

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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 N/A

	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	97	Sheltered Care (SC)	97	35,405	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	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	1,304	1,492	4,089	6,885	8
9	SNF/PED					9
10	ICF	18,934	57,915		76,849	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,238	59,407	4,089	83,734	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.42%

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

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

Outpatient Therapy - 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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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 17 and days of care provided 4,089

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 09/30/2006 Fiscal Year: 09/30/2006

* All facilities other than governmental must report on the accrual basi

STATE OF ILLINOIS

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Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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
1	A. General Services										
1	Dietary	857,460	51,055	20,184	928,699		928,699		928,699		1
2	Food Purchase		686,760		686,760		686,760	(21,407)	665,353		2
3	Housekeeping	242,389	43,622	27,525	313,536		313,536	(3,925)	309,611		3
4	Laundry	138,878		18,107	156,985		156,985		156,985		4
5	Heat and Other Utilities			377,872	377,872		377,872		377,872		5
6	Maintenance	267,274	49,681	152,735	469,690		469,690		469,690		6
7	Other (specify):*										7
8	TOTAL General Services	1,506,001	831,118	596,423	2,933,542		2,933,542	(25,332)	2,908,210		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	4,515,982	241,900	27,329	4,785,211		4,785,211		4,785,211		10
10a	Therapy		3,871	658,233	662,104		662,104		662,104		10a
11	Activities	156,027	3,360	11,040	170,427		170,427		170,427		11
12	Social Services	138,658	1,462	574	140,694		140,694		140,694		12
13	CNA Training	15,022		5,237	20,259		20,259		20,259		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,825,689	250,593	706,013	5,782,295		5,782,295		5,782,295		16
	C. General Administration										
17	Administrative	184,915			184,915		184,915		184,915		17
18	Directors Fees										18
19	Professional Services			38,088	38,088		38,088	(4,910)	33,178		19
20	Dues, Fees, Subscriptions & Promotion			42,377	42,377		42,377	(749)	41,628		20
21	Clerical & General Office Expense	421,908	61,319	103,570	586,797		586,797	(41,484)	545,313		21
22	Employee Benefits & Payroll Tax			1,491,565	1,491,565		1,491,565		1,491,565		22
23	Inservice Training & Education			559	559		559		559		23
24	Travel and Seminars			18,410	18,410		18,410	510	18,920		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			178,756	178,756		178,756		178,756		26
27	Other (specify):*										27
28	TOTAL General Administration	606,823	61,319	1,873,325	2,541,467		2,541,467	(46,633)	2,494,834		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,938,513	1,143,030	3,175,761	11,257,304		11,257,304	(71,965)	11,185,339		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.

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

Facility Name & ID Number Good Samaritan Home

#0009258

Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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			468,364	468,364		468,364	(11,926)	456,438			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle:											35
36	Other (specify): ³											36
37	TOTAL Ownership			468,364	468,364		468,364	(11,926)	456,438			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		99,967		99,967		99,967		99,967			39
40	Barber and Beauty Shops	60,030	3,632		63,662		63,662		63,662			40
41	Coffee and Gift Shop:	21,731	32,972	129	54,832		54,832		54,832			41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify): ³ Nonallowable Cost	66,818		801,043	867,861		867,861	(867,861)				43
44	TOTAL Special Cost Centers	148,579	136,571	898,627	1,183,777		1,183,777	(867,861)	315,916			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,087,092	1,279,601	4,542,752	12,909,445		12,909,445	(951,752)	11,957,693			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: 10/01/2005

Ending: 09/30/2006

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 Program				3
4	Non-Patient Meals	(21,407)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciator	(8,708)	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax	(2,018)	43		13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insuranc				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(27,977)	43		24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(891,642)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (951,752)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (951,752)		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 Shop:		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

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Schedule

Schedule 5A

VI. ADJUSTMENT DETAIL

NON-ALLOWABLE EXPENSES

LINE 29 - Other

<u>Description</u>	<u>Amount</u>	<u>Schedule V Reference</u>
Out of period legal fees	(350)	19
To disallow Rotary Club and Chamber of Commerce Dues	(749)	20
To disallow non-allowable Illinois Department of Public Aid Settlement	(1,950)	21
To disallow White Children Education Trust Donation	(1,000)	21
To disallow radio station expense	(1,107)	43
To disallow X-Ray expense	(2,731)	43
To disallow Lab expense	(8,214)	43
To disallow investment consultants	(263,949)	43
To disallow out of period seminar cost	(1,711)	24
To disallow out of state over fifty miles seminar cost	(1,197)	24
To record last year out of period cost for seminars that related to this y	3,418	24
To offset guest room income	(3,218)	30
To disallow cottage service income	(3,925)	3
To offset miscellaneous income	(1,033)	21
To offset discount earned income	(564)	21
To disallow Property Taxes	(34,371)	43
To disallow rental property expenses	(8,707)	43
To disallow radio station depreciation	(25)	43
To disallow cottage expenses	(518,762)	43
To disallow Development Cost for Cottages	(4,560)	19
To disallow Public Relation Wages	(36,937)	21
Total	(891,642)	

