

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721 Report Period Beginning: 1/1/06 Ending: 123106

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
		8	SNF	8,077	16,271	
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,077	16,271	978	25,326	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.37%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy.

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 _____ and days of care provided _____

Medicare Intermediary NORIDIAN

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/06 Ending: 123106**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 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	171,353	19,975	5,736	197,064		197,064	(175)	196,889		1
2	Food Purchase		152,535		152,535		152,535	(2,061)	150,474		2
3	Housekeeping	92,793	17,712		110,505		110,505	(239)	110,266		3
4	Laundry	70,020	15,424		85,444		85,444	(303)	85,141		4
5	Heat and Other Utilities			96,115	96,115		96,115		96,115		5
6	Maintenance	85,946	6,132	75,160	167,238		167,238	(124)	167,114		6
7	Other (specify):*			6,947	6,947		6,947	(335)	6,612		7
8	TOTAL General Services	420,112	211,778	183,958	815,848		815,848	(3,237)	812,611		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,237,117	113,441	5,332	1,355,890		1,355,890	(38,006)	1,317,884		10
10a	Therapy	4,216	256	174,249	178,721		178,721	(114,632)	64,089		10a
11	Activities	65,705	7,236	4,199	77,140		77,140	(1,012)	76,128		11
12	Social Services	28,762	141	996	29,899		29,899	(1)	29,898		12
13	CNA Training										13
14	Program Transportation			6,490	6,490		6,490		6,490		14
15	Other (specify):*	34,517			34,517		34,517		34,517		15
16	TOTAL Health Care and Programs	1,370,317	121,074	191,266	1,682,657		1,682,657	(153,651)	1,529,006		16
	C. General Administration										
17	Administrative	38,487		139,842	178,329		178,329	9,455	187,784		17
18	Directors Fees										18
19	Professional Services			4,083	4,083		4,083	(2,321)	1,762		19
20	Dues, Fees, Subscriptions & Promotions			31,635	31,635		31,635	(24,957)	6,678		20
21	Clerical & General Office Expenses	73,388	17,223	38,008	128,619		128,619	(1,070)	127,549		21
22	Employee Benefits & Payroll Taxes			407,181	407,181		407,181	(15,044)	392,137		22
23	Inservice Training & Education			21,981	21,981		21,981	(1,593)	20,388		23
24	Travel and Seminar			4,243	4,243		4,243	(3,796)	447		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			31,917	31,917		31,917	(7,648)	24,269		26
27	Other (specify):*	12,158		13,541	25,699		25,699	(25,699)			27
28	TOTAL General Administration	124,033	17,223	692,431	833,687		833,687	(72,673)	761,014		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,914,462	350,075	1,067,655	3,332,192		3,332,192	(229,561)	3,102,631		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.

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			200,526	200,526		200,526	(21,615)	178,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,159	9,159		9,159		9,159			32
33	Real Estate Taxes							(9,159)	(9,159)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,063	3,063		3,063		3,063			35
36	Other (specify):*											36
37	TOTAL Ownership			212,748	212,748		212,748	(30,774)	181,974			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			39,285	39,285		39,285		39,285			42
43	Other (specify):*			2,601	2,601		2,601	(3,063)	(462)			43
44	TOTAL Special Cost Centers			41,886	41,886		41,886	(3,063)	38,823			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,914,462	350,075	1,322,289	3,586,826		3,586,826	(263,398)	3,323,428			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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	(2,061)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,203	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	(24,957)	20		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	(226,262)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (251,077)		\$	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	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)	(12,321)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,321)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (263,398)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					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

