

		FOR OHF USE				

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**2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)**

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.

<p>I. IDPH Facility ID Number: <u>0009258</u></p> <p>Facility Name: <u>Good Samaritan Home</u></p> <p>Address: <u>2130 Harrison Street</u> <u>Quincy</u> <u>62301</u> Number City Zip Code</p> <p>County: <u>Adams</u></p> <p>Telephone Number: <u>(217) 223-8717</u> Fax # <u>(217) 223-6015</u></p> <p>IDPA ID Number: <u>370724112001</u></p> <p>Date of Initial License for Current Owners: <u>2/22/1957</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ms. Judy M. Graham</u> Telephone Number: <u>(217) 223-8717</u></p>	<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 <u>501(c)(3)</u>	<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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/01</u> to <u>09/30/02</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mr. Michael Duffy</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) _____</td> <td>Fax # _____</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001</p> <p align="right">Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mr. Michael Duffy</u>			(Title) <u>Administrator</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) _____	Fax # _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Firm Name & Address) _____																																									
	(Telephone) _____	Fax # _____																																								

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning: 10/01/01 Ending: 09/30/02

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 12/27/01

	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	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,180	3
4		Intermediate/DD			4
5	101	Sheltered Care (SC)	97	35,753	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	275	100,723	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	1,633	1,663	
9	SNF/PED					9
10	ICF	23,297	62,168		85,465	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,930	63,831	2,615	91,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.72%

D. How many bed-hold days during this year were paid by Public Aid? 279 (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 - Pool Exercise Classes

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 2/22/57

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 8 and days of care provided 2,615

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/02 Fiscal Year: 09/30/02

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

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/01 Ending: 09/30/02

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	718,880	40,062	16,061	775,003		775,003	775,003			1
2	Food Purchase		606,891		606,891		606,891	(8,384)	598,507		2
3	Housekeeping	248,344	35,491	20,546	304,381		304,381	(3,850)	300,531		3
4	Laundry	111,888		17,118	129,006		129,006		129,006		4
5	Heat and Other Utilities			334,688	334,688		334,688		334,688		5
6	Maintenance	219,787	32,960	85,054	337,801		337,801	6,930	344,731		6
7	Other (specify):*										7
8	TOTAL General Services	1,298,899	715,404	473,467	2,487,770		2,487,770	(5,304)	2,482,466		8
B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	3,768,790	223,755	27,538	4,020,083		4,020,083		4,020,083		10
10a	Therapy	137,601	7,665	132,600	277,866		277,866		277,866		10a
11	Activities	123,246	1,573	12,212	137,031		137,031		137,031		11
12	Social Services	130,529	350	1,110	131,989		131,989		131,989		12
13	Nurse Aide Training	11,365		1,191	12,556		12,556		12,556		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,171,531	233,343	178,251	4,583,125		4,583,125		4,583,125		16
C. General Administration											
17	Administrative	157,412			157,412		157,412		157,412		17
18	Directors Fees										18
19	Professional Services			38,976	38,976		38,976	(1,472)	37,504		19
20	Dues, Fees, Subscriptions & Promotions			61,298	61,298		61,298	(556)	60,742		20
21	Clerical & General Office Expenses	324,653	41,553	85,760	451,966		451,966	(56,344)	395,622		21
22	Employee Benefits & Payroll Taxes			1,194,824	1,194,824		1,194,824		1,194,824		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,402	8,402		8,402	(2,409)	5,993		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			162,172	162,172		162,172		162,172		26
27	Other (specify):*										27
28	TOTAL General Administration	482,065	41,553	1,551,432	2,075,050		2,075,050	(60,781)	2,014,269		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,952,495	990,300	2,203,150	9,145,945		9,145,945	(66,085)	9,079,860		29

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

**See schedule of adjustments attached at end of cost report

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 Home

#0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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			478,190	478,190		478,190	(1,970)	476,220			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			478,190	478,190		478,190	(1,970)	476,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,018		45,018		45,018		45,018			39
40	Barber and Beauty Shops	49,199	3,538	334	53,071		53,071		53,071			40
41	Coffee and Gift Shops	19,141	30,240		49,381		49,381		49,381			41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):* Nonallowable Costs	54,947		811,855	866,802		866,802	(866,802)				43
44	TOTAL Special Cost Centers	123,287	78,796	909,644	1,111,727		1,111,727	(866,802)	244,925			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,075,782	1,069,096	3,590,984	10,735,862		10,735,862	(934,857)	9,801,005			45

