

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0004721

Facility Name: GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

Address: 704 SOUTH ILLINOIS STREET GENESE0 61254
 Number City Zip Code

County: HENRY

Telephone Number: 309-994-6424 **Fax #** 309-944-6605

HFS ID Number: 45-0228055002

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: KIM KOURI **Telephone Number:** 605-362-3178

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>RAYE NAE NYLANDER</u>	
	(Title) <u>VIC PRESIDENT/CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEO VILLAGE# 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	<u>72</u>	Skilled (SNF)	<u>72</u>	<u>26,280</u>	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	<u>72</u>	TOTALS	<u>72</u>	<u>26,280</u>	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	<u>9,474</u>	<u>14,136</u>	<u>1,303</u>	<u>24,913</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,474</u>	<u>14,136</u>	<u>1,303</u>	<u>24,913</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.80%

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1971

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ 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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	185,496	15,146	7,673	208,315		208,315	(236)	208,079		1
2	Food Purchase		166,168		166,168		166,168	(4,302)	161,866		2
3	Housekeeping	94,938	21,338		116,276		116,276	(359)	115,917		3
4	Laundry	64,443	16,104		80,547		80,547	(196)	80,351		4
5	Heat and Other Utilities			87,939	87,939		87,939		87,939		5
6	Maintenance	76,625	10,581	74,808	162,014		162,014	(3,348)	158,666		6
7	Other (specify):*			10,576	10,576		10,576	30	10,606		7
8	TOTAL General Services	421,502	229,337	180,996	831,835		831,835	(8,411)	823,424		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,256,489	101,466	5,756	1,363,711		1,363,711	(38,126)	1,325,585		10
10a	Therapy	4,812	1,061	251,235	257,108		257,108	(115,355)	141,753		10a
11	Activities	66,766	11,323	5,017	83,106		83,106	(1,002)	82,104		11
12	Social Services	23,090	98	681	23,869		23,869	(2)	23,867		12
13	CNA Training										13
14	Program Transportation			6,375	6,375		6,375		6,375		14
15	Other (specify):*	40,134			40,134		40,134		40,134		15
16	TOTAL Health Care and Programs	1,391,291	113,948	269,064	1,774,303		1,774,303	(154,485)	1,619,818		16
	C. General Administration										
17	Administrative	54,261		149,881	204,142		204,142	15,629	219,771		17
18	Directors Fees										18
19	Professional Services			4,923	4,923		4,923		4,923		19
20	Dues, Fees, Subscriptions & Promotions			39,682	39,682		39,682	(32,048)	7,634		20
21	Clerical & General Office Expenses	62,926	18,642	49,684	131,252		131,252	(6,092)	125,160		21
22	Employee Benefits & Payroll Taxes			469,656	469,656		469,656	(35,946)	433,710		22
23	Inservice Training & Education			19,909	19,909		19,909	(1,145)	18,764		23
24	Travel and Seminar			2,708	2,708		2,708	(2,201)	507		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,404	35,404		35,404	(3,495)	31,909		26
27	Other (specify):*	12,105		8,931	21,036		21,036	(21,035)	1		27
28	TOTAL General Administration	129,292	18,642	780,778	928,712		928,712	(86,333)	842,379		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,942,085	361,927	1,230,838	3,534,850		3,534,850	(249,229)	3,285,621		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEO VILLAGE #0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			209,632	209,632	209,632	(18,669)	190,963			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			10,029	10,029	10,029	(10,029)				33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,563	3,563	3,563		3,563			35
36	Other (specify):*										36
37	TOTAL Ownership			223,224	223,224	223,224	(28,698)	194,526			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			39,420	39,420	39,420		39,420			42
43	Other (specify):*			4,490	4,490	4,490	(4,490)				43
44	TOTAL Special Cost Centers			43,910	43,910	43,910	(4,490)	39,420			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,942,085	361,927	1,497,972	3,801,984	3,801,984	(282,417)	3,519,567			45

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEO VILLAGE # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,302)	2		4
5	Telephone, TV & Radio in Resident Rooms	(675)	11		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	2,409	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)	(30)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,011)	21		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		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	(250,687)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (259,296)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,121)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (23,121)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (282,417)		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.

