

		FOR BHF USE				

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0007344

Facility Name: Carroll County Good Samaritan Center

Address: 1006 North Lowden, PO Box 8 Mount Carroll 61053
 Number City Zip Code

County: Carroll

Telephone Number: 815-224-7715 **Fax #** 815-224-3127

HFS ID Number: _____

Date of Initial License for Current Owners: 1/1/1970

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 1/1/2006 to 12/31/2006 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>Vice 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 Carroll County Good Samaritan Center

0007344 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,445	10,776	884	23,105	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,445	10,776	884	23,105	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.92%

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

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

Meals on Wheels

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 01/01/1970

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Noridian

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Carroll County Good Samaritan Center # 0007344 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	155,882	12,904	5,285	174,071		174,071	(253)	173,818		1
2	Food Purchase		126,829		126,829		126,829	(13,740)	113,089		2
3	Housekeeping	69,096	14,229		83,325		83,325	(272)	83,053		3
4	Laundry	41,718	11,618		53,336		53,336	(234)	53,102		4
5	Heat and Other Utilities			79,725	79,725		79,725		79,725		5
6	Maintenance	41,791	8,338	44,591	94,720		94,720	(2,552)	92,168		6
7	Other (specify):*			3,969	3,969		3,969	(13)	3,956		7
8	TOTAL General Services	308,487	173,918	133,570	615,975		615,975	(17,064)	598,911		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,097,747	89,438	2,638	1,189,823		1,189,823	(33,089)	1,156,734		10
10a	Therapy		1,243	93,771	95,014	(780)	94,234	(46,903)	47,331		10a
11	Activities	49,907	2,452	10,979	63,338		63,338	(4,032)	59,306		11
12	Social Services	27,773	84	3,177	31,034		31,034	(2)	31,032		12
13	CNA Training					780	780		780		13
14	Program Transportation			2,593	2,593		2,593		2,593		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,175,427	93,217	113,158	1,381,802		1,381,802	(84,026)	1,297,776		16
	C. General Administration										
17	Administrative	57,724		114,590	172,314		172,314	21,614	193,928		17
18	Directors Fees										18
19	Professional Services			6,233	6,233		6,233	(4,692)	1,541		19
20	Dues, Fees, Subscriptions & Promotions			14,580	14,580		14,580	(8,429)	6,151		20
21	Clerical & General Office Expenses	120,892	13,731	48,320	182,943		182,943	(10,896)	172,047		21
22	Employee Benefits & Payroll Taxes			379,906	379,906		379,906	(7,285)	372,621		22
23	Inservice Training & Education			7,758	7,758		7,758	(115)	7,643		23
24	Travel and Seminar			1,916	1,916		1,916	(856)	1,060		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			28,172	28,172		28,172	(4,257)	23,915		26
27	Other (specify):*										27
28	TOTAL General Administration	178,616	13,731	601,475	793,822		793,822	(14,916)	778,906		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,662,530	280,866	848,203	2,791,599		2,791,599	(116,006)	2,675,593		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 Carroll County Good Samaritan Center #0007344 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			161,610	161,610		161,610		161,610			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			455	455		455	(455)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,891	3,891		3,891		3,891			35
36	Other (specify):*											36
37	TOTAL Ownership			165,956	165,956		165,956	(455)	165,501			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			50	50		50	(50)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,285	39,285		39,285		39,285			42
43	Other (specify):*			2,602	2,602		2,602	(2,602)				43
44	TOTAL Special Cost Centers			41,937	41,937		41,937	(2,652)	39,285			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,662,530	280,866	1,056,096	2,999,492		2,999,492	(119,113)	2,880,379			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 Carroll County Good Samaritan Center

0007344

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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	(13,740)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,920)	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	(455)	32		10
11	Discounts, Allowances, Rebates & Refunds	2,009	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,275)	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	(8,429)	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	(92,375)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,185)		\$	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)			34
35	Other- Attach Schedule	10,072		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 10,072		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (119,113)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Carroll County Good Samaritan Center