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

**See schedule of adjustments attached at end of cost report

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/01

Ending: 09/30/02

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	(8,384)	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	(92)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,813)	43		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	(14,020)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,563)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attach Sch 5A	(897,985)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (934,857)		\$	30

OHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (934,857)		37

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

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

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

Good Samaritan Home
0009258
09/30/02

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Out of period legal fees	(185)	19
To disallow Chamber of Commerce dues	(556)	20
To disallow Rotary & Kiwanis Club dues	(888)	21
To disallow out of state travel	(2,139)	24
To set prepaid expense for Computer Contracts	(9,707)	21
To record prepaid Maintenance Expense for the year	2,748	6
To record deferred Maintenance Expense for year	4,182	6
To record this year expense on Computer Contracts	809	21
To disallow radio station expense	(488)	43
To disallow X-Ray expense	(4,620)	43
To disallow Lab expense	(578)	43
To disallow investment consultants	(219,974)	43
To disallow out of period seminar cost	(270)	24
To offset guest room income	(1,878)	30
To disallow cottage service income	(3,850)	3
To offset miscellaneous income	(647)	21
To offset discount earned income	(483)	21
To disallow rental property expenses	(7,272)	43
To disallow radio station depreciation	(935)	43
To disallow cottage expenses	(618,559)	43
To disallow Development expense	(1,287)	19
To disallow Public Relation Wages	(31,408)	21
Total	(897,985)	

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/01

Ending: 09/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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
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31			31
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33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,384)	0	0	0	0	0	0	0	0	0	0	(8,384)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,384)	0	0	0	0	0	0	0	0	0	0	(8,384)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(14,020)	0	0	0	0	0	0	0	0	0	0	(14,020)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,020)	0	0	0	0	0	0	0	0	0	0	(14,020)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,404)	0	0	0	0	0	0	0	0	0	0	(22,404)	29

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
N/A		N/A		N/A		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				3
4	V							4
5	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/01 Ending: 09/30/02

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	N/A								\$	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 Home

0009258 Report Period Beginning: 10/01/01

Ending: 09/30/02

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	N/A								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 Home # 0009258 Report Period Beginning: 10/01/01 Ending: 09/30/02

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2	N/A											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 2001 report.		\$	N/A
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.)	2001	\$	
3. Under or (over) accrual (line 2 minus line 1).		\$	
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	
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.)		\$	
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.)		\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 _____	8	
	1998 _____	9	
	1999 _____	10	
	2000 _____	11	
	2001 _____	12	
			FOR OHF USE ONLY
		13	FROM R. E. TAX STATEMENT FOR 2001 \$
		14	PLUS APPEAL COST FROM LINE 5 \$
		15	LESS REFUND FROM LINE 6 \$
		16	AMOUNT TO USE FOR RATE CALCULATION \$

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: 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 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,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

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 2001 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 2001

(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. <u>N/A</u>	_____	\$ _____	\$ _____
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 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Good Samaritan Home# 0009258 Report Period Beginning:10/01/01 Ending:09/30/02**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 169,463 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Residential Cottage Apartments 160 units for 174,278 square feetF. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	<u>Facility</u>	<u>1,219,680</u>	<u>1956-1999</u>	<u>\$ 128,278</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	1,219,680		\$ 128,278	3