5A

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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:

10/01/2005

Ending:

09/30/2006

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(21,407)	0	0	0	0	0	0	0	0	0	0	(21,407)	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	(21,407)	0	0	0	0	0	0	0	0	0	0	(21,407)	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	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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,407)	0	0	0	0	0	0	0	0	0	0	(21,407)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2005 Ending:09/30/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(8,708)	0	0	0	0	0	0	0	0	0	0	(8,708) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	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	(8,708)	0	0	0	0	0	0	0	0	0	0	(8,708) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(29,995)	0	0	0	0	0	0	0	0	0	0	(29,995) 43
44	TOTAL Special Cost Centers	(29,995)	0	0	0	0	0	0	0	0	0	0	(29,995) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(60,110)	0	0	0	0	0	0	0	0	0	0	(60,110) 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
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							3
4	V							4
5	V			N/A				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 V1

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	N/A										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: 10/01/2005 Ending: 9/30/2006

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

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5	N/A								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 (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2005 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2005	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	8	
	2002	9	
	2003	10	
	2004	11	
	2005	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filec

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning:

10/01/2005 Ending:

09/30/2006

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, CNA training facilities, et

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/ANature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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	<u>1,219,680</u>		<u>\$ 128,278</u>	<u>3</u>

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2005 Ending: 09/30/2006

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		
Bed(s)*	FOR BHF 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		40			683,823	5
6	99		1973	1,683,761	42,094	40	42,094		1,384,205	6
7	75		1984	1,953,541	48,839	40	48,839		1,102,940	7
8										8
Improvement Type**										
9	Building Improvements		1974	89,670		30			89,670	9
10	Building Improvements		1975							10
11	Building Improvements		1976	9,414		20			9,414	11
12	Building Improvements		1977	3,107		20			3,107	12
13	Building Service Equipment		1978	5,714		15			5,714	13
14	Building Service Equipment		1979	9,188		Various			9,188	14
15	Building Service Equipment		1980	324		Various			324	15
16	Building Improvements		1982	151,081	4,556	Various	4,556		126,399	16
17	Building Service Equipment		1982	17,350		Various			17,350	17
18	Building Service Equipment		1983	10,058		20			10,058	18
19	Land Improvements		1984	49,187		15			49,187	19
20	Building Service Equipment		1984	459,501	425	Various	425		456,349	20
21	Land Improvements		1985	2,601		20			2,601	21
22	Building Improvements		1985	250,935	6,273	40	6,273		133,416	22
23	Building Service Equipment		1985	179,735		Various			179,735	23
24	Land Improvements		1986	72,453	1,999	20	1,999		72,453	24
25	Building Improvements		1986	161,531	4,038	40	4,038		81,674	25
26	Building Service Equipment		1986	137,391	4,998	Various	4,998		125,293	26
27	Building Improvements		1987	19,089	500	Various	500		9,466	27
28	Building Service Equipment		1987	21,221	1,061	20	1,061		20,509	28
29	Building Service Equipment		1988	14,400	42	Various	42		14,117	29
30	Building Improvements		1989	174,123	4,421	Various	4,421		121,609	30
31	Building Service Equipment		1989	6,469		Various			6,469	31
32	Garage Additions		1990	78,563	2,619	30	2,619		43,646	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2005 Ending: 09/30/2006