		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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
GOOD SAMARITAN SOCIETY-GENESEVO VILLAGE

ID# 0004721

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	UNIFORM INC	\$ (8,848)	10	1
2	ADMINISTRATION	(81)	21	2
3	OPERATIONS AND MANTENACE	(3,247)	6	3
4	POSTAGE	(104)	21	4
5	RESIDENT SUPPLIES	30	7	5
6	ACTIVITIE	(148)	11	6
7	INT INC PAST DUE ACCTS	(659)	21	7
8	DEPR EXP APTS AND DUPLEXES	(18,669)	30	8
9	REAL ESTATE TAXES	(10,029)	33	9
10	PRESCR DRUGS REIMB	(25,612)	10	10
11	SALARIES RES DEV	(5,800)	27	11
12	BANK CHARGES	(104)	21	12
13	VACATION ACCUAL RES DEV	(505)	27	13
14	FICA RES DEV and TAXABLE GIFTS - RD	(445)	22	14
15	STAFF PENSION RES DEV	245	22	15
16	SUPPLIES RES DEV	(1,215)	21	16
17	TRAVEL RES DEV	(277)	24	17
18	STAFF DEVELOPMENT RES DEV	(1,145)	23	18
19	MIS FUNDRAISER EXP	(8,931)	27	19
20	SALARIES MARKETING	(5,799)	27	20
21	FICA MARKETING	(435)	22	21
22	STAFF PENSION MARKETING	(56)	22	22
23	TRAVEL OUTSIDE OF STATE	(1,924)	24	23
24	P/SERV LABORTORY MDCR	(3,035)	43	24
25	THERAPY OFFSET PT OT ST	(115,338)	10A	25
26	P/SERV CLINIC	(1,455)	43	26
27	MED SUPPLIES PART B	(2,035)	10	27
28	DISCOUNT ALLOW ADMIN	(212)	21	28
29	DISCOUNT ALLOW NURSING	(1,159)	10	29
30	DISCOUNT ALLOW THERAPY PT	(10)	10A	30
31	DISCOUNT ALLOW THERAPY OT	-7	10A	31
32	DISCOUNT ALLOW ACTIVITIES	-179	11	32
33	DISCOUNT ALLOW SOCIAL SERVICES	-2	12	33
34	DISCOUNT ALLOW LAUNDRY	-174	4	34
35	DISCOUNT ALLOW HOUSEKEEPING	-359	3	35
36	DISCOUNT ALLOW DIETARY	-236	1	36
37	DISCOUNT ALLOW OPERATIONS/MAINT	-71	6	37
38	PUBLIC RELATIONS - ADMIN	-3990	20	38
39	Advertising Res Dev	-266	20	39
40	Sm Equipment Res Dev	-15	21	40
41	Supplies Marketing Brochure	-49	21	41
42	Sm Equipment Marketing	-51	21	42
43	Advertising Marketing	-24065	20	43
44	Advertising Yellow pages/Signage Marketing	-413	20	44
45	Dues not related to resident care	-973	20	45
46	O/P Med/NSG Sply PVT	-472	10	46
47	Laundry	-22	4	47
48	Newsletter - admin	-2341	20	48
49	Total	(250,687)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	(236)	0	0	0	0	0	0	0	0	0	0	(236)	1
2	Food Purchase	(4,302)	0	0	0	0	0	0	0	0	0	0	(4,302)	2
3	Housekeeping	(359)	0	0	0	0	0	0	0	0	0	0	(359)	3
4	Laundry	(196)	0	0	0	0	0	0	0	0	0	0	(196)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,348)	0	0	0	0	0	0	0	0	0	0	(3,348)	6
7	Other (specify):*	30	0	0	0	0	0	0	0	0	0	0	30	7
8	TOTAL General Services	(8,411)	0	0	0	0	0	0	0	0	0	0	(8,411)	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	(38,126)	0	0	0	0	0	0	0	0	0	0	(38,126)	10
10a	Therapy	(115,355)	0	0	0	0	0	0	0	0	0	0	(115,355)	10a
11	Activities	(1,002)	0	0	0	0	0	0	0	0	0	0	(1,002)	11
12	Social Services	(2)	0	0	0	0	0	0	0	0	0	0	(2)	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	(154,485)	0	0	0	0	0	0	0	0	0	0	(154,485)	16
	C. General Administration													
17	Administrative	0	15,629	0	0	0	0	0	0	0	0	0	15,629	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	(32,048)	0	0	0	0	0	0	0	0	0	0	(32,048)	20
21	Clerical & General Office Expenses	(6,092)	0	0	0	0	0	0	0	0	0	0	(6,092)	21
22	Employee Benefits & Payroll Taxes	(691)	(35,255)	0	0	0	0	0	0	0	0	0	(35,946)	22
23	Inservice Training & Education	(1,145)	0	0	0	0	0	0	0	0	0	0	(1,145)	23
24	Travel and Seminar	(2,201)	0	0	0	0	0	0	0	0	0	0	(2,201)	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	(3,495)	0	0	0	0	0	0	0	0	0	(3,495)	26
27	Other (specify):*	(21,035)	0	0	0	0	0	0	0	0	0	0	(21,035)	27
28	TOTAL General Administration	(63,212)	(23,121)	0	(86,333)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(226,108)	(23,121)	0	(249,229)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(18,669)	0	0	0	0	0	0	0	0	0	0	(18,669)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(10,029)	0	0	0	0	0	0	0	0	0	0	(10,029)	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	(28,698)	0	0	0	0	0	0	0	0	0	0	(28,698)	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):*	(4,490)	0	0	0	0	0	0	0	0	0	0	(4,490)	43
44	TOTAL Special Cost Centers	(4,490)	0	0	0	0	0	0	0	0	0	0	(4,490)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(259,296)	(23,121)	0	(282,417)	45								