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	30		1957	\$ 358,309	\$	40	\$	\$	\$ 358,309	4
5	75		1962	683,823	11,384	40	11,384		683,823	5
6	99		1973	1,683,761	42,094	40	42,094		1,215,829	6
7	75		1984	1,953,541	48,839	40	48,839		907,587	7
8										8
Improvement Type**										
9	Building Service Equipment		1973	38,904		20			38,904	9
10	Land Improvements		1974	26,525	43	30	43		26,452	10
11	Building Improvements		1974	89,670	1,012	30	1,012		88,070	11
12	Building Improvements		1975	28,553		20			28,553	12
13	Building Improvements		1976	9,414		20			9,414	13
14	Building Improvements		1977	3,107		20			3,107	14
15	Building Service Equipment		1978	5,714		15			5,714	15
16	Building Improvements		1979	179		20			179	16
17	Building Service Equipment		1979	9,188		Various			9,188	17
18	Building Service Equipment		1980	1,596		Various			1,596	18
19	Building Improvements		1982	151,081	5,274	Various	5,274		108,177	19
20	Building Service Equipment		1982	17,350		Various			17,350	20
21	Building Service Equipment		1983	10,058	503	20	503		9,640	21
22	Land Improvements		1984	49,187		15			49,187	22
23	Building Service Equipment		1984	816,496	17,182	Various	17,182		787,905	23
24	Land Improvements		1985	29,707	1,355	20	1,355		25,413	24
25	Building Improvements		1985	250,935	6,273	40	6,273		108,322	25
26	Building Service Equipment		1985	184,917	8,643	Various	8,643		162,632	26
27	Land Improvements		1986	72,453	3,430	20	3,430		60,166	27
28	Building Improvements		1986	161,531	4,038	40	4,038		65,520	28
29	Building Service Equipment		1986	137,391	6,241	Various	6,241		101,573	29
30	Building Improvements		1987	19,089	500	Various	500		7,464	30
31	Building Service Equipment		1987	21,221	1,061	20	1,061		16,264	31
32	Land Improvements		1988	19,174	891	20	891		13,831	32
33	Building Service Equipment		1988	14,400	697	Various	697		13,528	33
34	Building Improvements		1989	174,123	6,666	Various	6,666		103,589	34
35	Building Service Equipment		1989	6,469	225	Various	225		6,132	35
36	Garage Additions		1990	78,563	2,619	30	2,619		33,171	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 Home

0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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	New Roof - North Wing	1990	\$ 43,980	\$ 2,199	20	\$ 2,199	\$	\$ 27,304	37
38	Phones	1990	600		10			600	38
39	Hall Renovations	1991	20,616	1,031	20	1,031		11,940	39
40	Building Improvements State Audit Adjustments 10881+30372	1991	511,992	18,441	30	17,066	(1,375)	193,362	40
41	Ceiling/partitions	1991	37,276	1,243	30	1,243		14,083	41
42	Office Entrance	1991	14,768	738	20	738		8,860	42
43	Building Services Equipment State Audit Adjustment of 355	1991	83,893	1,465	various	1,441	(24)	79,352	43
44	Parking Lot	1992	4,257	213	20	213		1,915	44
45	Building Services Equipment	1992	2,706	271	10	271		2,436	45
46	Parking Lot	1992	46,071	2,304	20	2,304		22,076	46
47	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		72,429	47
48	Building Services Equipment	1993	20,910	1,112	various	1,112		16,983	48
49	Parking Lot	1994	87,827	5,855	15	5,855		51,232	49
50	Manhole/Sewer	1994	2,859	191	15	191		1,652	50
51	Sidewalk	1994	7,875	525	15	525		4,244	51
52	West Nursing	1994	66,876	3,344	20	3,344		26,751	52
53	Dining Room	1994	6,990	384	various	384		3,420	53
54	Building Services Equipment	1994	134,323	5,768	various	5,768		98,212	54
55	West Nursing	1995	128,327	6,416	20	6,416		48,657	55
56	West Nursing	1995	3,151	158	20	158		1,024	56
57	Building Services Equipment	1995	22,482	1,469	various	1,469		14,816	57
58	Gas Line	1996	3,062	153	20	153		995	58
59	Gutters	1996	10,817	541	20	541		3,516	59
60	Eber Wing Improvements	1996	20,335	1,017	20	1,017		6,609	60
61	Roof	1996	9,016	451	20	451		2,930	61
62	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		20,945	62
63	Building Services Equipment	1996	46,663	2,950	various	2,950		19,177	63
64	Lights/Front Land Improvements	1997	5,360	357	15	357		2,054	64
65	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		11,490	65
66	Freezer Floor	1997	4,394	258	17	258		1,550	66
67	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		6,066	67
68	Sprinkling System	1997	3,354	336	10	336		1,510	68
69	Tamper Detectors	1997	2,818	282	10	282		1,268	69
70	TOTAL (lines 4 thru 69)		\$ 8,931,759	\$ 243,081		\$ 241,682	\$ (1,399)	\$ 5,846,047	70

