

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

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	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	2,259	921	5,049	8,229	8
9	SNF/PED					9
10	ICF	18,472	58,874		77,346	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,731	59,795	5,049	85,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.26%

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

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 5,049

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 09/30/2007 Fiscal Year: 09/30/2007

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

STATE OF ILLINOIS

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Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2006 Ending: 09/30/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	889,626	53,375	17,131	960,132		960,132		960,132		1
2	Food Purchase		713,284		713,284		713,284	(22,846)	690,438		2
3	Housekeeping	260,643	44,212	29,668	334,523		334,523	(3,150)	331,373		3
4	Laundry	146,092		17,355	163,447		163,447		163,447		4
5	Heat and Other Utilities			401,633	401,633		401,633		401,633		5
6	Maintenance	284,674	51,820	154,668	491,162		491,162		491,162		6
7	Other (specify):*										7
8	TOTAL General Services	1,581,035	862,691	620,455	3,064,181		3,064,181	(25,996)	3,038,185		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	4,382,954	268,822	21,956	4,673,732		4,673,732		4,673,732		10
10a	Therapy		1,949	577,913	579,862		579,862		579,862		10a
11	Activities	159,092	3,602	30,972	193,666		193,666		193,666		11
12	Social Services	142,331	1,409	643	144,383		144,383		144,383		12
13	CNA Training			6,051	6,051		6,051		6,051		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,684,377	275,782	641,135	5,601,294		5,601,294		5,601,294		16
	C. General Administration										
17	Administrative	213,118			213,118		213,118		213,118		17
18	Directors Fees										18
19	Professional Services			33,683	33,683		33,683	(1,204)	32,479		19
20	Dues, Fees, Subscriptions & Promotion			37,817	37,817		37,817	(1,251)	36,566		20
21	Clerical & General Office Expense	442,666	76,657	116,095	635,418		635,418	(52,975)	582,443		21
22	Employee Benefits & Payroll Tax			1,489,801	1,489,801		1,489,801		1,489,801		22
23	Inservice Training & Education			262	262		262		262		23
24	Travel and Seminars			17,193	17,193		17,193	(59)	17,134		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			159,451	159,451		159,451		159,451		26
27	Other (specify):*										27
28	TOTAL General Administration	655,784	76,657	1,854,302	2,586,743		2,586,743	(55,489)	2,531,254		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,921,196	1,215,130	3,115,892	11,252,218		11,252,218	(81,485)	11,170,733		29

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

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

Facility Name & ID Number Good Samaritan Home

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Report Period Beginning: 10/01/2006 Ending: 09/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			481,142	481,142		481,142	(4,647)	476,495			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			481,142	481,142		481,142	(4,647)	476,495			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		157,393		157,393		157,393		157,393			39
40	Barber and Beauty Shops	62,918	4,347	158	67,423		67,423		67,423			40
41	Coffee and Gift Shop:	22,373	32,776		55,149		55,149		55,149			41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify): ³ Non-allowable Cos	71,169		781,783	852,952		852,952	(852,952)				43
44	TOTAL Special Cost Centers	156,460	194,516	879,396	1,230,372		1,230,372	(852,952)	377,420			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,077,656	1,409,646	4,476,430	12,963,732		12,963,732	(939,084)	12,024,648			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: 10/01/2006

Ending: 09/30/2007

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(22,846)	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	(1,407)	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	(1,918)	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	(27,177)	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	(885,736)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (939,084)		\$	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))	\$ (939,084)		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

Description	Amount	Schedule V Reference
Out of period legal fees	(1,204)	19
To disallow Rotary Club and Chamber of Commerce Dues	(1,251)	20
To disallow non-allowable Administrative Expenses	(7,560)	21
To disallow radio station expense	(635)	43
To disallow X-Ray expense	(4,229)	43
To disallow Lab expense	(10,200)	43
To disallow investment consultants	(281,256)	43
To disallow out of period seminar cost	(1,770)	24
To disallow out of state over fifty miles seminar cost	0	24
To record last year out of period cost for seminars that related to this y	1,711	24
To offset guest room income	(3,240)	30
To disallow cottage service income	(3,150)	3
To offset miscellaneous income	(606)	21
To offset discount earned income	(6,302)	21
To disallow Property Taxes	(41,536)	43
To disallow rental property expenses	(12,447)	43
To disallow radio station depreciation	(77)	43
To disallow cottage expenses	(473,477)	43
To disallow Public Relation Wages	(38,507)	21
Total	(885,736)	