Page 5A

ID# 0004721

Report Period Beginning: 1/1/06

Ending: 123106

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	UNIFORM	\$ (5,947)	10	1
2	ADMINISTRATION	(189)	21	2
3	OPERATION/MAINTENANCE	(60)	6	3
4	POSTAGE	(57)	21	4
5	RESIDENTS SUPPLIES	(335)	7	5
6	ACTIVITY	(173)	11	6
7	INT INC PAST DUE ACCTS	0	21	7
8	DEPR EXP APTS AND DUPLEXES	(21,615)	30	8
9	REAL ESTATE TAXES	(9,159)	33	9
10	PRESCR DRUGS-REIMB	(28,248)	10	10
11	SALARIES RES DEV	(6,025)	27	11
12	BANK CHARGES	(66)	21	12
13	VACATION ACCUAL RES DEV	(108)	27	13
14	FICA- RES DEV	(462)	22	14
15	STAFF PENSION RES DEV	(196)	22	15
16	SUPPLIES RES DEV	(2,735)	21	16
17	TRAVEL REIMB RES DEV	(222)	24	17
18	STAFF DEVELOPMENT RES DEV	(1,593)	23	18
19	MIS FUNDRAISER EXP	(13,541)	27	19
20	SALARIES MARKETING	(6,025)	27	20
21	FICA-MARKETING	(462)	43	21
22	Supplies Marketing	(56)	21	22
23	TRAVEL OUT OF STATE	(3,574)	24	23
24	P/SERV LABORTORY-MDCR	(1,974)	43	24
25	THERAPY OFFSET PT OT ST	(114,625)	10A	25
26	P/SERV CLINIC	(627)	43	26
27	MED SUPPLIES PART B	(2,626)	10	27
28	DISCOUNT ALLOW-ADMIN	(170)	21	28
29	DISCOUNT ALLOW-NURSING	(1,120)	10	29
30	DISCOUNT ALLOW-THERAPY PT	(6)	10A	30
31	DISCOUNT ALLOW-THERAPY OT	-1	10A	31
32	DISCOUNT ALLOW-ACTIVITIES	-123	11	32
33	DISCOUNT ALLOW-SOCIAL SERVICES	-1	12	33
34	DISCOUNT ALLOW-LAUNDRY	-303	4	34
35	DISCOUNT ALLOW-HOUSEKEEPING	-239	3	35
36	DISCOUNT ALLOW-DIETARY	-175	1	36
37	DISCOUNT ALLOW-OPERATIONS/MAINT.	-64	6	37
38	O/P Med Supply	-62	10	38
39	O/P Nrsng Supply	-3	10	39
40	Cable TV	-716	11	40
41	Taxable Gifts- Res Dev	-40	22	41
42	Unemployment charges PD Marketing	-11	22	42
43	unemployment charges RES Dev	-11	22	43
44	Staff Pension - Marketing	-196	22	44
45	Legal Fees	-2321	19	45
46				46
47				47
48				48
49	Total	(226,262)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721

Report Period Beginning:

1/1/06

Ending:

123106

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	(175)	0	0	0	0	0	0	0	0	0	0	(175)	1
2	Food Purchase	(2,061)	0	0	0	0	0	0	0	0	0	0	(2,061)	2
3	Housekeeping	(239)	0	0	0	0	0	0	0	0	0	0	(239)	3
4	Laundry	(303)	0	0	0	0	0	0	0	0	0	0	(303)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(124)	0	0	0	0	0	0	0	0	0	0	(124)	6
7	Other (specify):*	(335)	0	0	0	0	0	0	0	0	0	0	(335)	7
8	TOTAL General Services	(3,237)	0	0	0	0	0	0	0	0	0	0	(3,237)	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	(38,006)	0	0	0	0	0	0	0	0	0	0	(38,006)	10
10a	Therapy	(114,632)	0	0	0	0	0	0	0	0	0	0	(114,632)	10a
11	Activities	(1,012)	0	0	0	0	0	0	0	0	0	0	(1,012)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(153,651)	0	0	0	0	0	0	0	0	0	0	(153,651)	16
C. General Administration														
17	Administrative	0	9,455	0	0	0	0	0	0	0	0	0	9,455	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,321)	0	0	0	0	0	0	0	0	0	0	(2,321)	19
20	Fees, Subscriptions & Promotions	(24,957)	0	0	0	0	0	0	0	0	0	0	(24,957)	20
21	Clerical & General Office Expenses	(1,070)	0	0	0	0	0	0	0	0	0	0	(1,070)	21
22	Employee Benefits & Payroll Taxes	(916)	(14,128)	0	0	0	0	0	0	0	0	0	(15,044)	22
23	Inservice Training & Education	(1,593)	0	0	0	0	0	0	0	0	0	0	(1,593)	23
24	Travel and Seminar	(3,796)	0	0	0	0	0	0	0	0	0	0	(3,796)	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	(7,648)	0	0	0	0	0	0	0	0	0	(7,648)	26
27	Other (specify):*	(25,699)	0	0	0	0	0	0	0	0	0	0	(25,699)	27
28	TOTAL General Administration	(60,352)	(12,321)	0	(72,673)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,240)	(12,321)	0	(229,561)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/06 Ending: 123106