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

Facility Name & ID Number Good Samaritan Home

0009258

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 12A, Carried Forward		\$ 8,931,759	\$ 243,081		\$ 241,682	\$ (1,399)	\$ 5,846,047	1
2	Compressor - Eber	1997	2,039	136	15	136		725	2
3	Compressor - East	1997	11,808	787	15	787		4,133	3
4	Sprinkler System	1997	102,875	5,144	20	5,144		26,148	4
5	Air Exchange -Pool Area State Audit adjustment 480	1997	8,092	572	15	539	(33)	2,830	5
6	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		5,544	6
7	Elevator Doors Dietary	1998	1,095	110	10	110		493	7
8	Underground Tanks	1998	23,092	2,309	10	2,309		10,391	8
9	Remodeling -Anna Brow Wing Walls, Celng, Floors,Lights	1999	199,131	4,978	39	4,978		15,972	9
10	Remodeling -Anna Brow Wing - Duct Detectors	1999	1,444	289	5	289		1,011	10
11	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	297	10	297		1,038	11
12	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	548	39	548		1,849	12
13	Chapel Roof	1999	21,515	538	39	538		2,084	13
14	Fire Damper Alarm	1999	5,490	1,098	5	1,098		3,843	14
15	Eber Parking Lot Lights	1999	5,495	366	15	366		1,282	15
16	Lawn	1999	661	132	5	132		462	16
17	Stainless Steel D/W Exhaust	1999	1,659	166	10	166		581	17
18	Wiring Chapel Roof	1999	332	33	10	33		116	18
19	HVAC Chapel	1999	23,760	1,584	15	1,584		5,544	19
20	Code Alert System	1999	61,985	12,397	5	12,397		43,389	20
21	Elevator Upgrade A/B East	1999	22,556	2,256	10	2,256		7,895	21
22	Elevator Upgrade - Special Care	1999	5,970	597	10	597		2,090	22
23	Fire Protection A/B	1999	4,500	450	10	450		1,575	23
24	Condensor Unit	1999	22,945	1,530	15	1,530		5,354	24
25	Fire Protection Pool Area	1999	776	78	10	78		272	25
26	Damper Duct Work	1999	5,602	373	15	373		1,307	26
27	Lighting- Special Care	1999	2,075	138	15	138		484	27
28	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		533	28
29	Chapel Remodeling - Sign	2000	77	15	5	15		38	29
30	Chapel Remodeling - Painting	2000	4,751	119	39	119		243	30
31	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		512	31
32	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		753	32
33	Kitchen Remodeling - Hood	2000	2,511	167	15	167		418	33
34	TOTAL (lines 1 thru 33)		\$ 9,565,455	\$ 282,243		\$ 280,811	\$ (1,432)	\$ 5,994,956	34

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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		\$ 9,565,455	\$ 282,243		\$ 280,811	\$ (1,432)	\$ 5,994,956	1
2	Kitchen Remodeling - Sky Roof Flashing	2000	3,086	206	15	206		515	2
3	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		581	3
4	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601	173	15	173		433	4
5	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		1,533	5
6	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		2,748	6
7	Special Care Lighting	2000	14,290	953	15	953		2,382	7
8	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		50,903	8
9	Groundkeeper	2000	5,298	757	7	757		1,892	9
10	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		463	10
11	Telephone Unit	2000	323	46	7	46		115	11
12	Elevator Up Grade East Wing	2000	12,776	852	15	852		2,130	12
13	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		183	13
14	Entrance Codelock Special Care	2000	1,848	123	15	123		308	14
15	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		1,167	15
16	Land Improvement New Sidewalk	2000	1,200	60	20	60		90	16
17	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		11,153	17
18	Exterior Painting	2001	14,347	956	15	956		1,434	18
19	Painting Kitchen	2001	2,550	170	15	170		255	19
20	Chapel Renovation	2000	2,001	50	39	50		94	20
21	Kitchen Electrical Work	2000	611	41	15	41		61	21
22	HVAC Rehab Eber Wing	2000	5,584	372	15	372		558	22
23	Sprinklers	2000	4,151	277	15	277		415	23
24	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		369	24
25	Electrical Work	2001	1,609	107	15	107		161	25
26	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		5,073	26
27	Air Compressor Anna Brown Wing	2001	10,911	727	15	727		1,091	27
28	3D Detectors in Elevators	2001	4,916	246	10	246		246	28
29	Exhaust fan	2001	1,815	91	10	91		91	29
30	Compensators	2001	2,724	136	10	136		136	30
31	33 Lever Passage Locks	2002	2,904	145	10	145		145	31
32	Exit Lights and Hold Opens	2002	966	48	10	48		48	32
33	16 Lever Passage Locks	2002	1,408	70	10	70		70	33
34	TOTAL (lines 1 thru 33)		\$ 10,450,040	\$ 324,793		\$ 323,361	\$ (1,432)	\$ 6,081,799	34