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		
37	New Roof - North Wing	1990	\$ 43,980	\$ 2,199	20	\$ 2,199		\$ 36,100	37
38	Phones	1990	600		10			600	38
39	Hall Renovations	1991	20,616	1,031	20	1,031		16,063	39
40	Building Improvements State Audit Adjustments 10881+30372	1991	511,992	18,441	30	17,066	(1,375)	261,626	40
41	Ceiling/partitions	1991	37,276	1,243	30	1,243		19,053	41
42	Office Entrance	1991	14,768	738	20	738		11,814	42
43	Building Services Equipment State Aduit Adjustment of 359	1991	83,893	221	various	219	(2)	83,893	43
44	Parking Lot	1992	4,257	213	20	213		2,767	44
45	Building Services Equipment	1992	2,706		10			2,706	45
46	Parking Lot	1992	46,071	2,303	20	2,303		31,290	46
47	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		103,471	47
48	Building Services Equipment	1993	20,910	238	various	238		18,078	48
49	Parking Lot	1994	87,827	5,855	15	5,855		74,653	49
50	Manhole/Sewer	1994	2,859	191	15	191		2,415	50
51	Sidewalk	1994	7,875	525	15	525		6,344	51
52	West Nursing	1994	66,876	3,344	20	3,344		40,126	52
53	Dining Room	1994	6,990	315	various	315		4,783	53
54	Building Services Equipment	1994	134,323	2,791	various	2,791		114,091	54
55	West Nursing	1995	128,327	6,416	20	6,416		74,323	55
56	West Nursing	1995	3,151	158	20	158		1,654	56
57	Building Services Equipment	1995	22,482	812	various	812		19,707	57
58	Gas Line	1996	3,062	153	20	153		1,607	58
59	Gutters	1996	10,817	541	20	541		5,679	59
60	Eber Wing Improvement:	1996	20,335	1,017	20	1,017		10,676	60
61	Roof	1996	9,016	451	20	451		4,734	61
62	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		35,105	62
63	Building Services Equipment	1996	46,663	2,539	various	2,539		30,567	63
64	Lights/Front Land Improvement:	1997	5,360	357	15	357		3,484	64
65	Walls/Floor - Anna Brown Win;	1997	41,780	2,089	20	2,089		19,846	65
66	Freezer Floor	1997	4,394	258	17	258		2,585	66
67	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		11,065	67
68	Sprinkling System	1997	3,354	335	10	335		2,851	68
69	Tamper Detectors	1997	2,818	282	10	282		2,395	69
70	TOTAL (lines 4 thru 69)		\$ 8,427,869	\$ 189,471		\$ 188,094	\$ (1,377)	\$ 6,173,176	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:

10/01/2005 Ending: 09/30/2006

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	\$ 8,427,869	\$ 189,471		\$ 188,094	\$ (1,377)	\$ 6,173,176		1
2	Compressor - Eber	1997 2,039	136	15	136		1,268		2
3	Compressor - East	1997 11,808	787	15	787		7,282		3
4	Sprinkler System	1997 102,875	5,144	20	5,144		46,722		4
5	Air Exchange -Pool Area State Audit adjustment 48t	1997 8,092	571	15	539	(32)	4,986		5
6	Roof- Kitchen/Dinning	1998 45,550	1,168	39	1,168		10,216		6
7	Elevator Doors Dietary	1998 1,095	110	10	110		931		7
8	Remodeling -Anna Brow Wing Walls, Ceiling, Floors,Light	1999 199,131	4,978	39	4,978		35,885		8
9	Remodeling -Anna Brow Wing - Duct Detector:	1999 1,444		5			1,444		9
10	Remodeling -Anna Brow Wing - Carpeting	1999 2,966	297	10	297		2,224		10
11	Remodeling -Anna Brow Wing - Fire Damp	1999 21,915	548	39	548		4,041		11
12	Chapel Roof	1999 21,515	538	39	538		4,236		12
13	Fire Damper Alarm	1999 5,490		5			5,490		13
14	Eber Parking Lot Lights	1999 5,495	366	15	366		2,747		14
15	Stainless Steel D/W Exhaust	1999 1,659	166	10	166		1,244		15
16	Wiring Chapel Roof	1999 332	33	10	33		249		16
17	HVAC Chapel	1999 23,760	1,584	15	1,584		11,880		17
18	Code Alert System	1999 61,985		5			61,985		18
19	Elevator Upgrade A/B East	1999 22,556	2,256	10	2,256		16,917		19
20	Elevator Upgrade - Special Car	1999 5,970	597	10	597		4,478		20
21	Fire Protection A/B	1999 4,500	450	10	450		3,375		21
22	Condensor Unit	1999 22,945	1,530	15	1,530		11,473		22
23	Fire Protection Pool Area	1999 776	78	10	78		582		23
24	Damper Duct Work	1999 5,602	374	15	374		2,801		24
25	Lighting- Special Care	1999 2,075	138	15	138		1,038		25
26	Chapel Remodeling - Fire Damper	2000 3,196	213	15	213		1,385		26
27	Chapel Remodeling - Sign	2000 77		5			77		27
28	Chapel Remodeling - Painting	2000 4,751	119	39	119		718		28
29	Chapel Remodeling - Carpeting	2000 3,073	205	15	205		1,332		29
30	Chapel Remodeling - Unify & Pews	2000 14,760	369	39	369		2,229		30
31	Kitchen Remodeling - Hood Move to Equip per State Audit	2000							31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 9,035,301	\$ 212,226		\$ 210,817	\$ (1,409)	\$ 6,422,411		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:

10/01/2005 Ending: 09/30/2006

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	\$ 9,035,301	\$ 212,226		\$ 210,817	\$ (1,409)	\$ 6,422,411		1
2	Kitchen Remodeling - Sky Roof Flashing	2000 3,086	206	15	206		1,337		2
3	Kitchen Remodeling - Sidewalls	2000 3,485	232	15	232		1,510		3
4	Kitchen Remodeling - Galvanized Wall Divide	2000 2,601	173	15	173		1,127		4
5	East Nursing Remodeling - Walls, Ceilings, Floors	2000 26,757	669	39	669		4,209		5
6	Eber Wing Smoke Damper	2000 16,485	1,099	15	1,099		7,144		6
7	Special Care Lighting	2000 14,290	953	15	953		6,192		7
8	HVAC Rehab Eber Wing	2000 305,419	20,361	15	20,361		132,348		8
9	Groundkeeper move to Equipment per state audi	2000							9
10	3 Ton Rooftop Unit A/C West Dining	2000 2,776	185	15	185		1,203		10
11	Telephone Unit	2000 323	46	7	46		300		11
12	Elevator Up Grade East Wing	2000 12,776	852	15	852		5,536		12
13	Superior Boiler Burner Up Grade	2000 1,101	73	15	73		477		13
14	Entrance Codelock Special Car	2000 1,848	123	15	123		801		14
15	Life Safety Code Sprinkler Drain	2000 7,000	467	15	467		3,033		15
16	Land Improvement New Sidewall	2000 1,200	60	20	60		330		16
17	Renovation of East nursing Wing	2001 369,213	9,230	39	9,230		48,075		17
18	Exterior Painting	2001 14,347	956	15	956		5,261		18
19	Painting Kitchen	2001 2,550	170	15	170		935		19
20	Chapel Renovation	2000 2,001	50	39	50		294		20
21	Kitchen Electrical Work	2000 611	41	15	41		224		21
22	HVAC Rehab Eber Wing	2000 5,584	372	15	372		2,047		22
23	Sprinklers	2000 4,151	277	15	277		1,522		23
24	Wet Chemical Fire Suppressor Work	2000 3,695	246	15	246		1,355		24
25	Electrical Work	2001 1,609	107	15	107		590		25
26	Smoke/ Fire Damper East, South and Eber	2001 50,735	3,382	15	3,382		18,603		26
27	Air Compressor Anna Brown Wing	2001 10,911	727	15	727		4,001		27
28	3D Detectors in Elevators	2001 4,916	344	10	344		1,875		28
29	Exhaust fan move to Equipment per state audi	2001							29
30	Compensators	2001 2,724	191	10	191		1,039		30
31	33 Lever Passage Locks	2002 2,904	203	10	203		1,108		31
32	Exit Lights and Hold Opens	2002 966	68	10	68		368		32
33	16 Lever Passage Locks	2002 1,408	99	10	99		537		33
34	TOTAL (lines 1 thru 33)	\$ 9,912,773	\$ 254,188		\$ 252,779	\$ (1,409)	\$ 6,675,792		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:

10/01/2005 Ending: 09/30/2006

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 12C, Carried Forward	\$ 9,912,773	\$ 254,188		\$ 252,779	\$ (1,409)	\$ 6,675,792		1
2	48 Lockouts	985	69	10	69		376		2
3	Water Piping	4,600	115	39	115		561		3
4	New Curb & Driveway	16,118	673	20	673		3,335		4
5	Buffet in Dining Area	2,977	198	15	198		730		5
6	Door - code alert and keypad	2,489	249	10	249		913		6
7	Fire Collars	3,619	362	10	362		1,310		7
8	Kitchen Exhaust Fans move to Equipment per state audi								8
9	Main Breaker	3,291	219	15	219		676		9
10	Elevator Master Door Operato	4,278	428	10	428		1,462		10
11	Training Room Drainage	731	19	39	19		66		11
12	Dietary - Floor Drain	223	6	39	6		20		12
13	Handicap Accessible Entrance and Sidewall	3,200	160	20	160		480		13
14	Annunciators	51,494	5,149	10	5,149		12,873		14
15	Sewer Lines	5,801	387	15	387		1,128		15
16	Smoke Damper - Eber	698	47	15	47		132		16
17	Beauty Shop Wiring	2,272	151	15	151		417		17
18	Dietary Doors	3,801	253	15	253		676		18
19	Roof	4,028	269	15	269		671		19
20	Remote Annunciator	4,650	465	10	465		1,085		20
21	Cooler Expansion	6,120	408	15	408		952		21
22	Parking Lot	6,800	453	15	453		1,020		22
23	Ambulance Garage Door	1,070	107	10	107		232		23
24	Kitchen Remodel	6,425	643	10	643		1,285		24
25	Motor for Laundry Washer move to Equip per state audi								25
26	Plumbing wok in Eber/South	5,147	343	15	343		629		26
27	Water Softener System	15,642	1,564	10	1,564		2,737		27
28	Storage Tank Replacemen	2,454	245	10	245		429		28
29	Air Handler in East Circle	1,297	130	10	130		184		29
30	Parking Lot Off-Street	68,884	4,592	15	4,592		6,123		30
31	Kitchen Electrical Worl	247	12	20	12		25		31
32	Kitchen Remodel	1,248	62	20	62		120		32
33	Sprinkler System	980	49	20	49		90		33
34	TOTAL (lines 1 thru 33)	\$ 10,144,342	\$ 272,015		\$ 270,606	\$ (1,409)	\$ 6,716,529		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:

10/01/2005 Ending: 09/30/2006

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 12D, Carried Forward		\$ 10,144,342	\$ 272,015		\$ 270,606	\$ (1,409)	\$ 6,716,529	1
2	Exhaust Fan for Dishwasher move to equip per state audi	2004							2
3	Sprinkler System	2005	2,373	119	20	119		198	3
4	Tunnel Closure	2005	1,888	126	15	126		210	4
5	Perry Suite Renovations	2005	2,470	165	15	165		261	5
6	Water Heater	2006	13,003	626	10	626		626	6
7	Telephone System	2006	65,476	2,505	various	2,505		2,505	7
8	Sprinkler System Pipes	2006	1,645	24	various	24		24	8
9	Overhead Door	2005	1,400	128	10	128		128	9
10	Concrete Work	2005	9,936	552	15	552		552	10
11	Fire Walls	2006	14,948	249	20	249		249	11
12	Fire Alarm System	2006	23,500	1,044	15	1,044		1,044	12
13	Life Safety Code Renovations	2006	1,905	111	10	111		111	13
14	Renovations to Building	2006	38,611	644	20	644		644	14
15	Telephone System Wiring	2006	35,781	317	10	317		317	15
16	Pool Area Renovations	2006	98,370	2,049	20	2,049		2,049	16
17	Concrete Work	2006	3,850	107	15	107		107	17
18	Lighting in the Hallway	2006	7,872	98	20	98		98	18
19	Laundry Renovations- Air Systen	2006	9,841	123	20	123		123	19
20	Smoke/Fire Dampers Special Care Are:	2006	14,683	184	20	184		184	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Guest Room Income Offset					(3,218)	(3,218)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,491,894	\$ 281,186		\$ 276,559	\$ (4,627)	\$ 6,725,959	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: 10/01/2005 Ending: 09/30/2006
 XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 1,256,400	\$ 145,001	\$ 145,670	\$ 669	3-20 yrs	\$ 603,010	71
72	Current Year Purchases	101,633	4,323	4,323		5-10 yrs	4,323	72
73	Fully Depreciated Assets	916,571				3-20 yrs	916,571	73
74								74
75	TOTALS	\$ 2,274,604	\$ 149,324	\$ 149,993	\$ 669		\$ 1,523,904	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	\$ 74,241	\$	\$	\$	3-5 yrs	\$ 74,241	76
77	Maintenance	Various	Various	43,395				5 yrs	43,395	77
78	Maintenance	Various	Various	1,219				3 yrs	1,219	78
79	See Attach Sch 13A	Various	Various	152,875	29,886	29,886		5 yrs	63,863	79
80	TOTALS			\$ 271,730	\$ 29,886	\$ 29,886	\$		\$ 182,718	80

E. Summary of Care-Related Asset

	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)	\$ 13,166,506	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 460,396	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 456,438	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,958)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,432,581	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	\$ 207,379	\$	\$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,238,037	223,358	4,979,412	88
89	Rental Property Fixed Assets	233,780	8,707	64,290	89
90	Radio Station	14,161	25	14,115	90
91	TOTALS	\$ 8,769,087	\$ 232,090	\$ 5,057,817	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	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 1

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	
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	\$ 116	\$ 116	\$ 0	5 yrs	\$ 594	42
43	Maintenance	Chevy S-10 98	2002	7,508	1,051	1,051	0	5 yrs	5,406	43
44	Facility	Toro mower	2003	7,139	1,428	1,428	0	5 yrs	4,997	44
44a	Facility	Ford/Goshen Bus (2)	2004	98,532	19,706	19,706	0	5 yrs	44,339	44a
44b	Facility	Lift for Van	2005	1,500	300	300	0	5 yrs	425	44b
44c	Facility	Toto mower	2005	9,792	1,958	1,958	0	5 yrs	2,775	44c
44d	Facility	2005 Chrysler Town	2005	21,931	4,386	4,386	0	5 yrs	4,386	44d
45	Facility	1999 Chevy Van	2005	5,648	941	941	0	5 yrs	941	45
46	TOTALS			\$ 152,875	\$ 29,886	\$ 29,886	\$ 0		\$ 63,863	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions	<u>N/A</u>						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 \$ N/A
 13. /2008 \$ N/A
 14. /2009 \$ N/A