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	(21,615)	0	0	0	0	0	0	0	0	0	0	(21,615) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	(9,159)	0	0	0	0	0	0	0	0	0	0	(9,159) 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	(30,774)	0	0	0	0	0	0	0	0	0	0	(30,774) 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):*	(3,063)	0	0	0	0	0	0	0	0	0	0	(3,063) 43
44	TOTAL Special Cost Centers	(3,063)	0	0	0	0	0	0	0	0	0	0	(3,063) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(251,077)	(12,321)	0	(263,398) 45								

Facility Name & ID Number **GENESEO GOOD SAMARITAN VILLAGE**

0004721

Report Period Beginning:

1/1/06

Ending:

123106

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

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	\$ 139,842	Evangelical Lutheran Good Samaritan Society	100.00%	\$ 149,297	\$ 9,455	1
2	V	22 Workers Comp	74,063			59,658	(14,405)	2
3	V	22 Unemploy Charges paid	(758)				758	3
4	V	26 Insurance	31,917			24,269	(7,648)	4
5	V	22 Group Health Ins	150,490			150,009	(481)	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		\$ 395,554			\$ 383,233	\$ * (12,321)	14

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAG] # 0004721 Report Period Beginning: 1/1/06 Ending: 123106

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/06 Ending: 123106

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/06 Ending: 123106

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
						Original	Balance				
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									
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											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 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 2006 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:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GENESEO GOOD SAMARITAN VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0004721

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior 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 ground (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	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

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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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1971	1971	\$ 494,740	\$ 12,368	40	\$ 12,368		\$ 442,174
5									
6									
7									
8									
Improvement Type**									
9									
10			1977	1,100		varies			1,100
11			1978	7,629		20			7,629
12			1981	168,876	5,451	varies	5,451		144,344
13			1982	2,299		varies			2,299
14			1986	2,926	15	varies	15		2,926
15			1987	15,313	520	varies	520		15,053
16			1988	123,266	5,248	varies	5,248		114,758
17			1989	26,987	168	varies	168		26,538
18			1990	108,417	5,100	varies	5,100		88,290
19			1991	3,157	31	varies	31		3,157
20			1992	36,754	145	varies	145		32,760
21			1993	37,071	648	varies	648		35,427
22			1994	69,097	2,971	varies	2,971		54,449
23			1995	76,363	4,460	varies	4,460		53,722
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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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	CERAMIC FLOORING/BATHROOM QA-M	1996	\$ 107	\$ 5	20	\$ 5	\$	\$ 59	37
38	LAUNDRY WALL PROTECTION	1996	1,109					1,109	38
39	ACTIVITY ROOM REMODEL/SINK	1996	2,132					2,132	39
40	LAUNDRY DOORS Q/A	1996	1,874	125	15	125		1,353	40
41	BATHROOM SINK	1996	678	34	20	34		370	41
42	AWNING FOR REHAB CLINIC	1996	983	25	10	25		983	42
43	REMLITE IN CLOSETS	1996	653	22	10	22		653	43
44	POWER ACCESS DOOR OPERATOR	1996	1,009	34	10	34		1,009	44
45	GENERATOR/MOVE TO GSS	1996	3,431	114	10	114		3,431	45
46	CARPET FOR PARLOR	1996	2,627		5			2,499	46
47	A/C ROOM TOP ON 200 WING	1996	229	15	15	15		161	47
48	ELECTRIC REMODEL PARLOR	1996	186	9	20	9		98	48
49	BUILDING REMODEL PARLOR	1996	1,132	57	20	57		594	49
50	PLUMING REMODEL PARLOR	1996	599	30	20	30		615	50
51	WALLPAPER REMODEL PARLOR	1996	2,645		5			2,517	51
52	SHOWER REMODEL GRAB BARS	1996	1,321	99	10	99		1,321	52
53	REPLACE FIXTURES FLOOR WALL	1996	3,955	198	20	198		2,011	53
54	WINDOWS	1996	25,212	1,681	15	1,681		17,088	54
55	BUILDING REMODEL	1996	1,692	85	20	85		881	55
56	WINDOW FOR DINING ROOM	1997	1,650	110	15	110		1,091	56
57	300 WING CEILING TILE WORK	1997	2,584		5			2,584	57
58	WALL BULT IN LAUDRY ROOM	1997	1,013	101	10	101		1,005	58
59	WINDOWS	1997	5,100	340	15	340		3,372	59
60	WALLPAPER FOR JACK ANDREWS	1997	2,221		5			2,221	60
61	CARPET FOR CONFERENCE ROOM	1997	2,192		5			2,192	61
62	CONFERENCE ROOM WORK	1997	1,350	135	10	135		1,338	62
63	WALL PROJECT	1997	739		5			739	63
64	NEW SPRINKLERS FOR OFFICE	1997	909	91	10	91		879	64
65	WALLPAPER RESIDENTS ROOM 308	1997	2,667		5			2,667	65
66	CARPET FOR RESIDENTS ROOM	1997	506		5			506	66
67	ROOF FONT ENTRY	1997	21,178	1,059	20	1,059		10,501	67
68	SOCIAL SERVICE AND CONFERENCE ROOM	1997	1,392	93	15	93		882	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,269,070	\$ 41,587		\$ 41,587	\$	\$ 1,093,487	70