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 10,450,040	\$ 324,793		\$ 323,361	\$ (1,432)	\$ 6,081,799		1
2	48 Lockouts	2002 985	49	10	49		49		2
3	Water Piping	2001 4,600	101	39	101		101		3
4	New Curb & Driveway	2002 16,118	403	20	403		403		4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Guest Room Income Offset				(1,878)	(1,878)			31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,471,743	\$ 325,346		\$ 322,036	\$ (3,310)	\$ 6,082,352		34

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/01

Ending:

09/30/02

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	\$ 1,001,063	\$ 126,171	\$ 127,511	\$ 1,340	20-3 yrs	\$ 672,375	71
72	Current Year Purchases	126,542	6,581	6,581		10-5 yrs	6,581	72
73	Fully Depreciated Assets	1,200,314				20-3 yrs	1,200,314	73
74								74
75	TOTALS	\$ 2,327,919	\$ 132,752	\$ 134,092	\$ 1,340		\$ 1,879,270	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	Various	Various	\$ 97,782	\$ 14,885	\$ 14,885		3-5 yrs	\$ 76,241	76
77	Maintenance	Various	Various	73,691	4,374	4,374		3-5 yrs	70,404	77
78	Maintenance	Various	Various	1,219				3	1,219	78
79	See Attach Sch 13A	Various	2002	8,333	833	833		5 yrs	833	79
80	TOTALS			\$ 181,025	\$ 20,092	\$ 20,092			\$ 148,697	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)	\$ 13,108,965 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 478,190 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 476,220 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,970) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,110,319 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	Cottage Land	\$ 76,532			86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,078,565	245,683	4,088,604	88
89	Rental Property Fixed Assets	219,235	7,272	31,739	89
90	Radio Station	14,032	935	14,029	90
91	TOTALS	\$ 8,464,094	\$ 253,890	\$ 4,134,372	91

G. Construction-in-Progress

	Description	Cost	
92	Building Improvement	\$ 386,697	92
93			93
94			94
95		\$ 386,697	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/01 Ending: 09/30/02

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	
37	Purchased in Prior Years	\$	\$	\$	0		\$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	41

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	
42	Facility	Toro 2001	2001	\$ 825	\$ 82	\$ 82	0	5 yrs	\$ 82	42
43	Maintenance	Chevy S-10 98	2002	7,508	751	751	0	5 yrs	751	43
44							0			44
45							0			45
46	TOTALS			\$ 8,333	\$ 833	\$ 833	\$ 0		\$ 833	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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: N/A
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

9. Option to Buy: YES NO Terms: N/A*

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: \$ N/A Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2003</u>	\$ <u>N/A</u>
13.	<u>/2004</u>	\$ <u>N/A</u>
14.	<u>/2005</u>	\$ <u>N/A</u>

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		<u>N/A</u>			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 aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1 Drop-outs	2 Completed	3 Contract	4 Total
1 Community College Tuition	\$	\$ 358	\$	\$ 358
2 Books and Supplies		523		523
3 Classroom Wages (a)		3,233		3,233
4 Clinical Wages (b)		1,617		1,617
5 In-House Trainer Wages (c)		6,515		6,515
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests		310		310
9 TOTALS	\$	\$ 12,556	\$	\$ 12,556
10 SUM OF line 9, col. 1 and 2 (e)	\$	12,556		

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
					Units	Cost						
1	Licensed Occupational Therapist	L. 10a C1, 2,3	1187	hrs	\$ 24,563	1,530	\$ 61,702	\$ 1,531	2,717	\$ 87,796	1	
2	Licensed Speech and Language Development Therapist	L. 10a C 3		hrs		354	18,248		354	18,248	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	L. 10a C 1,2,3	4944	hrs	113,038	1,309	52,536	6,134	6,253	171,708	4	
5	Physician Care			visits							5	
6	Dental Care	L.10 C 2, 3		visits			2,200	928		3,128	6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	L 39 C 2		# of prescripts				45,018		45,018	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				\$ 137,601	3,193	\$ 134,686	\$ 53,611	9,324	\$ 325,898	14	