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEVO VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	\$ 149,880	EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY	100.00%	\$ 165,509	\$ 15,629
2	V	22 WORKERS COMP	102,675			61,637	(41,038)
3	V	22 UNEMPLOY CHARGES PD	(52)			(50)	2
4	V	26 INSURANCE	35,402			31,907	(3,495)
5	V	22 GROUP HEALTH INS	172,586			178,367	5,781
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 460,491			\$ 437,370	\$ * (23,121)

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										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

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 2006 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 2007 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:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN SOCIETY-GENESEO VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0004721

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1971	1971	\$ 494,740	\$ 12,368	40	\$ 12,368		\$ 454,542	4
5											5
6											6
7											7
8											8
Improvement Type**											
9			1977		1,100		varies			1,100	9
10			1978		7,629		20			7,629	10
11			1981		167,276	5,451	varies	5,451		148,196	11
12			1982		2,299		varies			2,299	12
13			1986		2,249		varies			2,249	13
14			1987		15,313	260	varies	260		15,313	14
15			1988		112,950	5,098	varies	5,098		109,825	15
16			1989		28,690	365	varies	365		28,331	16
17			1990		108,416	5,091	varies	5,091		93,860	17
18			1991		3,157					3,157	18
19			1992		36,755	1,039	varies	1,039		33,619	19
20			1993		73,292	2,056	varies	2,056		56,035	20
21			1994		71,555	3,110	varies	3,110		59,379	21
22			1995		76,363	3,832	varies	3,832		57,555	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	\$	\$ 64	37
38	LAUNDRY WALL PROTECTION	1996	1,109					1,109	38
39	ACTIVITY ROOM REMODEL/SINK	1996	2,132					2,132	39
40	LAUNDRY DOOR Q/A	1996	1,874	125	15	125		1,478	40
41	BATHROOM SINK	1996	678	34	20	34		404	41
42	AWNING FOR REHAB CLINIC	1996	983					983	42
43	KEMLITE IN CLOSETS	1996	653					653	43
44	POWER ACCESS DOOR OPERATOR PLA	1996	1,009					1,009	44
45	GENERATOR MOVE TO GSS	1996	3,431					3,431	45
46	CARPET FOR PARLOR	1996	2,627					2,499	46
47	A/C ROOF TOP ON 200 WING	1996	229	15	15	15		176	47
48	ELECTRIC REMODEL PARLOR	1996	186	9	20	9		107	48
49	BUILDING REMODEL PARLOR	1996	1,132	57	20	57		651	49
50	PLUMBING REMODEL PARLOR	1996	599	30	20	30		345	50
51	WALLPAPER REMODEL PARLOR	1996	2,645					2,516	51
52	SHOWER REMODEL GRAB BARS	1996	1,321					1,321	52
53	REPLACE FIXTURES FLOOR WALL FI	1996	3,955	198	20	198		2,208	53
54	WINDOWS	1996	25,212	1,681	15	1,681		18,769	54
55	BUILDING REMODELING	1996	1,692	85	20	85		966	55
56	WINDOW FOR DINING ROOM AND CON	1997	1,650	110	15	110		1,201	56
57	300 WIND CEILING TILE WORK	1997	2,584					2,584	57
58	WALL BUILT IN LAUNDRY ROOM	1997	1,013	8	10	8		1,013	58
59	WINDOWS	1997	5,100	340	15	340		3,712	59
60	WALLPAPER FOR JACK ANDREWS	1997	2,221		5			2,221	60
61	CARPET FOR CONFERENCE ROOM	1997	2,192					2,192	61
62	CONFERENCE ROOM WORK	1997	1,350	11	10	11		1,350	62
63	WALL PROTECTION	1997	739					739	63
64	NEW SPRINKLERS FOR OFFICE AND	1997	909	30	10	30		909	64
65	WALLPAPER RESIDENTS ROOM 308	1997	2,667					2,667	65
66	CARPET FOR RESIDENTS ROOM	1997	506					506	66
67	ROOF-FRONT ENTRY	1997	21,178	1,059	20	1,059		11,560	67
68	SOCIAL SERVICE AND CONFERENCE ROOM	1997	1,392	93	15	93		974	68
69	DON AND STAFF DEVELOPMENT OFFICE	1997	1,236	82	15	82		865	69
70	TOTAL (lines 4 thru 69)		\$ 1,298,095	\$ 42,642		\$ 42,642	\$	\$ 1,146,403	70

