,557		560	33,557	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	1,196	\$ 63,073	\$	1,196	\$ 63,073	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **GENESEO GOOD SAMARITAN VILLAGE** # **0004721** Report Period Beginning: **1/1/2001** Ending: **12/31/2001**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2001** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 8,582	\$	1
2	Cash-Patient Deposits	4,608		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance #12991-4)	527,312		3
4	Supply Inventory (priced at COST)	8,314		4
5	Short-Term Investments	1,853,867		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,777		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,411,460	\$	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	4,126,079		14
15	Leasehold Improvements, at Historical Cost	271,747		15
16	Equipment, at Historical Cost	997,461		16
17	Accumulated Depreciation (book methods)	(2,356,479)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	22,817		21
22	Other Long-Term Assets (specify):	711		22
23	Other(specify): CIP	53,168		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,276,197	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,687,657	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 42,479	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	215,227		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	167,983		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,074		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Apt security Dep&Entry Fees	22,026		36
37	Misc W/holdings/Group Ins	(3,352)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 466,437	\$	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	Refund/NonRefd Duplex Entry Fees	1,046,979		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,046,979	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,513,416	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,174,241	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,687,657	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,097,597	1
2	Restatements (describe):		2
3	35 Congregate Living	90,734	3
4	Unit 40 Apts	3,913	4
5	Unit 45 Duplexes	33,258	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,225,502	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,261)	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) Donor Rest Prop/Oper Gift - Cash	4,280	15
16	Other (describe) Intra-co N/A - CO	4,769	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,212)	17
	B. Transfers (Itemize):		
18	Cash Assessment	(48,057)	18
19	Rounding	8	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (48,049)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,174,241	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/2001

Ending: 12/31/2001

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,919,205	1
2	Discounts and Allowances for all Levels	(256,536)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,662,669	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	10,690	5
6	Therapy	190,528	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 201,218	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	753	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,023	14
15	Telephone, Television and Radio	150	15
16	Rental of Facility Space	13,546	16
17	Sale of Drugs	38,367	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,835	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 67,674	23
D. Non-Operating Revenue			
24	Contributions	9,635	24
25	Interest and Other Investment Income***	(608)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,027	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical & Nursing Supplies	17,457	28
28a	Schedule Attached	2,448	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,905	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,960,493	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	740,950	31
32	Health Care	1,354,508	32
33	General Administration	666,083	33
B. Capital Expense			
34	Ownership	170,850	34
C. Ancillary Expense			
35	Special Cost Centers	834	35
36	Provider Participation Fee	39,529	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,972,754	40
41	Income before Income Taxes (line 30 minus line 40)**	(12,261)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (12,261)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 **GENESEO GOOD SAMARITAN VILLAGE**

0004721

Report Period Beginning: **1/1/2001**

Ending:

12/31/2001

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,875	2,145	\$ 48,771	\$ 22.74	1
2	Assistant Director of Nursing	216	280	4,920	17.57	2
3	Registered Nurses	10,611	11,307	184,021	16.27	3
4	Licensed Practical Nurses	5,915	6,322	83,184	13.16	4
5	Nurse Aides & Orderlies	53,552	59,959	588,951	9.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	589	1,141	19,646	17.22	7
8	Rehab/Therapy Aides	3,818	4,254	49,764	11.70	8
9	Activity Director	1,827	2,162	25,267	11.69	9
10	Activity Assistants	3,715	4,108	30,693	7.47	10
11	Social Service Workers	2,245	2,516	34,805	13.83	11
12	Dietician					12
13	Food Service Supervisor	1,997	2,143	25,527	11.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,944	19,301	163,309	8.46	15
16	Dishwashers					16
17	Maintenance Workers	6,287	7,103	75,322	10.60	17
18	Housekeepers	9,030	9,967	88,455	8.87	18
19	Laundry	6,373	7,049	63,528	9.01	19
20	Administrator	1,807	1,879	43,233	23.01	20
21	Assistant Administrator					21
22	Other Administrative	261	280	5,010	17.89	22
23	Office Manager	1,922	2,112	25,146	11.91	23
24	Clerical	1,638	1,933	22,481	11.63	24
25	Vocational Instruction					25
26	Academic Instruction	2,016	2,134	29,804	13.97	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	2,832	3,091	43,725	14.15	31
32	Other Health C: Nrsgr Secretary	1,615	2,131	28,428	13.34	32
33	Other(specify) Mrkg/Res Dev	1,176	1,312	18,554	14.14	33
34	TOTAL (lines 1 - 33)	139,261	154,629	\$ 1,702,544 *	\$ 11.01	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	135	\$ 6,355	line 1, col 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant			line 10, col 3	40
41	Occupational Therapy Consultant	6	295	line 10, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			line 10, col 3	43
44	Activity Consultant	7	589	line 11, col 3	44
45	Social Service Consultant	13	944	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	161	\$ 8,183		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mike Olson	Administrator		\$ 43,233	Workers' Compensation Insurance	\$ 31,478	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,573	Advertising: Employee Recruitment	2,696	
				FICA Taxes	128,929	Health Care Worker Background Check (Indicate # of checks performed _____)		
vacation accrual			4,570	Employee Health Insurance	114,983	Publications - Admin	1,982	
				Employee Meals	3,023	Public Rel	5,920	
				Illinois Municipal Retirement Fund (IMRF)*		Dues - Reimb	2,261	
				Taxable Gifts - Admin	50	Publications - Nrsg	122	
				Staff Pension	29,096	Less: Dues - Reimb	(2,261)	
				Employee Physicals	547	Less: Public Relations Expense	(5,920)	
				Admin/Consultant Savings	1,801	Non-allowable advertising	(2,696)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 47,803			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,104	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Adm/Acctg Serv			\$ 116,639				Out-of-State Travel	\$ 457
							In-State Travel	1,088
							Seminar Expense	805
							Less: Res Dev Travel	(222)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 116,639				(agree to Sch. V, line 24, col. 8)	\$ 2,128
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount			\$		
64540 BDO Seidman	MDCR-CR Prep		700					
64541 Good Sam Society	MDCD-CR Prep		480					
64360 Berens & Tate	Prof Svc		10,221					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 11,401			\$		