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

STATE OF ILLINOIS

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Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/01

Ending:

09/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/02

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 179,431	\$ 179,431	1
2	Cash-Patient Deposits	27,492	27,492	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	680,382	680,382	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	998,864	998,864	5
6	Prepaid Insurance	100,560	100,560	6
7	Other Prepaid Expenses	1,307	10,205	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,988,036	\$ 1,996,934	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	21,746,512	21,746,512	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,722,455	10,471,743	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,502,245	2,508,944	16
17	Accumulated Depreciation (book methods)	(8,333,025)	(8,110,319)	17
18	Deferred Charges		6,273	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spt <u>CIP</u>)	386,697	386,697	22
23	Other(specify): <u>Cottage & Rental Property</u>	4,329,721	4,329,721	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,482,883	\$ 31,467,849	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,470,919	\$ 33,464,783	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 169,325	\$ 169,325	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,492	27,492	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	588,765	588,765	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,717	19,717	31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,566		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Sch 17C</u>	72,633	72,633	36
37	<u>Prepaid Residents Rent</u>	652,745	652,745	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,614,243	\$ 1,530,677	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,614,243	\$ 1,530,677	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,856,676	\$ 31,934,106	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,470,919	\$ 33,464,783	48

*(See instructions.)

Good Samaritan Home
0009258
09/30/02

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued United Way	48	48
Accrued Miscellaneous Payable Deduction	870	870
Employee Assist Fund Withheld	5,956	5,956
Benevolent Fund Payable	454	454
Flower Fund Payable	(1,575)	(1,575)
Ceramics Payable	1,550	1,550
Application Fee Payable	30,280	30,280
Medicare Liability	13,017	13,017
Medicaid Liability	8,768	8,768
F.W. Education Cost Payable	13,265	13,265
Total Line 36 - Other Current Liabilities(specify):	72,633	72,633

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 33,355,439	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 33,355,439	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,498,763)	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)	\$ (1,498,763)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,856,676	24 *

Operating Entity Only

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/01

Ending:

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09/30/02

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	\$ 8,262,307	1
2	Discounts and Allowances for all Levels	(674,522)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,587,785	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	611,599	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 611,599	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	33,240	12
13	Barber and Beauty Care	58,276	13
14	Non-Patient Meals	8,384	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	55,454	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,403	19
20	Radiology and X-Ray	825	20
21	Other Medical Services	36,690	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,272	23
D. Non-Operating Revenue			
24	Contributions	398,458	24
25	Interest and Other Investment Income***	(745,760)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (347,302)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attach Schedule 19E	20,728	28
28a	Cottage and Rental Property Income	1,151,017	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,171,745	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,237,099	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,487,770	31
32	Health Care	4,583,125	32
33	General Administration	2,075,050	33
B. Capital Expense			
34	Ownership	478,190	34
C. Ancillary Expense			
35	Special Cost Centers	1,014,272	35
36	Provider Participation Fee	97,455	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,735,862	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,498,763)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,498,763)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

Good Samaritan Home
0009258
09/30/02

Schedule 19E

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	647
Discount Earned Income	483
Guest Room Income	1,878
Van Transportation	8,895
Cottage Services Income	3,850
Application Fee Income	<u>4,975</u>
Total Line 28 - Other Revenue (specify):	<u><u>20,728</u></u>