ID# 0007344

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	ADMINISTRATION	\$ (216)	21	1
2	POSTAGE	(61)	21	2
3	TRANSPORTATION	(3,703)	6	3
4	RESIDENT SUPPLIES	(13)	7	4
5	INT INC PAST DUE ACCTS	(18)	21	5
6	ACTIVITY	(63)	11	6
7	BANK CHARGES	(57)	21	7
8	PROF SERVICES	(4,692)	19	8
9	PRESCR DRUGES	(31,800)	10	9
10	SUPPLIES MARKETING	(51)	21	10
11	TRAVEL REIMB MARKETING	(24)	24	11
12	STAFF DEVELOPMENT MARKETING	(115)	23	12
13	SPECIAL EVENTS	(63)	21	13
14	SUPPLIES RES DEV	(9)	21	14
15	PURCH SERVICE RADIOLOGY MEDICARE	(952)	43	15
16	THERAPY OFFSET	(46,834)	10A	16
17	PURCH SERV LAB	(1,650)	43	17
18	PURCH SERV CLINIC	(44)	10A	18
19	MED SUPPLIES PART B	(294)	10	19
20	BARBER AND BEAUTY	(50)	40	20
21	DISCOUNT ALLOWANCE ADMIN	(155)	21	21
22	DISCOUNT ALLOWANCE NURSING	(955)	10	22
23	DISCOUNT ALLOWANCE ACTIVITIES	(49)	11	23
24	DISCOUNT ALLOWANCE SOCIAL SERVICE	(2)	12	24
25	DISCOUNT ALLOWANCE LAUNDRY	(234)	4	25
26	DISCOUNT ALLOWANCE HSK	(272)	3	26
27	DISCOUNT ALLOWANCE DIETARY	(253)	1	27
28	DISCOUNT ALLOWANCE PLANT	(63)	6	28
29	DISCOUNT ALLOWANCE THERAPY	(25)	10A	29
30	OUT OF STATE TRAVEL	(832)	24	30
31	INOCULATIONS	-40	10	31
32				32
33	Deferred Maintainance Cost	1214	6	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	(92,375)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carroll County Good Samaritan Center

0007344

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	(253)	0	0	0	0	0	0	0	0	0	0	(253)	1
2	Food Purchase	(13,740)	0	0	0	0	0	0	0	0	0	0	(13,740)	2
3	Housekeeping	(272)	0	0	0	0	0	0	0	0	0	0	(272)	3
4	Laundry	(234)	0	0	0	0	0	0	0	0	0	0	(234)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,552)	0	0	0	0	0	0	0	0	0	0	(2,552)	6
7	Other (specify):*	(13)	0	0	0	0	0	0	0	0	0	0	(13)	7
8	TOTAL General Services	(17,064)	0	0	0	0	0	0	0	0	0	0	(17,064)	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	(33,089)	0	0	0	0	0	0	0	0	0	0	(33,089)	10
10a	Therapy	(46,903)	0	0	0	0	0	0	0	0	0	0	(46,903)	10a
11	Activities	(4,032)	0	0	0	0	0	0	0	0	0	0	(4,032)	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	(84,026)	0	0	0	0	0	0	0	0	0	0	(84,026)	16
	C. General Administration													
17	Administrative	0	21,614	0	0	0	0	0	0	0	0	0	21,614	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,692)	0	0	0	0	0	0	0	0	0	0	(4,692)	19
20	Fees, Subscriptions & Promotions	(8,429)	0	0	0	0	0	0	0	0	0	0	(8,429)	20
21	Clerical & General Office Expenses	(10,896)	0	0	0	0	0	0	0	0	0	0	(10,896)	21
22	Employee Benefits & Payroll Taxes	0	(7,285)	0	0	0	0	0	0	0	0	0	(7,285)	22
23	Inservice Training & Education	(115)	0	0	0	0	0	0	0	0	0	0	(115)	23
24	Travel and Seminar	(856)	0	0	0	0	0	0	0	0	0	0	(856)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(4,257)	0	0	0	0	0	0	0	0	0	(4,257)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,988)	10,072	0	(14,916)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(126,078)	10,072	0	(116,006)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carroll County Good Samaritan Center

0007344

Report Period Beginning:

1/1/2006 Ending:

12/31/2006

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(455)	0	0	0	0	0	0	0	0	0	0	(455)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(455)	0	0	0	0	0	0	0	0	0	0	(455)	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	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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):*	(2,602)	0	0	0	0	0	0	0	0	0	0	(2,602)	43
44	TOTAL Special Cost Centers	(2,652)	0	0	0	0	0	0	0	0	0	0	(2,652)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(129,185)	10,072	0	(119,113)	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	17 Admin/Accounting	\$ 114,590	The Evangelical Lutheran Good Samaritan Society	100.00%	\$ 136,204	\$ 21,614	1
2	V	22 Workers Comp	59,899			53,851	(6,048)	2
3	V	22 Unemploy Charges PD	720			(6)	(726)	3
4	V	26 Insurance	28,172			23,915	(4,257)	4
5	V	22 Group Health Ins	159,768			159,257	(511)	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		\$ 363,149			\$ 373,221	\$ * 10,072	14