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

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 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. 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 CNA <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 CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$ 1,824	\$	\$ 1,824
2	Books and Supplies		129		2,573
3	Classroom Wages (a)		5,094		5,094
4	Clinical Wages (b)		2,546		2,546
5	In-House Trainer Wage (c)		7,382		7,382
6	Transportation				
7	Contractual Payments:		140		140
8	CNA Competency Tests		700		700
9	TOTALS	\$ 129	\$ 20,130	\$	\$ 20,259
10	SUM OF line 9, col. 1 and 2 (e)	\$ 20,259			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	15

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L. 10a C 3	hrs	\$	2,275	\$	204,718	\$	220	2,275	\$	204,938	1	
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		959		86,296			959		86,296	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	L. 10a C 2,3	hrs		4,080		367,219		3,651	4,080		370,870	4	
5	Physician Care		visits										5	
6	Dental Care	L.10 C 2, 3	visits		12		2,400		691	12		3,091	6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	L 39 C 2	# of prescripts						99,967			99,967	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			\$	7,326	\$	660,633	\$	104,529	7,326	\$	765,162	14	

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

Good Samaritan Home
Provider #: 0009258
10/01/2005 to 09/30/2006

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	-----------------------	---------------------------------	-------------	-----------------

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/2005

Ending:

09/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2006

(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	\$ 101,825	\$ 101,825	1
2	Cash-Patient Deposits	20,246	20,246	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,615,652	1,615,652	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	1,754,698	1,754,698	5
6	Prepaid Insurance	150,128	150,128	6
7	Other Prepaid Expenses	1,340	1,340	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Application Fee Repurchase</u>	29,822	29,822	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,673,711	\$ 3,673,711	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	28,624,497	28,624,497	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,790,435	10,491,894	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,539,635	2,546,334	16
17	Accumulated Depreciation (book methods)	(8,704,134)	(8,432,581)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Cottage & Rental Property</u>	3,711,270	3,711,270	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 37,089,981	\$ 37,069,692	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 40,763,692	\$ 40,743,403	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 262,003	\$ 262,003	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,246	20,246	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	410,319	410,319	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,527		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>	58,600	58,600	36
37	<u>Prepaid Residents Rent</u>	720,162	720,162	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,496,857	\$ 1,471,330	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)	\$ 1,496,857	\$ 1,471,330	46
47	TOTAL EQUITY(page 18, line 24)	\$ 39,266,835	\$ 39,272,073	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 40,763,692	\$ 40,743,403	48

*(See instructions.)

Good Samaritan Home
0009258
09/30/2006

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Miscellaneous Employee Deductions	5,496	5,496
Employee Assist Fund Withheld	7,690	7,690
Benevolent Fund Payable	5,897	5,897
Flower Fund Payable	(1,403)	(1,403)
Application Fee Payable	27,880	27,880
Medicare Liability	13,017	13,017
Medicaid Liability	23	23
Employee Health/Life Liability		
Total Line 36 - Other Current Liabilities(specify):	58,600	58,600

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 38,429,664	1
2	Restatements (describe):		2
3	Audit Adjust for Market Value on Securities	1,262	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 38,430,926	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	835,909	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)	\$ 835,909	17
B. Transfers (Itemize):			
18	Round		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)	\$ 39,266,835	24 *

Operating Entity Only

* This must agree with page 17, line 47.

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2005Ending: 09/30/2006**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 expenses.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,049,008	1
2	Discounts and Allowances for all Level	(1,227,535)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,821,473	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,081,889	6
7	Oxygen	6,008	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,087,897	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	38,311	12
13	Barber and Beauty Care	54,651	13
14	Non-Patient Meals	21,407	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	196,652	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	16,232	19
20	Radiology and X-Ray	5,244	20
21	Other Medical Services	117,774	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 450,271	23
D. Non-Operating Revenue			
24	Contributions	38,348	24
25	Interest and Other Investment Income**	2,008,258	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,046,606	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attach Schedule 19E	42,850	28
28a	Cottage and Rental Property Income	1,296,257	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,339,107	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,745,354	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,933,542	31
32	Health Care	5,782,295	32
33	General Administrator	2,541,467	33
B. Capital Expense			
34	Ownership	468,364	34
C. Ancillary Expense			
35	Special Cost Centers	1,086,322	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)*	\$ 12,909,445	40
41	Income before Income Taxes (line 30 minus line 40)**	835,909	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 835,909	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
09/30/2006