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/01

Ending: 09/30/02

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	2,016	2,080	\$ 55,758	\$ 26.81	1
2	Assistant Director of Nursing	1,960	2,080	38,255	18.39	2
3	Registered Nurses	24,569	26,645	446,725	16.77	3
4	Licensed Practical Nurses	65,835	72,279	1,007,921	13.94	4
5	Nurse Aides & Orderlies	182,189	197,720	1,934,035	9.78	5
6	Nurse Aide Trainees	687	687	4,849	7.06	6
7	Licensed Therapist	5,792	6,131	137,601	22.44	7
8	Rehab/Therapy Aides	11,557	12,941	139,729	10.80	8
9	Activity Director	1,960	2,080	22,856	10.99	9
10	Activity Assistants	12,058	13,111	100,390	7.66	10
11	Social Service Workers	13,822	15,188	130,529	8.59	11
12	Dietician					12
13	Food Service Supervisor	7,610	8,404	114,389	13.61	13
14	Head Cook	6,858	7,333	68,558	9.35	14
15	Cook Helpers/Assistants	49,511	54,087	441,304	8.16	15
16	Dishwashers	10,744	11,843	94,629	7.99	16
17	Maintenance Workers	21,756	23,675	219,787	9.28	17
18	Housekeepers	26,625	29,513	248,344	8.41	18
19	Laundry	12,045	13,063	111,888	8.57	19
20	Administrator	1,900	2,080	88,184	42.40	20
21	Assistant Administrator	1,924	2,080	69,228	33.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,647	26,762	324,653	12.13	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	1,996	2,188	30,693	14.03	31
32	Other Health C: Sch 20A	11,509	12,901	122,190	9.47	32
33	Other(specify) Sch 20A	12,487	13,689	123,287	9.01	33
34	TOTAL (lines 1 - 33)	512,057	558,560	\$ 6,075,782 *	\$ 10.88	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	444	\$ 13,245	L 1 C3	35
36	Medical Director	Monthly	3,600	L 9 C3	36
37	Medical Records Consultant	Monthly	1,620	L 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	114	L 10a, C 3	43
44	Activity Consultant	46	3,137	L 11 C3	44
45	Social Service Consultant	19	1,110	L 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	511	\$ 32,870		49

C. CONTRACT NURSES

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

Good Samaritan Home
0009258
09/30/02

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Nursing Secretary	7,457	8,370	\$ 74,934	8.95
Medical Supply Clerk	2,107	2,344	20,918	8.92
Staff Coord.	1,945	2,187	26,338	12.04
Total Line 32 - Other	11,509	12,901	\$ 122,190	\$ 9.47

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Maintenance Cottages	5,439	5,919	\$ 54,947	9.28
Beauty Shop	4,617	5,105	49,199	9.64
General Store	2,431	2,665	19,141	7.18
Total Line 33 - Other	12,487	13,689	\$ 123,287	\$ 9.01

Good Samaritan Home
0009258
09/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	38,976
Out of period legal expenses	(185)
Development Cost for Cottages	(1,287)
Total (agree to Schedule V, line 19, column 8)	<u>37,504</u>

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Elevator Repairs	Jan 2001	\$ 6,737	3	\$	\$	\$ 1,123	\$ 2,246	\$ 2,246	\$ 1,122	\$	\$
2	Water Heater Repair	Dec 2000	1,311	3			218	437	437	219		
3	Kitchen Garbage Disp.	Apr 2001	4,498	3			750	1,499	1,499	750		
4												
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18												
19												
20	TOTALS		\$ 12,546		\$	\$	\$ 2,091	\$ 4,182	\$ 4,182	\$ 2,091	\$	\$