5A

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/2006

Ending: 09/30/2007

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:

10/01/2006

Ending:

09/30/2007

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	(22,846)	0	0	0	0	0	0	0	0	0	0	(22,846)	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	(22,846)	0	0	0	0	0	0	0	0	0	0	(22,846)	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)	(22,846)	0	0	0	0	0	0	0	0	0	0	(22,846)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2006 Ending:09/30/2007

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	(1,407)	0	0	0	0	0	0	0	0	0	0	(1,407) 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	(1,407)	0	0	0	0	0	0	0	0	0	0	(1,407) 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):*	(29,095)	0	0	0	0	0	0	0	0	0	0	(29,095) 43
44	TOTAL Special Cost Centers	(29,095)	0	0	0	0	0	0	0	0	0	0	(29,095) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(53,348)	0	0	0	0	0	0	0	0	0	0	(53,348) 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							5
6	V			N/A				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: 10/01/2006 Ending: 09/30/2007

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: 10/01/2006 Ending: 9/30/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2006

Ending:

09/30/2007

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		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	N/A											3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

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

0009258 Report Period Beginning: **10/01/2006** Ending: **09/30/2007**

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 2006 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning:

10/01/2006 Ending: 09/30/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 169,463 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, 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 feet

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: N/A 2. Number of Years Over Which it is Being Amortized N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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	1,219,680		\$ 128,278	3

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2006 Ending: 09/30/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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		1,426,299	6
7	75		1984	1,953,541	48,839	40	48,839		1,151,779	7
8										8
Improvement Type**										
9	Building Improvements		1974	89,670		30			89,670	9
10	Building Improvements		1976	9,414		20			9,414	10
11	Building Improvements		1977	3,107		20			3,107	11
12	Building Service Equipment		1978	5,714		15			5,714	12
13	Building Service Equipment		1979	9,188		Various			9,188	13
14	Building Service Equipment		1980	324		Various			324	14
15	Building Improvements		1982	151,081	4,556	Various	4,556		130,955	15
16	Building Service Equipment		1982	17,350		Various			17,350	16
17	Building Service Equipment		1983	10,058		20			10,058	17
18	Land Improvements		1984	49,187		15			49,187	18
19	Building Service Equipment		1984	459,501	425	Various	425		456,774	19
20	Land Improvements		1985	2,601		20			2,601	20
21	Building Improvements		1985	250,935	6,273	40	6,273		139,690	21
22	Building Service Equipment		1985	179,735		Various			179,735	22
23	Land Improvements		1986	72,453		20			72,453	23
24	Building Improvements		1986	161,531	4,038	40	4,038		85,712	24
25	Building Service Equipment		1986	137,391	2,514	Various	2,514		127,807	25
26	Building Improvements		1987	19,089	500	Various	500		9,966	26
27	Building Service Equipment		1987	21,221	683	20	683		21,192	27
28	Building Service Equipment		1988	14,400	42	Various	42		14,159	28
29	Building Improvements		1989	174,123	4,421	Various	4,421		126,030	29
30	Building Service Equipment		1989	6,469		Various			6,469	30
31	Garage Additions		1990	78,563	2,619	30	2,619		46,264	31
32	New Roof - North Wing		1990	43,980	2,199	20	2,199		38,299	32
33	Phones		1990	600		10			600	33
34	Hall Renovations		1991	20,616	1,031	20	1,031		17,094	34
35	Building Improvements State Audit Adjustments 10881+30372		1991	511,992	18,441	30	17,066	(1,375)	278,692	35
36	Ceiling/partitions		1991	37,276	1,243	30	1,243		20,295	36