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEVO VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		\$ 1,298,095	\$ 42,642		\$ 42,642	\$	\$ 1,146,403	1
2	WALLPAPER ROOM 308	1997	1,440					1,440	2
3	DRAIN/SEWER WORK	1997	389	26	15	26		270	3
4	REMODEL IN ROOM 309	1997	1,464	98	15	98		992	4
5	SIDERAIL 1/2 DELUXE	1997		43	15	43			5
6	SIDERAILS	1997		25	15	25	0		6
7	DRYWALL NURSE STATION	1997	625					625	7
8	REHAB WALL WORK	1997	414					414	8
9	REROOFING	1997	64,129	3,206	20	3,206		32,599	9
10	BUILDING REMODEL NURSES STATION	1998	18,510	740	25	740		7,404	10
11	CARPET REMODEL NURSES STATION	1998	1,753					1,753	11
12	WALLPAPER REMODEL NURSES STATION	1998	1,794					1,794	12
13	FORM AND POUR LAMP POST BASES	1998	800					800	13
14	SIDE RAILS	1998	812	54	15	54		541	14
15	KITCHEN DOOR	1998	1,242	83	15	83		807	15
16	CABINETRY AND INSTALLATION	1998	3,799	190	20	190		1,852	16
17	ROOM 204 WORK	1998	2,532	253	10	253		2,469	17
18	VINYL COVERING KICK PLATES AND DOOR	1998	1,367	137	10	137		1,333	18
19	HANDRAIL AND INSTALLATION	1998	700	47	15	47		455	19
20	FIRE ALARM SYSTEM WORK	1998	1,090	109	10	109		1,054	20
21	BATHROOM FIXTURES	1998	412	41	10	41		395	21
22	ROOF FLASHING STALLATION	1998	753	75	10	75		722	22
23	KOROGUARD IN MED ROOM AND BATH	1998	1,008	101	10	101		966	23
24	GENERATOR	1998	47,534	2,377	20	2,377		23,173	24
25	DOOR FRAME GARDS	1998	593	40	15	40		376	25
26	WATER HEATER AND LABOR	1998	1,339	134	10	134		1,261	26
27	FLOORCOVERING CEILING TILE	1998	1,398					1,398	27
28	RESIDENT ROOM WORK	1998	996					996	28
29	CEILING TILE	1998	20,525	1,026	20	1,026		9,578	29
30	2000 PROJECT	1998	6,817	341	20	341		3,153	30
31	BATHROOM WORK	1998	2,121	212	10	212		1,961	31
32	ALUMINUM ENTERANCE/;AMBULANCE	1999	1,726	115	15	115		1,026	32
33	AIR CONDITIONING	1998	24,279	1,623	15	1,623		14,671	33
34	TOTAL (lines 1 thru 33)		\$ 1,510,456	\$ 53,738		\$ 53,738	\$ 0	\$ 1,262,681	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		\$ 1,510,456	\$ 53,738		\$ 53,738	\$ 0	\$ 1,262,681	1
2	HVAC SYSTEM	1998	4,285	287	15	287		2,589	2
3	ROOF WORK	1999	2,800	280	10	280		2,403	3
4	HOUSE AND PROPERTY	1999	86,726	2,168	40	2,168		17,887	4
5	WOOD SIGN	1999	327	33	10	33		275	5
6	HVAC	1999	2,350	235	10	235		2,017	6
7	PLUMBING BATHROOM REMODEL	1999	4,739	237	20	237		2,053	7
8	BUILDING REMODEL RESIDENT ROOM	1999	6,265	251	25	251		2,047	8
9	DRAPES REMODEL RESIDENT ROOM	1999	279					279	9
10	ELECTRIC REMODEL RESIDENT ROOM	1999	197	10	20	10		80	10
11	PAINT REMODEL RESIDENT ROOM	1999	2,697					2,697	11
12	THERMOSTATES FOR APT	2000	1,412	94	15	94		730	12