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

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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	\$ 1,269,070	\$ 41,587		\$ 41,587	\$	\$ 1,093,487		1
2	DON & STAFF DEVELOPMENT OFFICE	1997 1,236	82	15	82		783		2
3	WALLPAPER ROOM 308	1997 1,440		5			1,440		3
4	DRAIN/SEWER WORK	1997 389	26	15	26		244		4
5	REMODEL WORK IN ROOM 309	1997 1,464	98	15	98		895		5
6	SIDERAIL 1/2 DELUXE	1997 958	64	15	64		585		6
7	SIDERAILS	1997 556	37	15	37		337		7
8	DRYWLL-NURSE STATION	1997 625		5			625		8
9	REHAB WALL WORK	1997 414		5			414		9
10	REROOF	1997 64,129	3,206	20	3,206		29,392		10
11	BUILDING REMODEL NURSES STATION	1998 18,510	740	25	740		6,664		11
12	CARPET REMODEL NURSES STATION	1998 1,753		5			1,753		12
13	WALLCOVERING REMODEL NURSES STATION	1998 1,794		5			1,794		13
14	FORM &POUR LAMP POST BASES	1998 800		5			800		14
15	SIDE RAILS	1998 812	54	15	54		487		15
16	KITCHEN DOOR	1998 1,242	83	15	83		724		16
17	CABINERY & INSTALLATION	1998 3,799	190	20	190		1,662		17
18	ROOM 204 WORK	1998 2,532	253	10	253		2,215		18
19	VINYL COVERING KICK PLATES	1998 1,367	137	10	137		1,197		19
20	HANDRAIL & INSTALLATION	1998 700	47	15	47		408		20
21	FIRE ALARM SYSTEM WORK	1998 1,090	109	10	109		945		21
22	BATHROOM FIXTURES	1998 412	41	10	41		353		22
23	ROOF FLASHING INSTALLATION	1998 753	75	10	75		646		23
24	KOROGUARD IN MED ROOM AND BATH	1998 1,008	101	10	101		865		24
25	GENERATOR	1998 47,534	2,377	20	2,377		20,796		25
26	DOOR FRAM GUARDS	1998 593	40	15	40		336		26
27	WATER HEATER	1998 1,339	134	10	134		1,127		27
28	FLOORCOVERING CEILING TILE	1998 1,398		5			1,398		28
29	RESIDENT ROOM WORK	1998 996		5			996		29
30	CEILING TILE	1998 20,525	1,026	20	1,026		8,552		30
31	2000 PROJECT	1998 6,817	341	20	341		2,812		31
32	BATHROOM WORK	1998 2,121	212	10	212		1,749		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,458,176	\$ 51,060		\$ 51,060	\$	\$ 1,186,481		34