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

See Page 12A, Line 70 for total

**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:

10/01/2006 Ending: 09/30/2007

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	Office Entrance	1991	\$ 14,768	\$ 738	20	\$ 738		\$ 12,553	37
38	Building Services Equipment State Audit Adjustment of 359	1991	83,893		various			83,893	38
39	Parking Lot	1992	4,257	213	20	213		2,979	39
40	Building Services Equipment	1992	2,706		10			2,706	40
41	Parking Lot	1992	46,071	2,303	20	2,303		33,594	41
42	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		111,231	42
43	Building Services Equipment	1993	20,910	238	various	238		18,316	43
44	Parking Lot	1994	87,827	5,855	15	5,855		80,509	44
45	Manhole/Sewer	1994	2,859	192	15	192		2,605	45
46	Sidewalk	1994	7,875	525	15	525		6,869	46
47	West Nursing	1994	66,876	3,344	20	3,344		43,470	47
48	Dining Room	1994	6,990	315	various	315		5,099	48
49	Building Services Equipment	1994	134,323	2,791	various	2,791		116,882	49
50	West Nursing	1995	128,327	6,416	20	6,416		80,739	50
51	West Nursing	1995	3,151	158	20	158		1,812	51
52	Building Services Equipment	1995	22,482	812	various	812		20,519	52
53	Gas Line	1996	3,062	153	20	153		1,761	53
54	Gutters	1996	10,817	541	20	541		6,220	54
55	Eber Wing Improvement	1996	20,335	1,017	20	1,017		11,693	55
56	Roof	1996	9,016	451	20	451		5,184	56
57	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		38,645	57
58	Building Services Equipment	1996	46,663	2,128	various	2,128		32,695	58
59	Lights/Front Land Improvement	1997	5,360	357	15	357		3,841	59
60	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		21,935	60
61	Freezer Floor	1997	4,394	258	17	258		2,843	61
62	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		12,314	62
63	Sprinkling System	1997	3,354	335	10	335		3,186	63
64	Tamper Detectors	1997	2,818	282	10	282		2,677	64
65	Compressor - Eber	1997	2,039	136	15	136		1,404	65
66	Compressor - East	1997	11,808	787	15	787		8,069	66
67	Sprinkler System	1997	102,875	5,144	20	5,144		51,866	67
68	Air Exchange -Pool Area State Audit adjustment 481	1997	8,092	571	15	539	(32)	5,525	68
69	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		11,384	69
70	TOTAL (lines 4 thru 69)		\$ 8,598,233	\$ 191,785		\$ 190,378	\$ (1,407)	\$ 6,434,027	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:

10/01/2006 Ending: 09/30/2007

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	\$ 8,598,233	\$ 191,785		\$ 190,378	\$ (1,407)	\$ 6,434,027		1
2	Elevator Doors - Dietary	1998	1,095	110	10	110		1,040	2
3	Remodeling -Anna Brow Wing Walls, Ceiling, Floors,Light	1999	199,131	4,978	39	4,978		40,863	3
4	Remodeling -Anna Brow Wing - Duct Detector:	1999	1,444		5			1,444	4
5	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	297	10	297		2,521	5
6	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	548	39	548		4,588	6
7	Chapel Roof	1999	21,515	538	39	538		4,774	7
8	Fire Damper Alarm	1999	5,490		5			5,490	8
9	Eber Parking Lot Lights	1999	5,495	366	15	366		3,114	9
10	Stainless Steel D/W Exhaust	1999	1,659	166	10	166		1,410	10
11	Wiring Chapel Roof	1999	332	33	10	33		283	11
12	HVAC Chapel	1999	23,760	1,584	15	1,584		13,464	12
13	Code Alert System	1999	61,985		5			61,985	13
14	Elevator Upgrade A/B East	1999	22,556	2,256	10	2,256		19,173	14
15	Elevator Upgrade - Special Care	1999	5,970	597	10	597		5,074	15
16	Fire Protection A/B	1999	4,500	450	10	450		3,825	16
17	Condensor Unit	1999	22,945	1,530	15	1,530		13,002	17
18	Fire Protection Pool Area	1999	776	78	10	78		660	18
19	Damper Duct Work	1999	5,602	373	15	373		3,174	19
20	Lighting- Special Care	1999	2,075	138	15	138		1,176	20
21	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		1,598	21
22	Chapel Remodeling - Sign	2000	77		5			77	22
23	Chapel Remodeling - Painting	2000	4,751	119	39	119		837	23
24	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		1,537	24
25	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		2,598	25
26	Kitchen Remodeling - Skv Roof Flashing	2000	3,086	206	15	206		1,543	26
27	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		1,742	27
28	Kitchen Remodeling - Galvanized Wall Divide	2000	2,601	173	15	173		1,300	28
29	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		4,878	29
30	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		8,242	30
31	Special Care Lighting	2000	14,290	953	15	953		7,145	31
32	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		152,709	32
33	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		1,388	33
34	TOTAL (lines 1 thru 33)	\$ 9,410,200	\$ 230,611		\$ 229,204	\$ (1,407)	\$ 6,806,681		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:

10/01/2006 Ending: 09/30/2007

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		\$ 9,410,200	\$ 230,611		\$ 229,204	\$ (1,407)	\$ 6,806,681	1
2	Telephone Unit	2000	323	23	7	23		324	2
3	Elevator Up Grade East Wing	2000	12,776	852	15	852		6,388	3
4	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		550	4
5	Entrance Codelock Special Car	2000	1,848	123	15	123		924	5
6	Life Safety Code Sprinkler Drain	2000	7,000	467	15	467		3,500	6
7	Land Improvement New Sidewall	2000	1,200	60	20	60		390	7
8	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		57,305	8
9	Exterior Painting	2001	14,347	956	15	956		6,217	9
10	Painting Kitchen	2001	2,550	170	15	170		1,105	10
11	Chapel Renovation	2000	2,001	50	39	50		344	11
12	Kitchen Electrical Work	2000	611	41	15	41		265	12
13	HVAC Rehab Eber Wing	2000	5,584	372	15	372		2,420	13
14	Sprinklers	2000	4,151	277	15	277		1,799	14
15	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		1,601	15
16	Electrical Work	2001	1,609	107	15	107		697	16
17	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		21,985	17
18	Air Compressor Anna Brown Wing	2001	10,911	727	15	727		4,728	18
19	3D Detectors in Elevators	2001	4,916	344	10	344		2,220	19
20	Compensators	2001	2,724	191	10	191		1,230	20
21	33 Lever Passage Locks	2002	2,904	203	10	203		1,311	21
22	Exit Lights and Hold Opens	2002	966	68	10	68		436	22
23	16 Lever Passage Locks	2002	1,408	99	10	99		636	23
24	48 Lockouts	2002	985	69	10	69		445	24
25	Water Piping	2001	4,600	115	39	115		676	25
26	New Curb & Driveway	2002	16,118	639	20	639		3,974	26
27	Buffet in Dining Area	2003	2,977	198	15	198		929	27
28	Door - code alert and keypad	2003	2,489	249	10	249		1,162	28
29	Fire Collars	2003	3,619	362	10	362		1,672	29
30	Main Breaker	2003	3,291	219	15	219		896	30
31	Elevator Master Door Operator	2003	4,278	428	10	428		1,889	31
32	Training Room Drainage	2003	731	19	39	19		84	32
33	Dietary - Floor Drain	2003	223	6	39	6		25	33
34	TOTAL (lines 1 thru 33)		\$ 9,952,084	\$ 250,976		\$ 249,569	\$ (1,407)	\$ 6,934,808	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:

10/01/2006 Ending: 09/30/2007

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		\$ 9,952,084	\$ 250,976		\$ 249,569	\$ (1,407)	\$ 6,934,808	1
2	Handicap Accessible Entrance and Sidewall	2003	3,200	160	20	160		640	2
3	Annunciators	2004	51,494	5,149	10	5,149		18,023	3
4	Sewer Lines	2003	5,801	387	15	387		1,515	4
5	Smoke Damper - Eber	2003	698	47	15	47		178	5
6	Beauty Shop Wiring	2003	2,272	152	15	152		568	6
7	Dietary Doors	2004	3,801	253	15	253		929	7
8	Roof	2004	4,028	269	15	269		940	8
9	Remote Annunciator	2004	4,650	465	10	465		1,550	9
10	Cooler Expansion	2004	6,120	408	15	408		1,360	10
11	Parking Lot	2004	6,800	453	15	453		1,473	11
12	Ambulance Garage Door	2004	1,070	107	10	107		339	12
13	Kitchen Remodel	2004	6,425	641	10	641		1,928	13
14	Plumbing work in Eber/South	2004	5,147	343	15	343		972	14
15	Water Softener System	2004	15,642	1,564	10	1,564		4,302	15
16	Storage Tank Replacement	2004	2,454	245	10	245		675	16
17	Air Handler in East Circle	2005	1,297	130	10	130		313	17
18	Parking Lot Off-Street	2005	68,884	4,592	15	4,592		10,715	18
19	Kitchen Electrical Work	2004	247	12	20	12		37	19
20	Kitchen Remodel	2004	1,248	62	20	62		182	20
21	Sprinkler System	2004	980	49	20	49		139	21
22	Sprinkler System	2005	2,373	119	20	119		316	22
23	Tunnel Closure	2005	1,888	126	15	126		336	23
24	Perry Suite Renovations	2005	2,470	165	15	165		425	24
25	Water Heater	2006	13,003	1,300	10	1,300		1,926	25
26	Telephone System	2006	65,476	4,613	various	4,613		7,118	26
27	Sprinkler System Pipes	2006	1,645	142	various	142		166	27
28	Overhead Door	2005	1,400	140	10	140		268	28
29	Concrete Work	2005	9,936	662	15	662		1,214	29
30	Fire Walls	2006	14,948	747	20	747		997	30
31	Fire Alarm System	2006	23,500	1,568	15	1,568		2,611	31
32	Life Safety Code Renovations	2006	1,905	191	10	191		302	32
33	Renovations to Building	2006	38,611	1,931	20	1,931		2,574	33
34	TOTAL (lines 1 thru 33)		\$ 10,321,497	\$ 278,168		\$ 276,761	\$ (1,407)	\$ 6,999,839	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:

10/01/2006 Ending: 09/30/2007

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	\$ 10,321,497	\$ 278,168		\$ 276,761	\$ (1,407)	\$ 6,999,839		1
2	Telephone System Wiring	2006 35,781	3,578	10	3,578		3,895		2
3	Pool Area Renovations	2006 98,370	4,918	20	4,918		6,968		3
4	Concrete Work	2006 3,850	257	15	257		364		4
5	Lighting in the Hallway	2006 7,872	394	20	394		492		5
6	Laundry Renovations- Air Systen	2006 9,841	492	20	492		615		6
7	Smoke/Fire Dampers Special Care Area	2006 14,683	734	20	734		918		7
8	Eber Elevator Remodel	2006 12,769	780	15	780		780		8
9	Sprinkler System Head	2006 20,456	1,023	15	1,023		1,023		9
10	South Wing Fiber Service	2007 2,526	126	15	126		126		10
11	Smoke/Fire Detectors	2007 10,431	695	10	695		695		11
12	Repairs to Boiler Motor	2007 954	64	10	64		64		12
13	Smoke/Fire Dampers	2007 1,125	75	10	75		75		13
14	CO Detectors	2007 1,483	25	10	25		25		14
15	Call Lights - Dining Hall	2007 823	7	10	7		7		15
16	Hot Water Tank	2007 2,588	43	10	43		43		16
17	Repairs to Hot Water Shower Area	2007 1,113		10					17
18	Compressor - Walk in	2007 2,922		10					18
19	Repairs to Wiring in Chapel Area	2007 14,516		15					19
20	HVAC Controllers	2007 11,952		15					20
21	Physical Therapy Ductwork Repair	2006 2,254	138	15	138		138		21
22	Alarm Stations Repairs	2006 27,685	1,384	15	1,384		1,384		22
23	Dining Hall Electric	2007 890	45	15	45		45		23
24	Chapel Roof Repair	2007 3,528	176	15	176		176		24
25	Special Care Area Door	2007 3,038	203	10	203		203		25
26	Dining Hall Paint	2007 7,401	432	10	432		432		26
27	Special Care Area Bathroom Repair	2007 4,106	137	15	137		137		27
28	Pool Area Renovations	2007 5,108	170	15	170		170		28
29	Dinning Hall Roof Repairs	2007 573	19	15	19		19		29
30	Front Hall Area Roof Repair	2007 3,100	103	15	103		103		30
31	Storm Sewer Line	2007 3,459	77	15	77		77		31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,636,694	\$ 294,263		\$ 292,856	\$ (1,407)	\$ 7,018,813		34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 10,636,694	\$ 294,263		\$ 292,856	\$ (1,407)	\$ 7,018,813		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	Guest Room Income Offset				(3,240)	(3,240)			31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,636,694	\$ 294,263		\$ 289,616	\$ (4,647)	\$ 7,018,813		34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See 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	\$ 1,264,958	\$ 146,901	\$ 146,901	\$	3-20 yrs	\$ 661,161	71
72	Current Year Purchases	160,036	7,573	7,573		5-10 yrs	7,573	72
73	Fully Depreciated Assets	1,009,646				3-20 yrs	1,009,646	73
74								74
75	TOTALS	\$ 2,434,640	\$ 154,474	\$ 154,474	\$		\$ 1,678,380	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	201,994	32,405	32,405		5-10 yrs	96,269	79
80	TOTALS			\$ 320,849	\$ 32,405	\$ 32,405	\$		\$ 215,124	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)	\$ 13,520,461	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 481,142	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 476,495	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,647)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,912,317	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	8,292,453	158,439	5,137,851	88
89	Rental Property Fixed Assets	371,077	12,447	76,737	89
90	Radio Station	15,038	77	14,192	90
91	TOTALS	\$ 8,961,677	\$ 170,963	\$ 5,228,780	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	Building Construction	573,352	93
94			94
95		\$ 573,352	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: 10/01/2006 Ending: 09/30/2007

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	\$ 115	\$ 115	\$ 0	5 yrs	\$ 709	42
43	Maintenance	Chevy S-10 98	2002	7,508	1,051	1,051	0	5 yrs	6,457	43
44	Facility	Toro mower	2003	7,139	1,428	1,428	0	5 yrs	6,425	44
44a	Facility	Ford/Goshen Bus (2)	2004	98,532	19,706	19,706	0	5 yrs	64,046	44a
44b	Facility	Lift for Van	2005	1,500	300	300	0	5 yrs	725	44b
44c	Facility	Toto mower	2005	9,792	1,958	1,958	0	5 yrs	4,733	44c
44d	Facility	2005 Chrysler Town	2005	21,931	4,386	4,386	0	5 yrs	8,772	44d
44e	Facility	1999 Chevy Van	2005	5,648	1,130	1,130	0	5 yrs	2,071	
44f	Facility	Kubota L3430	2006	18,895	1,575	1,575	0	10 yrs	1,575	
44g	Facility	Ford F350	2007	30,224	756	756	0	10 yrs	756	
44h	Facility									
45							0			45
46	TOTALS			\$ 201,994	\$ 32,405	\$ 32,405	\$ 0		\$ 96,269	46

E. Summary of Care-Related Asset

	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. /2008 \$ N/A
 13. /2009 \$ N/A
 14. /2010 \$ 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: \$ 0 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.