13	FAUCETS	2000	1,159	58	20	58		440	13
14	OAK CABINETS FOR KITCHEN	2000	1,603	107	15	107		828	14
15	LAUNDRY REPAIR	2000	533					533	15
16	BUILDING RENTAL PROP IMPROVEMENT	2000	19,696	788	25	788		5,974	16
17	CARPET-RENTAL PROP IMPROVEMT	2000	60					60	17
18	GENERATOR REPAIR	2000	2,258	226	10	226		1,618	18
19	WATER SOFTENER	2000	541	54	10	54		383	19
20	MAINTENANCE GARAGE	2001	79,709	5,314	15	5,314		36,312	20
21	BLDG REDECORATE 300 WING CORR	2001	8,062	322	25	322		2,096	21
22	CARPET REDECORATE 300 WING COR	2001	1,986					1,986	22
23	FIRE ALARM CONTROL PANEL	2001	414	41	10	41		262	23
24	WORK ON HEAT UNITS	2001	3,857	386	10	386		2,346	24
25	FURNACE	2001	508	51	10	51		305	25
26	LAMINATE CABINETS ACT ROOM	2002	2,779	185	15	185		1,081	26
27	PHONE CABLE WIRING TO ROOMS	2002	700	70	10	70		397	27
28	AIR CONDITIONERS BULDING A	2002	6,175	617	10	617		3,602	28
29	BUILDING REMODEL RESIDENT RMS	2002	32,873	1,315	25	1,315		7,451	29
30	CAULKING REMODEL RESIDENT RMS	2002	193	19	10	19		109	30
31	CERAMIC TILE REMDL RESIDENT RM	2002	181	9	20	9		51	31
32	CORNER GUARD REMODEL RESIDENT RM	2002	90	9	10	9		51	32
33	DRAPES REMODEL RESIDENT ROOM	2002	1,152	77	5	77		1,152	33
34	TOTAL (lines 1 thru 33)		\$ 1,787,062	\$ 66,981		\$ 66,981	\$ 0	\$ 1,362,775	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		\$ 1,787,062	\$ 66,981		\$ 66,981	\$ 0	\$ 1,362,775	1
2	DRAPERY RODS REMDL RESIDETN TM	2002	174	17	10	17		99	2
3	WALL PAPER REMDL RESIDENT RM	2002	1,809	121	5	121		1,809	3
4	BLINDS REMDL RESIDETN TM	2002	533	36	5	36		533	4
5	CARPET THERAPY	2002	622	104	5	104		622	5
6	BUILDING REDECORATE 100/200 HA	2002	11,912	476	25	476		2,541	6
7	CARPET REDECORATE 100/200 HALL	2002	5,069	676	5	676		5,069	7
8	CORNER GUARDS REDECO 100/200	2002	170	17	10	17		91	8
9	DOORS REDECORATE 100/200	2002	199	13	15	13		71	9
10	WALLPAPER REDECORATE 100/200	2002	1,905	254	10	254		1,905	10
11	HOUSE AT CONGRESS ST	2002	86,553	3,462	25	3,462		17,599	11
12	SOLID CORE DOORS SNF	2003	1,656	110	15	110		534	12
13	HOUSE AT 725 S CONGRESS	2003	86,972	3,479	25	3,479		15,940	13
14	LIGHTING FIXTURES	2003	6,755	676	10	676		2,927	14
15	HOUSE REMODEL	2003	8,234	329	25	329		1,455	15
16	BLD REMODEL 200 WING TUBROOM	2003	5,173	207	25	207		914	16
17	WINDOWS	2003	2,494	166	15	166		693	17
18	DUAL SENSOR SMOKE ALARM	2003	1,276	128	10	128		521	18
19	HOUSE AT 721 CONGRESS	2004	66,566	2,663	25	2,663		10,651	19
20	TILE FOR DIETARY OFFICE	2004	775	78	10	78		297	20
21	ROOF SIDING RENTAL HOUSE	2004	4,326	216	20	216		829	21
22	REPAIR DINING ROOM ROOF	2004	3,253	325	10	325		1,193	22
23	BUILDING RMDL 721 S CONGRESS	2004	11,152	446	25	446		1,598	23