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

Facility Name & ID Number Carroll County Good Samaritan Center # 0007344 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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 Carroll County Good Samaritan Center

0007344

Report Period Beginning: 1/1/2006

Ending: 2/31/2006

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	Annuities					5,000	5,000		(455)	10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$ 5,000	\$ 5,000		\$ (455)	14										
15	TOTALS (line 9+line14)					\$ 5,000	\$ 5,000		\$ (455)	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.)

IMPORTANT NOTICE

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

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

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carroll County Good Samaritan Center COUNTY Carroll

FACILITY IDPH LICENSE NUMBER 0007344

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 2005 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 2005.

(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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,795 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1968	\$ 5,720	1
2					2
3	TOTALS			\$ 5,720	3

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			1970	1970	\$ 418,766	\$ 10,469	40	\$ 10,469		\$ 386,486	4
5			1991	1991	912,127	36,035	varies	36,035		760,618	5
6											6
7											7
8											8
Improvement Type**											
9											9
10				1971	382	9	varies	9		338	10
11				1976	3,352		varies			3,352	11
12				1979	5,570					5,570	12
13				1980	1,419					1,419	13
14				1981	33,937					33,627	14
15				1982	29,188					29,188	15
16				1983	8,193					8,193	16
17				1984	1,224					1,224	17
18				1985	14,500					14,500	18
19				1986	11,402	9	varies	9		11,402	19
20				1987	15,273	543	varies	543		14,831	20
21				1988	14,405	674	varies	674		13,576	21
22				1989	5,233	180	varies	180		4,799	22
23				1990	24,930	26	varies	26		24,838	23
24				1992	10,950	517	varies	517		8,363	24
25				1993	2,434					2,434	25
26				1994	48,104	963	varies	963		42,717	26
27				1995	36,887	137	varies	137		36,472	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 Carroll County Good Samaritan Center

0007344

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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		\$	\$		\$	\$	\$	37
38	Air Conditioning	1996	98,766	6,584	15	6,584	72,429	38
39	Compressor/Contol Board	1996	2,028	135	15	135	1,487	39
40	Return Air Ducts	1996	1,030	52	15	52	545	40
41	Roof	1996	75,405	3,770	15	3,770	38,959	41
42	Installation of Annumciator PA	1997	7,151				7,151	42
43	Installation of New Ambulance	1997	1,925	128	15	128	1,165	43
44	Replace Roof	1997	11,920	596	20	596	5,413	44
45	Handrails	1998	5,049	338	15	338	2,973	45
46	Electric-Emergency Panel	1998	4,300	215	20	215	1,935	46
47	Wiring for Network	1998	6,096	304	20	304	2,515	47
48	Repair roof	1998	1,325	132	10	132	1,093	48
49	Steel Door	1999	2,284	153	15	153	1,205	49
50	Alarm System	1999	20,000	2,000	10	2,000	14,833	50
51	Alarm System	1999	8,080	404	20	404	2,862	51
52	Electric-Maint Storage Building	2000	2,100	105	20	105	735	52
53	Mantenacne Storage Building	2000	20,196	505	20	505	3,534	53
54	Water Heater	2000	3,500	350	10	350	2,362	54
55	Water Heater	2000	1,639	164	10	164	1,120	55
56	Piping and Wiring Dishwasher	2000	2,180	218	10	218	1,435	56
57	Painting for Kitchen	2000	2,128				2,126	57
58	Building Interior Renovations	2000	2,800	112	25	112	737	58
59	Paint Interior Renovations	2000	637				637	59
60	Wallpaper Interior Renovations	2000	15,388				15,389	60
61	Extension of Firewall	2000	3,985	199	20	199	1,245	61
62	Carpet Interior Renovations	2000	26,529				26,529	62
63	Oak Doors	2002	3,544	236	15	236	1,123	63
64	Wiring for Call Light	2002	663	66	10	66	276	64
65	Vertical Blinds	2002	510	102	5	102	425	65
66	Restroom Remodeling	2002	385	39	10	39	160	66
67	Window Replacement Resident RM	2002	28,542	1,904	15	1,904	7,928	67
68	Tile	2002	536	53	10	53	219	68
69	Commercial Door	2002	509	34	15	34	141	69
70	TOTAL (lines 4 thru 69)		\$ 1,959,406	\$ 68,460		\$ 68,460	\$ 1,624,633	70