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

STATE OF ILLINOIS

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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	\$ 1,458,176	\$ 51,060		\$ 51,060		\$ 1,186,481		1
2	AIR CONDITIONING	1998 24,279	1,624	15	1,624		13,047		2
3	HVAC SYSTEMS	1998 4,284	287	15	287		2,302		3
4	ALUMINUM ENTERANCE/AMBULANCE	1999 1,726	115	15	115		911		4
5	ROOF WORK	1999 2,800	280	10	280		2,123		5
6	WOOD SIGN	1999 327	33	10	33		243		6
7	HVAC SYSTEMS	1999 2,350	235	10	235		1,782		7
8	PLUMBING BATHROOM REMODEL	1999 4,739	237	20	237		1,816		8
9	BUILDING REMODEL RESIDENT ROOM	1999 6,265	251	25	251		1,797		9
10	DRAPES REMODEL RESIDENTS ROOM	1999 279		5			279		10
11	ELECTRIC REMODEL RESIDENT ROOM	1999 197	10	20	10		71		11
12	PAINT REMODEL RESIDENT ROOM	1999 2,697		2			2,697		12
13	FAUCETS	2000 1,159	58	20	58		382		13
14	OAK CABINETS FOR KITCHEN	2000 1,603	107	15	107		721		14
15	LAUNDRY REPAIR	2000 533	27	5	27		533		15
16	WATER SOFTENER	2000 541	54	10	54		329		16
17	GENERATOR REPAIR	2000 2,258	226	10	226		1,392		17
18	BLDG REDECORATE 300 WING CORR	2001 8,062	322	25	322		1,774		18
19	CARPET REDECORATE 300 WING	2001 1,986	199	5	199		1,986		19
20	FIRE ALARM CONTROL PANEL	2001 414	41	10	41		221		20
21	MAINTENANCE GARAGE	2001 79,709	5,314	15	5,314		30,998		21
22	WORK ON HEAT UNITS	2001 3,856	386	10	386		1,961		22
23	FURNACE	2001 508	51	10	51		254		23
24	LAMINATE CABINETS ACT. ROOM	2002 2,779	185	15	185		896		24
25	PHONE CABLE WIRING TO ROOMS	2002 700	70	10	70		327		25
26	AIR CONDITIONERS BUILDING A	2002 6,175	617	10	617		2,984		26
27	BUILDING REMODEL RESIDENT ROOMS	2002 32,873	1,315	25	1,315		6,136		27
28	CAULKING REMODEL RESIDENTS ROOMS	2002 193	19	10	19		90		28
29	CERAMIC TILE REMDL RESIDENT RM	2002 181	9	20	9		42		29
30	CORNER GUARD REMDL RESIDENT RM	2002 90	9	10	9		42		30
31	DRAPES REMDL RES RM	2002 1,152	230	5	230		1,075		31
32	DRAPERY RODS REMDL RES RM	2002 174	17	10	17		81		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,653,065	\$ 63,388		\$ 63,388		\$ 1,265,773		34

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

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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	\$ 1,653,065	\$ 63,388		\$ 63,388		\$ 1,265,773		1
2	WALLPAPER REMDL RES RM	2002 1,809	362	5	362		1,689		2
3	BLINDS REMDL RESIDENT RM	2002 533	107	5	107		498		3
4	CARPET THERAPY	2002 622	124	5	124		518		4
5	BUILDING REDECORATE 100/200	2002 11,912	476	35	476		2,065		5
6	CARPET REDECORATE 100/200	2002 5,069	1,014	5	1,014		4,393		6
7	CORNER GUARDS REDECO 100/200	2002 170	17	10	17		74		7
8	DOORS REDECORATE 100/200	2002 199	13	15	13		57		8
9	WALLPAPER REDECORATE 100/200	2002 1,905	381	5	381		1,651		9
10	SOLID CORE DOOR/SNF	2003 1,656	110	15	110		423		10
11	LIGHT FIXTURES	2003 6,755	676	10	676		2,252		11
12	BLDG REMODEL	2003 5,173	207	25	207		707		12
13	WINDOWS	2003 2,494	166	15	166		526		13
14	DUAL SENSOR SMOKE ALARM	2003 1,276	128	10	128		393		14
15	TILE FOR DIETRY OFFICE	2004 775	78	10	78		220		15
16	REPAIR DINING ROOM ROOF	2004 3,253	325	10	325		867		16
17	BLINDS RESIDENT ROOM REMODEL	2004 1,257	252	5	252		524		17
18	BUILDING RESIDENT ROOM REMODEL	2004 23,806	952	25	952		1,984		18
19	DRAPES RESIDENT TOOM REMODEL	2004 66	13	5	13		28		19
20	ELECTRIC RESIDENT ROOM REMODEL	2004 1,109	55	20	55		116		20
21	WALL PAPER RESIDENT ROM RMDL	2004 88	18	5	18		37		21
22	CERAMIC FLOOR FOR KITCHEN	2004 1,280	53	20	53		117		22
23	FIRE SPRINKER SYSTEM	2004 111,341	4,454	25	4,454		7,794		23
24	BOILER REPLACEMENT	2005 107,947	5,397	20	5,397		10,795		24
25	CEILING TILE	2005 7,373	369	20	369		646		25
26	REKEY BUILDING	2005 5,753	575	10	575		863		26
27	REKEY CAMPUS	2005 6,484	648	10	648		702		27
28	FIRE PROTECTION SYSTEM UPGRADE	2005 20,284	2,028	10	2,028		2,366		28
29	ROOF WORK	2006 1,016	51	10	51		51		29
30	CANOPY & PRKING LOT PLANS	2006 4,100	85	20	85		85		30
31	STEEL DOORS	2006 769	30	15	30		30		31
32	BLDG RMDL 100/200 WING TUB RM	2006 5,358	71	25	71		71		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,994,697	\$ 82,623		\$ 82,623		\$ 1,308,315		34