24	BLINDS RESIDENT ROOM REMODEL	2004	1,257	252	5	252		775	24
25	BUILDING RESIDENT ROOM REMODEL	2004	23,806	952	25	952		2,936	25
26	DRAPES RESIDENT ROOM REMODEL	2004	66	13	5	13		41	26
27	ELECTRIC RESIDENT TOOM REMODEL	2004	1,109	55	20	55		171	27
28	WALLPAPER RESIDENT ROOM REMODEL	2004	88	18	5	18		54	28
29	CERAMIC FLOOR KITCHEN	2005	1,278	64	20	64		181	29
30	FIRE SPRINKLER SYSTEM	2005	111,341	4,454	25	4,454		12,247	30
31	APT/NF LINK	2005	63,632	3,182	20	3,182		9,280	31
32	BOILER REPLACEMENT	2005	107,947	5,397	20	5,397		16,192	32
33	CEILING TILE	2005	7,373	369	20	369		1,014	33
34	TOTAL (lines 1 thru 33)		\$ 2,412,537	\$ 95,736		\$ 95,736	\$ 0	\$ 1,473,557	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		\$ 2,412,537	\$ 95,736		\$ 95,736	\$ 0	\$ 1,473,557	1
2	REKEY BUILDINGS	2005	5,753	575	10	575		1,438	2
3	REKEY CAMPUS	2005	6,484	648	10	648		1,351	3
4	FIRE PROTECTION SYSTEM UPGRADE	2005	20,284	2,028	10	2,028		4,395	4
5	FLOOR KIT AND DOOR	2006	420	28	15	28		54	5
6	BUILDING RESIDENT ROOM REMDL	2006	16,225	649	25	649		1,298	6
7	VINYL FLR RESIDENT ROOM REMDL	2006	1,076	108	10	108		215	7
8	LIFE SAFETY CODE UPGRADES	2005	22,517	901	25	901		2,327	8
9	CEILING TILES KTAG COMPLIANCE	2006	466	23	20	23		43	9
10	DOORS FOR RESIDENT ROOMS	2006	606	40	15	40		71	10
11	VENTILATION IMPROVMENTS	2006	404,885	26,992	15	26,992		44,987	11
12	LINEN CLOSETS	2006	5,277	264	20	264		440	12
13	DRAPES	2006	493	99	5	99		156	13
14	CABINETS	2006	611	31	20	31		46	14
15	GARAGE DOOR 720 S IL	2006	630	42	15	42		60	15
16	ROOF WORK	2006	1,016	102	10	102		152	16
17	CANOPY AND PARKING	2006	4,100	205	20	205		290	17
18	STEEL DOORS	2006	769	51	15	51		81	18
19	BLDG RMDL 100/200 WING TUB RM	2006	5,358	214	25	214		286	19
20	TILE RMDL 100/200 WING TUB RM	2006	2,975	149	20	149		198	20
21	DRAPE TMDL 100/200 WING TUB RM	2006	343	69	5	69		91	21
22	NSG COUNTR 100/200 WING TUB RM	2006	21	1	15	1		2	22
23	PAINT RMDL 100/200 WING TUB RM	2006	25	5	5	5		7	23
24	PLUMB RMD 100/200 WING TUB RM	2006	1,291	65	20	65		86	24
25	VINAL RMDL 100/200 WING TUB RM	2006	663	66	10	66		88	25
26	WALLPAPER 100/200 WING TUB RM	2006	900	180	5	180		240	26
27	BUILDING RMDL RESIDENT ROOMS	2007	14,749	590	25	590		590	27
28	DRAPES RMDL RESIDENTS ROOMS	2007	120	12	10	12		12	28
29	PAINT RMDL RESIDENT ROOMS	2007	2,975	595	5	595		595	29
30	DOOR	2007	1,729	77	15	77		77	30
31	100 GAL /75K BTU GAS HEATER	2007	1,645	55	10	55		55	31
32	UPGRADE FIRE DETECTIONS SYSTEM	2007	4,127	138	10	138		138	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,941,070	\$ 130,738		\$ 130,738	\$ 0	\$ 1,533,426	34