Schedule 19E

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	839
Discount Earned Income	564
Adjustments	194
Guest Room Income	3,218
Van Transportation	31,960
Cottage Services Income	3,925
Application Fee Income	<u>2,150</u>
Total Line 28 - Other Revenue (specify):	<u><u>42,850</u></u>

Facility Name & ID Number **Good Samaritan Home**

0009258

Report Period Beginning: **10/01/2005**

Ending:

09/30/2006

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	1,917	2,121	\$ 74,458	\$ 35.11	1
2	Assistant Director of Nursing	1,923	2,095	54,526	26.03	2
3	Registered Nurses	17,945	19,604	395,380	20.17	3
4	Licensed Practical Nurses	76,895	84,044	1,309,212	15.58	4
5	CNAs & Orderlies	206,823	225,521	2,314,782	10.26	5
6	CNA Trainees	1,099	1,099	7,640	6.95	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,326	15,092	168,275	11.15	8
9	Activity Director	1,975	2,080	29,189	14.03	9
10	Activity Assistants	12,777	14,128	126,838	8.98	10
11	Social Service Worker	13,007	14,299	138,658	9.70	11
12	Dietician					12
13	Food Service Supervisor	6,605	7,342	114,654	15.62	13
14	Head Cook	7,275	8,044	96,092	11.95	14
15	Cook Helpers/Assistants	59,871	64,845	569,949	8.79	15
16	Dishwashers	7,641	8,485	76,765	9.05	16
17	Maintenance Worker	23,778	25,968	267,274	10.29	17
18	Housekeepers	24,727	27,190	242,389	8.91	18
19	Laundry	13,403	14,805	138,878	9.38	19
20	Administrator	1,868	2,088	101,259	48.50	20
21	Assistant Administrator	1,895	2,087	83,656	40.08	21
22	Other Administrative	10,890	11,760	201,789	17.16	22
23	Office Manager					23
24	Clerical	16,353	17,947	220,119	12.26	24
25	Vocational Instructor					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	1,941	2,157	32,500	15.07	31
32	Other Health C: Sch 20A	13,851	15,531	174,231	11.22	32
33	Other(specify) Sch 20A	13,128	14,345	148,579	10.36	33
34	TOTAL (lines 1 - 33)	550,913	602,677	\$ 7,087,092 *	\$ 11.76	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	343	\$ 14,108	L 1 C3	35
36	Medical Director	Monthly	3,600	L 9 C3	36
37	Medical Records Consultant	Monthly	2,380	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				43
44	Activity Consultant	8	569	L 11 C3	44
45	Social Service Consultant	10	574	L 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	361	\$ 31,275		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	N/A		51
52	Certified Nurse Assistants/Aides	N/A		52
53	TOTAL (lines 50 - 52)		\$	53

Good Samaritan Home
0009258
09/30/2006

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>
Nurse Aide Instructor	368	368	\$ 7,382	20.06
Nursing Secretary	9,325	10,465	100,976	9.65
Medical Supply Clerk	2,000	2,258	23,373	10.35
Staff Coord.	2,158	2,440	42,500	17.42
Total Line 32 - Other	13,851	15,531	\$ 174,231	\$ 11.22

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	5,944	6,492	\$ 66,818	10.29
Beauty Shop	4,724	5,269	60,030	11.39
General Store	2,460	2,584	21,731	8.41
Total Line 33 - Other	13,128	14,345	\$ 148,579	\$ 10.36

Good Samaritan Home
Provider #: 0009258
10/01/2005 to 09/30/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	38,088
Out of Period Cost for Legal	(350)
Development Cost for Cottages	(4,560)
Total (agree to Schedule V, line 19, column 8)	<u><u>33,178</u></u>