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

Facility Name & ID Number Carroll County Good Samaritan Center

0007344

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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		\$ 1,959,406	\$ 68,460		\$ 68,460	\$	\$ 1,624,633	1
2	Open front Toilet Seat	2002	568	28	20	28		118	2
3	Water Heater	2002	3,840	384	10	384		1,536	3
4	Heater Covers	2002	9,000	900	10	900		3,825	4
5	300 Wing Shower Room Tile	2003	599	60	10	60		210	5
6	Boiler System Replacement	2003	49,162	2,458	20	2,458		8,399	6
7	Counter Top	2003	1,508	75	20	75		258	7
8	Tile for 300 Wing Shower Room	2003	537	54	10	54		188	8
9	Locks	2003	399	40	10	40		136	9
10	Outside Door For Kitchen	2003	1,326	88	15	88		273	10
11	Smoke Detectors	2004	1,650	165	10	165		412	11
12	Cabinets for Activity	2004	4,368	218	20	218		455	12
13	Window	2004	643	43	15	43		75	13
14	Exterior Door	2005	2,611	174	15	174		276	14
15	Heat/AC Unit	2005	2,975	298	10	298		368	15
16	AC Unit	2005	811	81	10	81		95	16
17	Blinds-Reesident Room Remodel	2005	656	131	5	131		142	17
18	Building Resident room Remodel	2005	75,207	3,008	25	3,008		3,259	18
19	Drapes Resident Room Re	2005	8,199	1,640	5	1,640		1,776	19
20	Wallpaper Resident Room Remodel	2005	17,523	3,505	5	3,505		3,797	20
21	Wood Blinds	2006	636	58	10	58		58	21
22	Fire Sprinkler System	2006	140,294	4,676	25	4,676		4,676	22
23	Emergency Generator	2006	203,450	6,782	20	6,782		6,782	23
24	Fire Caulk	2006	2,650	155	10	155		155	24
25	Wall and Door Protectors	2006	6,729	168	10	168		168	25
26	Heat Pump	2006	685	6	10	6		6	26
27	Building Addition/Remodel	2006	18,692	312	25	312		312	27
28	Emergency Generator	2006	5,925	206	12	206		206	28
29	Salaries/Benefits	2006	573	10	25	10		10	29
30									30
31	Generator								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,520,622	\$ 94,183		\$ 94,183	\$	\$ 1,662,604	34

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

Facility Name & ID Number Carroll County Good Samaritan Center

0007344

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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		\$ 2,520,622	\$ 94,183		\$ 94,183	\$	\$ 1,662,604	1
2	Land Improvements								2
3		1970	3,702		15			3,702	3
4		1975	1,986		15			1,986	4
5		1977	185		15			185	5
6		1979	466		15			466	6
7		1980	140		15			140	7
8		1986	3,061		10			3,061	8
9		1988	3,474		15			3,474	9
10		1989	1,419		10			1,419	10
11		1991	98,155	3,320	Varies	3,320		97,932	11
12		1993	2,560		10			2,560	12
13		1994	20,508	1,174	Varies	1,174		18,370	13
14	Seal cost Driveways and Parking	1997	3,050	153	20	153		1,449	14
15	Paving-Additional Parking Lot	1999	6,640	332	20	332		2,435	15
16	Lumber for Raised Garden	2000	330	33	10	33		218	16
17	Garden Bed	2000	1,650	110	15	110		715	17
18	Shrubs	2000	677	68	10	68		434	18
19	Driveway Repair	2000	4,455	445	10	445		2,821	19
20	Land scaping	2000	392	26	15	26		165	20
21	Repair sidewalk	2002	4,270	427	10	427		1,886	21
22	Gazebo	2003	4,006	200	20	200		751	22
23	Fencing	2003	732	73	10	73		262	23
24	Stripping/Repair Parking Lot	2004	5,865	1,173	5	1,173		2,932	24
25	Concrete work	2004	3,335	222	15	222		519	25
26	Shed	2005	398	40	10	40		73	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,692,078	\$ 101,979		\$ 101,979	\$	\$ 1,810,559	34