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

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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	\$ 1,994,697	\$ 82,623		\$ 82,623		\$ 1,308,315		1
2	TILE RMDL 100/200 WING TUB ROOM	2006 2,975	50	25	50		50		2
3	DRAPE RMDL 100/200 WING TUB RM	2006 343	23	5	23		23		3
4	NSG COUNTR-100/200 WING TUB RM	2006 21	1	15	1		1		4
5	PAINT RMDL 100/200 WING TUB RM	2006 25	2	5	2		2		5
6	PLUMB RMDL 100/200 WING TUB RM	2006 1,291	22	20	22		22		6
7	VINYL RMDL 100/200 WING TUB RM	2006 663	22	10	22		22		7
8	WALL PAPER 100/200 WING TUB RM	2006 900	60	5	60		60		8
9	FLOOR KIT & DOOR	2006 420	26	15	26		26		9
10	BULDING RESIDENT ROOM REMDL	2006 16,225	649	25	649		649		10
11	VINYL FLR RESIDENT TOOM REMDL	2006 1,076	108	10	108		108		11
12	LIFE SAFETY CODE UPGRADES	2005 22,517	901	25	901		1,426		12
13	CEILING TILES, KTAG COMPLIANCE	2006 461	19	20	19		19		13
14	DOORS FOR RES ROOMS	2006 606	31	15	31		31		14
15	VENTILATION IMPROVEMENTS	2006 404,885	17,995	15	17,995		17,995		15
16	LINEN CLOSESTS	2006 5,277	176	20	176		176		16
17	DRAPES	2006 493	57	5	57		57		17
18	CABINETS	2006 611	15	20	15		15		18
19									19
20									20
21									21
22									22
23									23
24	LIFE SAFETY CODE UPGRADES - PR YR DEPR		525		525				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)	\$ 2,453,486	\$ 103,305		\$ 103,305		\$ 1,328,997		34

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

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Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/06

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123106

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	\$ 2,453,486	\$ 103,305		\$ 103,305	\$ (0)	\$ 1,328,997		1
2	LAND IMPROVEMENTS								2
3	DRIVES-GRADING-WALKS	1971	9,171		15		9,171		3
4	BLACKTOP	1973	5,865		15		5,865		4
5	PAVING	1974	3,499		15		3,499		5
6	IMPROVE WEST SIDE OF PARKING	1975	1,018		15		1,018		6
7	DIRT EE SNODGRASS	1975	83		15		83		7
8	RESURFACE PARKING LOT	1978	3,817		15		3,817		8
9	SIDEWALK AROUND CENTER DRAIN	1981	3,842		20		3,796		9
10	SOD AROUND BLDG	1981	1,450		10		1,450		10
11	PAVING ASPHALT	1985	6,089		15		6,089		11
12	SEED	1990	803		10		803		12
13	DEMOLITION OF HOSES	1990	2,985		10		2,985		13
14	LANDSCAPE	1990	69		10		69		14
15	GAZEBO	1991	11,223	561	20	561	8,557		15
16	ISABEL BLOOM FOR MEMORIAL	1992	300	20	15	20	290		16
17	ILLUMINATED SIGN BOX AND COVE	1992	5,288		12		5,288		17
18	TO LAY BRICKS FOR NEW SIGN	1992	383		12		383		18
19	LANDSCAPE MATERIAL	1992	2,764		10		2,764		19
20	GAZEBO	1995	9,618	641	15	641	7,213		20
21	FENCE	1995	6,242	416	15	416	4,681		21
22	BURY ELECTRIC LINE	1996	3,347	28	10	28	3,347		22
23	GAZEBO	1997	2,850	143	20	143	1,378		23
24	WALK	1997	2,500	167	15	167	1,611		24
25	ENTRANCE AREA LANDSCAPING	1997	2,450	245	10	245	2,307		25
26	SPRINKLER SYSTEM	1997	726	48	15	48	440		26
27	PARKING LOT	1997	2,266	113	20	113	1,048		27
28	COURTHOUSE RESEARCH FOR PREP	1998	515	52	10	52	459		28
29	PATIO	1998	1,313	131	10	131	1,106		29
30	SKYLIGHT & FLASHING WORK	1998	1,607	161	10	161	1,353		30
31	PARKING OT CHESTNUT STREET	1988	62,030		15		62,030		31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,607,599	\$ 106,031		\$ 106,031	\$ (0)	\$ 1,471,897		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:

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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 12F, Carried Forward		\$ 2,607,599	\$ 106,031		\$ 106,031	\$ (0)	\$ 1,471,897	1
2	PARKING LOT EXPANSION	1999	13,797	690	20	690		4,944	2
3	SIDEWALK	1999	475	48	10	48		360	3
4	BLOCKS RETENTION POND	2001	1,128	56	20	56		301	4
5	FENCING ARROUNDS SCREEN	2002	1,520	152	10	152		671	5
6	PARKING LOT LAMP POST	2003	508	51	10	51		199	6
7	STRIPPING PARKING LOT	2004	839	168	5	168		378	7
8	REHAB SHED	2005	2,948	295	10	295		516	8
9	SLAB FOR SHED	2005	1,723	115	15	115		153	9
10	BENCH FOR MEMORIAL GARDEN	2005	321	32	10	32		40	10
11	BRICKS FOR MEMORIAL GARDEN	2005	350	17	20	17		23	11
12	CADD FOR PARKING LOT AND CANOPY	2006	4,125	52	20	52		52	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)		\$ 2,635,333	\$ 107,707		\$ 107,707	\$ (0)	\$ 1,479,534	34

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

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	\$ 579,226	\$ 56,028	\$ 56,028	\$		\$ 336,799	71
72	Current Year Purchases	72,845	4,161	4,161			4,275	72
73	Fully Depreciated Assets	399,514	3,388	3,388			399,514	73
74								74
75	TOTALS	\$ 1,051,585	\$ 63,577	\$ 63,577	\$		\$ 740,588	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	RESIDENT CARE	19 PASSANGER VAN	1998	\$ 46,953	\$	\$	\$	4	\$ 46,953	76
77		WCHAIR BELTS/2004 DODGE J	2003	21,602	3,667	3,667		5	11,083	77
78		SNOW PLOW/2000 MINI VAN	2003	17,059	3,123	3,123		7	8,538	78
79		TAILGATE FOR TRUCK	2006	550	31	31		1	31	79
80	TOTALS			\$ 86,164	\$ 6,821	\$ 6,821	\$		\$ 66,605	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,799,082 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,105 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,105 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)	\$ 2,286,727 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	2,978,137	96,501	862,304	87
88	LAND IMP	82,847	3,687	38,906	88
89	FFE	99,715	3,947	73,101	89
90	NON-CARE ASSETS ALLOC TO 01	530,617	21,615	140,931	90
91	TOTALS	\$ 3,826,009	\$ 125,750	\$ 1,115,242	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 19,953	92
93			93
94			94
95		\$ 19,953	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? _____

If NO, see instructions. YES NO

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

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

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

	Fiscal Year Ending	Annual Rent
12.	_____/2007	\$ _____
13.	_____/2008	\$ _____
14.	_____/2009	\$ _____

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: \$ _____ Description: _____
(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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											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			\$		\$		\$		\$			\$	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.