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

Facility Name & ID Number **GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE**

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,941,070	\$ 130,738		\$ 130,738	\$ 0	\$ 1,533,426	1
2	DRIVE THRU CANOPY	2007	68,562	457	25	457		457	2
3	CABINETS DINING ROOM	2007	19,676	164	20	164		164	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11	Gain / Loss on Disposal (#72600)			4,095		4,095			11
12	Pr Yr Depreciation (#71564)			10		10			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)		\$ 3,029,307	\$ 135,464		\$ 135,464	\$ 0	\$ 1,534,047	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEVO VILLAGE

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		\$ 3,029,307	\$ 135,464		\$ 135,464	\$ 0	\$ 1,534,047	1
2	Drives grading walks	1971	9,171					9,171	2
3	Paving	1974	3,499					3,499	3
4	Improve West Side of Parking	1975	1,018					1,018	4
5	Dirt EE Snodgrass	1975	83					83	5
6	Resurface Parking Lot	1978	3,817					3,817	6
7	Sidewalk Around Center Drai	1981	3,842					3,796	7
8	Sod Around Bldg	1981	1,450					1,450	8
9	Paving Asphalt	1985	6,089					6,089	9
10	Parking Lot Chestnut Street	1988	62,030					62,030	10
11	Demolition of Houses	1990	2,985					2,985	11
12	Seed	1990	803					803	12
13	Landscape	1990	69					69	13
14	Gazebo	1991	11,223	561	20	561		9,118	14
15	Isabel Bloom for Memorial Foundaton	1992	300	10	15	10		300	15
16	Illuminated Sign Box and Cove	1992	5,288					5,288	16
17	To lay bridkes for new sign	1992	383					383	17
18	Landscaping material	1992	2,764					2,764	18
19	Gazebo	1995	9,618	641	15	641		7,855	19
20	Fence	1995	6,242	416	15	416		5,097	20
21	Bury Electric Line	1996	3,347					3,347	21
22	Site improvements Duplexes	1996	50,912					50,912	22
23	Gazebo	1997	2,850	143	20	143		1,520	23
24	Walk	1997	2,500	167	15	167		1,778	24
25	Entrance area landscaping	1997	2,450	143	10	143		2,450	25
26	Sprinkler System	1997	727	48	15	48		488	26
27	Parking Lot	1997	2,266	113	20	113		1,161	27
28	Courthouse Research for Prepari	1998	515	52	10	52		511	28
29	Padio	1998	1,314	131	10	131		1,237	29
30	Skylight and Flashing work	1998	1,607	161	10	161		1,513	30
31	Sidwalk	1999	475	48	10	48		408	31
32	Blocks/ Retention Pond	2001	1,129	56	20	56		357	32
33	Fencing around Screen	2002	1,520	152	10	152		823	33
34	TOTAL (lines 1 thru 33)		\$ 3,231,590	\$ 138,305		\$ 138,306	\$ 0	\$ 1,726,164	34

**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 12G, Carried Forward		\$ 3,231,590	\$ 138,305		\$ 138,306	\$ 1	\$ 1,726,164	1
2	Parking Lot Lamp Posts	2003	508	51	10	51		248	2
3	Striping Paring Lot	2004		112	5	112			3
4	Rehab Shed	2005	2,948	295	10	295		811	4
5	Slab for Building	2005	1,723	115	15	115		268	5
6	Bench for Memorial Garden	2005	321	32	10	32		72	6
7	Bricks for Memorial Garden	2005	350	18	20	18		41	7
8	CADD for Parking Lot and Camopy	2006	4,125	206	20	206		258	8
9	Front Parking Lot Replacement	2007	98,229	819	20	819		819	9
10									10
11									11
12									12
13	Parking Lot Expansion (50% to nursing)	1999	13,797	690	20	690		5,634	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)		\$ 3,353,591	\$ 140,643		\$ 140,644	\$ 1	\$ 1,734,315	34