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

Facility Name & ID Number Carroll County Good Samaritan Center # 0007344 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	\$ 183,392	\$ 40,134	\$ 40,134	\$		\$ 266,302	71
72	Current Year Purchases	379,634	12,372	12,372			12,372	72
73	Fully Depreciated Assets	298,502	1,007	1,007			298,502	73
74								74
75	TOTALS	\$ 861,528	\$ 53,513	\$ 53,513	\$		\$ 577,176	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	Bus	2002	\$ 42,763	\$ 7,127	\$ 7,127	\$	6	\$ 34,449	76
77		1994 4x4 Truck	2004	3,500	875	875		4	2,042	77
78		Oldsmobile Silhouette 2002	2005	15,173	3,793	3,793		4	4,425	78
79										79
80	TOTALS			\$ 61,436	\$ 11,795	\$ 11,795	\$		\$ 40,916	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)	\$ 3,620,762	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,287	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 167,287	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,428,651	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 1,500	92
93			93
94			94
95		\$ 1,500	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,891 Description: Network Computer Equip-Admin Technicare Nursing

(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 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. <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 <u>80</u></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 <u>40</u></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)		520		520
4	Clinical Wages (b)		260		260
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 780	\$	\$ 780
10	SUM OF line 9, col. 1 and 2 (e)	\$	780		

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

- (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	Ln 10a Col 3	1436 hrs	\$ 27,495		\$		1,436	\$ 27,495	1
2	Licensed Speech and Language Development Therapist	Ln 10a Col 3	249 hrs	7,610				249	7,610	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a Col 3	3981 hrs	58,665				3,981	58,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 93,770		\$	\$	5,666	\$ 93,770	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.

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	\$ 105,161	\$	1
2	Cash-Patient Deposits	8,466		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	346,865		3
4	Supply Inventory (priced at)	16,364		4
5	Short-Term Investments	1,385,697		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,862,553	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	2,520,621		14
15	Leasehold Improvements, at Historical Cost	171,456		15
16	Equipment, at Historical Cost	922,964		16
17	Accumulated Depreciation (book methods)	(2,428,652)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	107,870		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Asset Man</u>	(8,036)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,291,943	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,154,496	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 53,475	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,806		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,845		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,793		31
32	Accrued Real Estate Taxes(Sch.IX-B)			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</u>	(363)		36
37	<u>Garnishments</u>	192		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 268,748	\$	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>Annuities</u>	5,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 273,748	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,880,749	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,154,497	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,868,570	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,868,570	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	85,283	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) <u>Dnr Rst Prop/ Oper Gft Cash</u>	105	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 85,388	17
B. Transfers (Itemize):			
18	<u>Cash Asset Assessment- Co</u>	(73,209)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (73,209)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,880,749	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Carroll County Good Samaritan Center# 0007344Report Period Beginning: 1/1/2006Ending: 12/31/2006**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	\$ 3,353,539	1
2	Discounts and Allowances for all Levels	(813,870)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,539,669	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	212,278	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 212,278	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	13,740	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	70,268	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,243	19
20	Radiology and X-Ray	848	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 94,099	23
D. Non-Operating Revenue			
24	Contributions	8,384	24
25	Interest and Other Investment Income***	160,106	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 168,490	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Nsg & Med Supplies</u>	64,418	28
28a	<u>Schedule Attached</u>	5,820	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 70,238	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,084,774	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	615,975	31
32	Health Care	1,381,800	32
33	General Administration	793,822	33
B. Capital Expense			
34	Ownership	165,956	34
C. Ancillary Expense			
35	Special Cost Centers	50	35
36	Provider Participation Fee	39,285	36
D. Other Expenses (specify):			
37	<u>Purchase Lab and Radiology</u>	2,600	37
38			38
39	<u>ROUNDING</u>	3	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,999,491	40
41	Income before Income Taxes (line 30 minus line 40)**	85,283	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 85,283	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 Carroll County Good Samaritan Center

0007344

Report Period Beginning: 1/1/2006

Ending:

12/31/2006

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	1,858	2,082	\$ 47,382	\$ 22.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,618	12,748	269,926	21.17	3
4	Licensed Practical Nurses	5,469	6,080	108,820	17.90	4
5	CNAs & Orderlies	46,391	50,318	470,423	9.35	5
6	CNA Trainees	9,017	9,728	70,951	7.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,659	4,258	51,126	12.01	8
9	Activity Director	1,806	1,945	22,389	11.51	9
10	Activity Assistants	3,668	3,913	26,869	6.87	10
11	Social Service Workers	1,835	2,023	27,717	13.70	11
12	Dietician	6	6	63	10.50	12
13	Food Service Supervisor	1,864	2,073	24,568	11.85	13
14	Head Cook	5,903	6,502	56,130	8.63	14
15	Cook Helpers/Assistants	8,569	9,386	73,629	7.84	15
16	Dishwashers					16
17	Maintenance Workers	4,822	5,320	47,971	9.02	17
18	Housekeepers	7,179	8,010	68,597	8.56	18
19	Laundry	4,469	4,968	41,893	8.43	19
20	Administrator	1,861	2,083	57,720	27.71	20
21	Assistant Administrator					21
22	Other Administrative	9,837	10,829	143,851	13.28	22
23	Office Manager	34	34	363	10.68	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,009	1,153	23,530	20.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>HIM</u>	1,662	1,878	26,103	13.90	33
34	TOTAL (lines 1 - 33)	132,536	145,337	\$ 1,660,021 *	\$ 11.42	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	96	\$ 5,373	Ln 1 Col 3	35
36	Medical Director	16	2,400	Ln 10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,425	Ln 10 Col 2	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	3,170	Ln 11 Col 3	44
45	Social Service Consultant	49	3,170	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	210	\$ 16,538		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 Carroll County Good Samaritan Center

0007344

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Dunk	Administrator	100	\$ 57,720	Workers' Compensation Insurance	\$ 53,851	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(6)	Advertising: Employee Recruitment	7,030	
				FICA Taxes	124,302	Health Care Worker Background Check		
				Employee Health Insurance	159,257	(Indicate # of checks performed)		
				Employee Meals		Public Relations	553	
				Illinois Municipal Retirement Fund (IMRF)*		Dues Reimbursable	4,689	
				Taxable gift	100	Publications	1,532	
				Staff Pension	32,198	Newsletter	779	
				Employee Recruitment Nursing	749			
				Admin Consultant Savings	2,169			
						Less Marketing Res Dev, Newsletter	(7,884)	
						Less: Public Relations Expense	(553)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 57,720				\$ 372,620			\$ 6,146	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Admin & Accounting Services			\$ 114,590			\$	Out-of-State Travel	\$ 832
							In-State Travel	769
							Seminar Expense	315
							LESS RESOURCE DEV TRAVEL	(24)
							LESS OUT OF STATE TRAVEL	
							Entertainment Expense	(832)
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 114,590				\$			\$ 1,060	
C. Professional Services								
Vendor/Payee	Type		Amount					
National Campus MDCR	Medicare Cost Report Prp		\$ 600					
National Campus MDCD	Medicaid Cost Report Prp		900					
Elvidge Kelly	Legal		4,693					
National Campus	ARC Bar		40					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 6,233								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Carroll County Good Samaritan Center

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	HEATING	1/02	\$ 1,738	10	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174
2	HEATING	4/02	1,288	10	129	129	129	129	129	129	129	129	129
3	HEATING	1/01	219	10	22	22	22	22	22	22	22	22	
4	PLUMBING	2/01	910	10	91	91	91	91	91	91	91	91	
5	WALLPAPER	7/01	230	5	61	61	61	23					
6	PAINT	8/01	390	5	102	102	102	49					
7	AIR CONDITIONING	9/01	511	10	51	51	51	51	51	51	51	51	51
8	AIR CONDITIONING	10/01	1,841	10	184	184	184	184	184	184	184	184	184
9	AIR CONDITIONING	2/01	901	10	90	90	90	90	90	90	90	90	90
10	PLUMBING	4/01	87	10	9	9	9	9	9	9	9	9	9
11	PLUMBING	4/01	5,879	10	58	58	58	58	58	58	58	58	58
12	HEATING	5/01	152	10	15	15	15	15	15	15	15	15	15
13	PLUMBING	8/01	1,402	10	140	140	140	140	140	140	140	140	140
14	PLUMBING	1/03	1,787	10	179	179	179	179	178	178	178	178	178
15													
16													
17													
18													
19													
20	TOTALS		\$ 17,335		\$ 1,305	\$ 1,305	\$ 1,305	\$ 1,214	\$ 1,141	\$ 1,141	\$ 1,141	\$ 1,141	\$ 1,028

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?
If YES, give association name and amount. LIFE SERVICE NETWORK
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7.5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,913 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 NO NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 39,285
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 13,740
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 19%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Henry Scholten & company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, 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.