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2005Ending: 09/30/2006**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 \$15,560 CHHS \$7,451
- (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? N/A If YES, what is the capacity? No
- (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? 8.82 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 73,016 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 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 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 if 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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount \$ 21,407
- (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 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	857,460	51,055	20,184	928,699	0	928,699	0	928,699
2. Food Purchase	0	686,760	0	686,760	0	686,760	-21,407	665,353
3. Housekeeping	242,389	43,622	27,525	313,536	0	313,536	-3,925	309,611
4. Laundry	138,878	0	18,107	156,985	0	156,985	0	156,985
5. Heat and Other Utilities	0	0	377,872	377,872	0	377,872	0	377,872
6. Maintenance	267,274	49,681	152,735	469,690	0	469,690	0	469,690
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,506,001	831,118	596,423	2,933,542	0	2,933,542	-25,332	2,908,210
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	4,515,982	241,900	27,329	4,785,211	0	4,785,211	0	4,785,211
10a. Therapy	0	3,871	658,233	662,104	0	662,104	0	662,104
11. Activities	156,027	3,360	11,040	170,427	0	170,427	0	170,427
12. Social Services	138,658	1,462	574	140,694	0	140,694	0	140,694
13. Nurse Aide Training	15,022	0	5,237	20,259	0	20,259	0	20,259
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	4,825,689	250,593	706,013	5,782,295	0	5,782,295	0	5,782,295
17. Administrative	184,915	0	0	184,915	0	184,915	0	184,915
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	38,088	38,088	0	38,088	-4,910	33,178
20. Fees, Subscriptions & Promotion	0	0	42,377	42,377	0	42,377	-749	41,628
21. Clerical & General Office	421,908	61,319	103,570	586,797	0	586,797	-41,484	545,313
22. Employee Benefits & Payroll	0	0	1,491,565	1,491,565	0	1,491,565	0	1,491,565
23. Inservice Training & Education	0	0	559	559	0	559	0	559
24. Travel and Seminar	0	0	18,410	18,410	0	18,410	510	18,920
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	178,756	178,756	0	178,756	0	178,756
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	606,823	61,319	1,873,325	2,541,467	0	2,541,467	-46,633	2,494,834
29. Total General Administrative	6,938,513	1,143,030	3,175,761	11,257,304	0	11,257,304	-71,965	11,185,339
30. Depreciation	0	0	468,364	468,364	0	468,364	-11,926	456,438
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	468,364	468,364	0	468,364	-11,926	456,438
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	99,967	0	99,967	0	99,967	0	99,967
40. Barber and Beauty Shop	60,030	3,632	0	63,662	0	63,662	0	63,662
41. Coffee and Gift Shops	21,731	32,972	129	54,832	0	54,832	0	54,832
42	0	0	97,455	97,455	0	97,455	0	97,455
43. Other (specify):*	66,818	0	801,043	867,861	0	867,861	-867,861	0
44. Total Special Cost Ce	148,579	136,571	898,627	1,183,777	0	1,183,777	-867,861	315,916
45. Grand Total	7,087,092	1,279,601	4,542,752	12,909,445	0	12,909,445	-951,752	11,957,693

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	101,825	101,825
2. Cash - Patient Deposits	20,246	20,246
3. Accounts & Notes Recievable	1,615,652	1,615,652
4. Supply Inventory	0	0
5. Short-Term Investments	1,754,698	1,754,698
6. Prepaid Insurance	150,128	150,128
7. Other Prepaid Expenses	1,340	1,340
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	29,822	29,822
10. Total current assets	3,673,711	3,673,711
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	28,624,497	28,624,497
13. Land	128,278	128,278
14. Buildings, at Historical Cost	10,790,435	10,491,894
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,539,635	2,546,334
17. Accumulated Depreciation (book methods)	-8,704,134	-8,432,581
18. Deferred Charges	0	0
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):	0	0
23. other (specify):	3,711,270	3,711,270
24. Total Long-Term Assets	37,089,981	37,069,692
25. Total Assets	40,763,692	40,743,403
CURRENT LIABILITIES		
26. Accounts Payable	262,003	262,003
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	20,246	20,246
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	410,319	410,319
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	25,527	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):	58,600	58,600
37. Other Current Liabilities (specify):	720,162	720,162
38. Total Current Liabilities	1,496,857	1,471,330
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	1,496,857	1,471,330
47. Total Equity	39,266,835	39,272,073
48. Total Liabilities and Equity	40,763,692	40,743,403

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,049,008
2. Discounts and Allowances for all Levels	-1,227,535
Subtotal - Inpatient Care	8,821,473
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,081,889
7. Oxygen	6,008
Subtotal - Ancillary Revenue	1,087,897
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	38,311
13. Barber and Beauty Care	54,651
14. Non-Patient Meals	21,407
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	196,652
18. Sale of Supplies to Non-Patients	0
19. Laboratory	16,232
20. Radiology and X-Ray	5,244
21. Other Medical Services	117,774
22. Laundry	0
Subtotal - Other Operating Revenue	450,271
24. Contributions	38,348
25. Interest and Other Investments Income	2,008,258
Subtotal - Non-Operating Revenue	2,046,606
27. Other Revenue (specify):	42,850
28. Other Revenue (specify):	1,296,257
Subtotal - Other Revenue	1,339,107
30. Total Revenue	13,745,354
31. General Services	2,844,687
32. Health Care	5,423,486
33. General Administration	2,475,383
34. Ownership	482,726
35. Special Cost Centers	977,729
35. Provider Participation Fee	100,505
37. Other	0
40. Total Expenses	12,304,516
41. Income Before Income Taxes	1,440,838
42. Income Taxes	0
43. Net Income or Loss for the Year	1,440,838