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

Facility Name & ID Number **GOOD SAMARITAN SOCIETY-GENESEVO VILLAGE**

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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 12H, Carried Forward		\$ 3,353,591	\$ 140,643		\$ 140,644	\$ 1	\$ 1,734,315	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
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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)		\$ 3,353,591	\$ 140,643		\$ 140,644	\$ 1	\$ 1,734,315	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLA# 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 538,198	\$ 53,982	\$ 53,982	\$		\$ 290,528	71
72	Current Year Purchases	34,654	3,695	3,695			3,738	72
73	Fully Depreciated Assets	458,321	4,397	4,397			458,321	73
74								74
75	TOTALS	\$ 1,031,173	\$ 62,074	\$ 62,074	\$		\$ 752,587	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 Pass Van	1998	\$ 46,953	\$	\$	\$	4	\$ 46,953	76
77		W/Chair 2004 Dodge	2003	21,602	3,584	3,584		5	14,667	77
78		Snowplow on 2000 Min Van	2003	17,059	3,123	3,123		7	11,661	78
79		Tailgate for Truck		1,220	210	210		6	240	79
80	TOTALS			\$ 86,834	\$ 6,917	\$ 6,917	\$		\$ 73,521	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)		\$ 4,497,598	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 209,634	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 209,635	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 1	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,560,423	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	\$ 134,694	\$	\$	86
87	Building	2,982,195	95,104	957,408	87
88	Land Imp	82,847	3,687	42,591	88
89	FFE	99,476	3,947	74,733	89
90	Non Care assets Allocation to 01				90
91	TOTALS	\$ 3,299,212	\$ 102,738	\$ 1,074,732	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 62,136	92
93			93
94			94
95		\$ 62,136	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 3,563 Description: Computer Leasing and 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	10a, col 3	hrs	\$		\$ 95,846	\$		\$ 95,846	1
2	Licensed Speech and Language Development Therapist	10a, col 3	hrs			42,824			42,824	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, col 3	hrs			112,565			112,565	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			\$		\$ 251,235	\$		\$ 251,235	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILLAGE # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ 217,769	\$	1
2	Cash-Patient Deposits	11,024		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	674,466		3
4	Supply Inventory (priced at)	8,792		4
5	Short-Term Investments	1,741,860		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(40,617)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,613,294	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,693		13
14	Buildings, at Historical Cost	6,011,499		14
15	Leasehold Improvements, at Historical Cost	407,131		15
16	Equipment, at Historical Cost	1,217,483		16
17	Accumulated Depreciation (book methods)	(3,635,158)		17
18	Deferred Charges	82,105		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 ,MGMNT CIP</u>	77,238		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,320,991	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,934,285	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable	100,475		27
28	Accounts Payable-Patient Deposits	5,546		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,602		30
31	Accrued Taxes Payable (excluding real estate taxes)	96,566		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,219		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 garnishments</u>			36
37	<u>security deposit priority payment</u>	33,824		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 407,232	\$	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-dplz ent fee</u>	1,786,418		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,786,418	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,193,650	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,740,635	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,934,285	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,606,624	1
2	Restatements (describe):		2
3	SENIOR LIVING	23,175	3
4	APATMENTS	(2,431)	4
5	DUPLEX	37,578	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,664,946	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	61,589	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)	\$ 61,589	17
B. Transfers (Itemize):			
18	Reserve Fund Assesment NC	(107,887)	18
19	Technology User Assessment NC	(8,496)	19
20	DNR Rst Prop Gft Cash	20,558	20
21	DNR Rst Oper Gft Cash	1,693	21
22	DNR Rst End FD Bal Rst Gen	108,232	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 14,100	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,740,635	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESE0 VILI # 0004721 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 3,936,619	1
2	Discounts and Allowances for all Levels	(821,247)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,115,372	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	20,258	5
6	Therapy	615,488	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 635,746	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	2,070	13
14	Non-Patient Meals	4,301	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	28,200	16
17	Sale of Drugs	68,471	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	22	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 103,064	23
D. Non-Operating Revenue			
24	Contributions	21,050	24
25	Interest and Other Investment Income***	34,894	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 55,944	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NS&MED SUPPLIES	29,992	28
28a	SEE SCHEDULE ATTACHED	(76,545)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (46,553)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,863,573	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	831,835	31
32	Health Care	1,774,303	32
33	General Administration	928,712	33
B. Capital Expense			
34	Ownership	223,224	34
C. Ancillary Expense			
35	Special Cost Centers	4,490	35
36	Provider Participation Fee	39,420	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,801,984	40
41	Income before Income Taxes (line 30 minus line 40)**	61,589	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 61,589	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 **GOOD SAMARITAN SOCIETY-GENESEO VILLAGE**

0004721

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	1,926	2,217	\$ 61,106	\$ 27.56	1
2	Assistant Director of Nursing	192	208	4,847	23.30	2
3	Registered Nurses	7,653	8,520	179,927	21.12	3
4	Licensed Practical Nurses	7,411	8,199	140,910	17.19	4
5	CNAs & Orderlies	58,994	66,108	752,529	11.38	5
6	CNA Trainees	297	305	2,949	9.67	6
7	Licensed Therapist	192	208	4,812	23.13	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,873	2,130	29,719	13.95	9
10	Activity Assistants	3,830	4,214	36,097	8.57	10
11	Social Service Workers	1,620	1,748	23,182	13.26	11
12	Dietician					12
13	Food Service Supervisor	2,189	2,292	35,219	15.37	13
14	Head Cook	6,099	6,733	66,424	9.87	14
15	Cook Helpers/Assistants	9,487	10,396	82,234	7.91	15
16	Dishwashers					16
17	Maintenance Workers	5,168	5,555	74,503	13.41	17
18	Housekeepers	8,163	9,230	95,806	10.38	18
19	Laundry	5,370	6,472	69,183	10.69	19
20	Administrator	1,519	1,912	56,601	29.60	20
21	Assistant Administrator					21
22	Other Administrative	5,443	5,940	90,939	15.31	22
23	Office Manager	1,160	1,364	19,839	14.54	23
24	Clerical	4,517	5,160	92,429	17.91	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	1,922	2,094	29,689	14.18	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MRKT/RD</u>	670	714	11,600	16.25	33
34	TOTAL (lines 1 - 33)	135,695	151,719	\$ 1,960,544 *	\$ 12.92	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	126	\$ 7,176	Ln1 Col 3	35
36	Medical Director	0	1,200	Ln 10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,292	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	683	Ln 11 Col 3	44
45	Social Service Consultant	10	683	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 12,034		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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-GENESEO VILLAGE

0004721

Report Period Beginning: 1/1/07

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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. LSNI - 4552
- (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? _____
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. \$ 15,580 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. \$ 39,420
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 4,301
- (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? 70%
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: LarsonAllen,LLP 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.