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/01Ending: 09/30/02

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. Life Services Network \$15,103 CHHS \$6,483
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8.68 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 75,377 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. N/A
- (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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 97,455
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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? Yes 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,384
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wade Stables P. C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	718,880	40,062	16,061	775,003	0	775,003	0	775,003
2. Food Purchase	0	606,891	0	606,891	0	606,891	-8,384	598,507
3. Housekeeping	248,344	35,491	20,546	304,381	0	304,381	-3,850	300,531
4. Laundry	111,888	0	17,118	129,006	0	129,006	0	129,006
5. Heat and Other Utilities	0	0	334,688	334,688	0	334,688	0	334,688
6. Maintenance	219,787	32,960	85,054	337,801	0	337,801	6,930	344,731
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,298,899	715,404	473,467	2,487,770	0	2,487,770	-5,304	2,482,466
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	3,768,790	223,755	27,538	4,020,083	0	4,020,083	0	4,020,083
10a. Therapy	137,601	7,665	132,600	277,866	0	277,866	0	277,866
11. Activities	123,246	1,573	12,212	137,031	0	137,031	0	137,031
12. Social Services	130,529	350	1,110	131,989	0	131,989	0	131,989
13. Nurse Aide Training	11,365	0	1,191	12,556	0	12,556	0	12,556
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,171,531	233,343	178,251	4,583,125	0	4,583,125	0	4,583,125
17. Administrative	157,412	0	0	157,412	0	157,412	0	157,412
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	38,976	38,976	0	38,976	-1,472	37,504
20. Fees, Subscriptions & Promotion	0	0	61,298	61,298	0	61,298	-556	60,742
21. Clerical & General Office	324,653	41,553	85,760	451,966	0	451,966	-56,344	395,622
22. Employee Benefits & Payroll	0	0	1,194,824	1,194,824	0	1,194,824	0	1,194,824
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	8,402	8,402	0	8,402	-2,409	5,993
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	162,172	162,172	0	162,172	0	162,172
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	482,065	41,553	1,551,432	2,075,050	0	2,075,050	-60,781	2,014,269
29. Total General Administrative	5,952,495	990,300	2,203,150	9,145,945	0	9,145,945	-66,085	9,079,860
30. Depreciation	0	0	478,190	478,190	0	478,190	-1,970	476,220
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	478,190	478,190	0	478,190	-1,970	476,220
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	45,018	0	45,018	0	45,018	0	45,018
40. Barber and Beauty Shop	49,199	3,538	334	53,071	0	53,071	0	53,071
41. Coffee and Gift Shops	19,141	30,240	0	49,381	0	49,381	0	49,381
42	0	0	97,455	97,455	0	97,455	0	97,455
43. Other (specify):*	54,947	0	811,855	866,802	0	866,802	-866,802	0
44. Total Special Cost Ce	123,287	78,796	909,644	1,111,727	0	1,111,727	-866,802	244,925
45. Grand Total	6,075,782	1,069,096	3,590,984	10,735,862	0	10,735,862	-934,857	9,801,005

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	179,431	179,431
2. Cash - Patient Deposits	27,492	27,492
3. Accounts & Notes Receivable	680,382	680,382
4. Supply Inventory	0	0
5. Short-Term Investments	998,864	998,864
6. Prepaid Insurance	100,560	100,560
7. Other Prepaid Expenses	1,307	10,205
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,988,036	1,996,934
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	21,746,512	21,746,512
13. Land	128,278	128,278
14. Buildings, at Historical Cost	10,722,455	10,471,743
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,502,245	2,508,944
17. Accumulated Depreciation (book methods)	-8,333,025	-8,110,319
18. Deferred Charges	0	6,273
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	386,697	386,697
23. other (specify):	4,329,721	4,329,721
24. Total Long-Term Assets	31,482,883	31,467,849
25. Total Assets	33,470,919	33,464,783
CURRENT LIABILITIES		
26. Accounts Payable	169,325	169,325
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	27,492	27,492
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	588,765	588,765
31. Accrued Taxes Payable	19,717	19,717
32. Accrued Real Estate Taxes	83,566	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	72,633	72,633
37. Other Current Liabilities (specify):	652,745	652,745
38. Total Current Liabilities	1,614,243	1,530,677
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	0
46. Total Liabilities	1,614,243	1,530,677
47. Total Equity	31,856,676	31,934,106
48. Total Liabilities and Equity	33,470,919	33,464,783

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,262,307
2. Discounts and Allowances for all Levels	-674,522
Subtotal - Inpatient Care	7,587,785
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	611,599
7. Oxygen	0
Subtotal - Ancillary Revenue	611,599
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	33,240
13. Barber and Beauty Care	58,276
14. Non-Patient Meals	8,384
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	55,454
18. Sale of Supplies to Non-Patients	0
19. Laboratory	20,403
20. Radiology and X-Ray	825
21. Other Medical Services	36,690
22. Laundry	0
Subtotal - Other Operating Revenue	213,272
24. Contributions	398,458
25. Interest and Other Investments Income	-745,760
Subtotal - Non-Operating Revenue	-347,302
27. Other Revenue (specify):	20,728
28. Other Revenue (specify):	1,151,017
Subtotal - Other Revenue	1,171,745
30. Total Revenue	9,237,099
31. General Services	2,595,831
32. Health Care	4,389,400
33. General Administration	1,827,969
34. Ownership	480,920
35. Special Cost Centers	939,597
35. Provider Participation Fee	97,455
37. Other	0
40. Total Expenses	10,331,172
41. Income Before Income Taxes	-1,094,073
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,094,073

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9 Line 16 for mortgage insurance.

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