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13	
													Improvement Type
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING	6/96	\$ 2,178	5	\$ 436	\$ 436	\$ 436	\$ 217	\$	\$	\$	\$	\$
2	WALLPAPER	12/96	1,679	5	336	336	336	335					
3	PAINTING	11/96	843	5	169	169	169	153					
4	WALLPAPER/PAINT	12/96	1,524	5	305	305	305	304					
5	WALLPAPER/PAINT	10/96	181	5	36	36	36	31					
6	PAINTING	8/96	425	5	85	85	85	57					
7	PAINTING	7/96	33	5	7	7	7	2					
8	PAINTING	6/96	239	5	48	48	48	23					
9	PAINTING	5/96	117	5	23	23	23	11					
10	PAINTING	4/96	38	5	8	8	8	1					
11	PAINTING	3/96	123	5	25	25	25	5					
12	PAINTING	2/96	22	5	4	4	4	3					
13	PAINTING PT ROOM	12/95	1,791	5	358	358	359	0					
14	PAINT & LABOR	1/97	1,539	5	308	308	308	308	25				
15	PAINT	3/97	23	5	4	4	4	4	4				
16	PAINT	4/97	37	5	7	7	7	7	4				
17	PAINT	5/97	45	5	9	9	9	9	4				
18													
19													
20	TOTALS		\$ 10,837		\$ 2,168	\$ 2,168	\$ 2,169	\$ 1,470	\$ 37	\$	\$	\$	\$

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? 0
If YES, give association name and amount. _____
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,380 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 of Public Aid during this cost report period. \$ 39,529
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? yes Indicate the amount. \$ 3,024
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 41%
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?
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: Henry Scholten & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

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

1	2 Improvement Type	3 Month & Year Improvement Was Made	4 Total Cost	5 Useful Life	6 Amount of Expense Amortized Per Year								
					7 FY1998	8 FY1999	9 FY2000	10 FY2001	11 FY2002	12 FY2003	13 FY2004	14 FY2005	15 FY2006
1	PAINTING	1/98	283	5	\$ 57	\$ 57	\$ 57	\$ 57	\$ 55	\$	\$	\$	\$
2	WALLPAPER	3/98	362	5	54	72	72	72	72	20			
3	PAINTING	4/98	343	5	45	69	69	69	69	22			
4	WALLPAPER/PAINT	5/98	723	5	83	145	145	145	145	60			
5	WALLPAPER/PAINT	6/98	38	5	4	8	8	8	8	2			
6	PAINTING	7/98	65	5	7	13	13	13	13	6			
7	PAINTING	8/98	361	5	30	72	72	72	72	43			
8	PAINTING	10/98	75	5	4	15	15	15	15	11			
9	PAINTING	12/98	864	5	14	173	173	173	173	158			
10	PAINTING	2/99	1,800	5		300	360	360	360	360	60		
11	PAINTING	3/99	4,032	5		605	806	806	806	806	203		
12	PAINTING	4/99	97	5		13	19	19	19	19	8		
13	PAINTING PT ROOM	7/99	44	5		4	9	9	9	9	4		
14	PAINT & LABOR	8/99	10	5		1	2	2	2	2	1		
15	PAINT	9/99	130	5		6	26	26	26	26	20		
16	PAINT	11/99	34	5		1	7	7	7	7	5		
17													
18													
19													
20	TOTALS		\$ 9,261		\$ 298	\$ 1,554	\$ 1,853	\$ 1,853	\$ 1,851	\$ 1,551	\$ 301	\$	\$