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Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

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Report Period Beginning: 1/1/06

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123106

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 123106

(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	\$ 167,032	\$	1
2	Cash-Patient Deposits	5,854		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	507,265		3
4	Supply Inventory (priced at)	5,027		4
5	Short-Term Investments	1,812,195		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(28,501)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,468,872	\$	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	5,911,329		14
15	Leasehold Improvements, at Historical Cost	315,605		15
16	Equipment, at Historical Cost	1,237,464		16
17	Accumulated Depreciation (book methods)	(3,401,963)		17
18	Deferred Charges	61,072		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):			22
23	Other(specify): <u>Asset Mgmt, CIP</u>	19,861		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,304,061	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,772,933	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 65,168	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,931		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,009		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,575		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,383		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Group insurance garnishemnts</u>	16		36
37	<u>Security deposit, Priority payment</u>	27,894		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 425,976	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Rfd-Dplx Ent Fee</u>	1,740,333		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,740,333	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,166,309	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,606,624	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,772,933	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,397,384	1
2	Restatements (describe):		2
3	Senior Living	24,303	3
4	Apartments	8,025	4
5	Duplex	76,462	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,506,174	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	176,523	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)	\$ 176,523	17
	B. Transfers (Itemize):		
18	Intra co N/A - NC	(27)	18
19	Cash Asset Assessment	(73,401)	19
20	Dnr Rst prop/Oper Gft -Cash	7,227	20
21	Dnr Rst oper Gft Grant Cash	(9,875)	21
22	rounding	3	22
23	TOTAL Transfers (sum of lines 18-22)	\$ (76,073)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,606,624	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number **GENESEO GOOD SAMARITAN VILLAGE**

0004721

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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	\$ 3,752,529	1
2	Discounts and Allowances for all Levels	(636,026)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,116,503	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	18,942	5
6	Therapy	422,325	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 441,267	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	1,807	13
14	Non-Patient Meals	2,061	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	28,090	16
17	Sale of Drugs	72,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	822	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,463	23
D. Non-Operating Revenue			
24	Contributions	25,507	24
25	Interest and Other Investment Income***	84,528	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 110,035	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NSG & MED SUPPLIES	27,239	28
28a	SCEDULE ATTACHED and rounding	(37,156)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (9,917)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,763,351	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	815,848	31
32	Health Care	1,682,598	32
33	General Administration	833,748	33
B. Capital Expense			
34	Ownership	212,748	34
C. Ancillary Expense			
35	Special Cost Centers	39,285	35
36	Provider Participation Fee	2,601	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,586,828	40
41	Income before Income Taxes (line 30 minus line 40)**	176,523	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 176,523	43

* 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 GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

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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	1,927	2,153	\$ 56,202	\$ 26.10	1
2	Assistant Director of Nursing	187	187	4,217	22.55	2
3	Registered Nurses	7,924	8,637	180,559	20.91	3
4	Licensed Practical Nurses	7,721	8,308	140,729	16.94	4
5	CNAs & Orderlies	59,877	65,710	739,276	11.25	5
6	CNA Trainees	620	652	6,124	9.39	6
7	Licensed Therapist	187	187	4,216	22.55	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,681	2,143	29,113	13.59	9
10	Activity Assistants	4,006	4,443	36,295	8.17	10
11	Social Service Workers	1,706	1,957	30,296	15.48	11
12	Dietician					12
13	Food Service Supervisor	2,070	2,232	33,440	14.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,151	16,669	137,105	8.23	15
16	Dishwashers					16
17	Maintenance Workers	6,173	6,857	84,882	12.38	17
18	Housekeepers	8,269	9,492	93,412	9.84	18
19	Laundry	5,795	6,519	70,222	10.77	19
20	Administrator	1,177	1,331	38,271	28.75	20
21	Assistant Administrator					21
22	Other Administrative	5,956	6,491	87,939	13.55	22
23	Office Manager	1,206	1,358	19,360	14.26	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	1,789	1,948	26,253	13.48	31
32	Other Health Care(specify)	4,713	5,233	73,560	14.06	32
33	Other(specify) MRKT/RD	752	828	12,050	14.55	33
34	TOTAL (lines 1 - 33)	138,887	153,335	\$ 1,903,521 *	\$ 12.41	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	100	\$ 5,735	Ln 1, Col 3	35
36	Medical Director		1,200	Ln10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,593	Ln10, Col 3	39
40	Physical Therapy Consultant		78,754	Ln 10 Col 3	40
41	Occupational Therapy Consultant		62,199	Ln 10 Col 3	41
42	Respiratory Therapy Consultant		33,295	Ln 10 Col 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	995	Ln 11, Col 3	44
45	Social Service Consultant	18	995	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	136	\$ 185,766		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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 \$4443
- (3) Did the nursing home make political contributions or payments to a political 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? _____
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,622 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. \$ 39,285
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 benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,061
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
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. \$ Yes
c. What percent of all travel expense relates to transportation of nurses and patients? 25%
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?
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.