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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" 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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 5,303	\$	\$ 5,303
2	Books and Supplies		398		398
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	CNA Competency Tests		350		350
9	TOTALS	\$	\$ 6,051	\$	\$ 6,051
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,051		

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (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

- (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	L. 10a C 3	hrs	\$	3,221	\$ 166,121	\$	3,221	\$ 166,121	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		244	16,220		244	16,220	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 3	hrs		6,798	395,471	1,949	6,798	397,420	4
5	Physician Care		visits							5
6	Dental Care	L.10 C 2, 3	visits		12	2,400	751	12	3,151	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39 C 2	# of prescripts				156,571		156,571	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Sch 16A				1	101	822	1	923	13
14	TOTAL			\$	10,276	\$ 580,313	\$ 160,093	10,276	\$ 740,406	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

10/01/2006 to 09/30/2007

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>
Ambulance -Medicare	L. 39 C 2			822
Respiratory Therapy	L. 10a C 2	1	101	
Total		1	101	822

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/2006

Ending:

09/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2007

(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	\$ 141,351	\$ 141,351	1
2	Cash-Patient Deposits	18,789	18,789	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,903,058	1,903,058	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	1,989,266	1,989,266	5
6	Prepaid Insurance	132,709	132,709	6
7	Other Prepaid Expenses	1,229	1,229	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Application Fee Repurchase</u>	31,311	31,311	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,217,713	\$ 4,217,713	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	32,341,967	32,341,967	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,935,236	10,636,694	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,748,790	2,755,489	16
17	Accumulated Depreciation (book methods)	(9,185,276)	(8,912,317)	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 (sp <u>CIP</u>)	573,352		22
23	Other(specify): <u>Cottage & Rental Property</u>	3,732,897		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 41,275,244	\$ 36,950,111	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 45,492,957	\$ 41,167,824	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 178,626	\$ 178,626	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,789	18,789	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	479,971	479,971	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,287	2,287	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,702		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>	106,704	106,704	36
37	<u>Prepaid Residents Rent</u>	743,988	743,988	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,559,067	\$ 1,530,365	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)	\$ 1,559,067	\$ 1,530,365	46
47	TOTAL EQUITY(page 18, line 24)	\$ 43,933,890	\$ 39,637,459	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 45,492,957	\$ 41,167,824	48

*(See instructions.)

Good Samaritan Home
0009258
09/30/2007

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Miscellaneous Employee Deductions	3,589	3,589
United Way Deduction	3	3
Employee Assist Fund Withheld	9,369	9,369
Benevolent Fund Payable	8,086	8,086
Flower Fund Payable	(4,149)	(4,149)
Application Fee Payable	27,280	27,280
Medicare Liability	13,017	13,017
Medicaid Liability	23	23
Employee Health/Life Liability	49,486	49,486
Total Line 36 - Other Current Liabilities(specify):	106,704	106,704

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 39,266,835	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 39,266,833	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,667,057	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)	\$ 4,667,057	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 43,933,890	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/2006

Ending: 09/30/2007

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	\$ 10,723,289	1
2	Discounts and Allowances for all Level	(1,385,055)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,338,234	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	971,701	6
7	Oxygen	5,736	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 977,437	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop	35,928	12
13	Barber and Beauty Care	56,166	13
14	Non-Patient Meals	22,846	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	301,100	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	20,369	19
20	Radiology and X-Ray	8,490	20
21	Other Medical Services	141,617	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 586,516	23
D. Non-Operating Revenue			
24	Contributions	63,885	24
25	Interest and Other Investment Income**	5,251,159	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,315,044	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attach Schedule 19E	44,028	28
28a	Cottage and Rental Property Income	1,369,530	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,413,558	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,630,789	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,064,181	31
32	Health Care	5,601,294	32
33	General Administrator	2,586,743	33
B. Capital Expense			
34	Ownership	481,142	34
C. Ancillary Expense			
35	Special Cost Centers	1,132,917	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)*	\$ 12,963,732	40
41	Income before Income Taxes (line 30 minus line 40)**	4,667,057	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,667,057	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
09/30/2007

Schedule 19E

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	604
Discount Earned Income	6,302
Adjustments	2
Guest Room Income	3,240
Van Transportation	30,730
Cottage Services Income	3,150
Application Fee Income	<u>0</u>
Total Line 28 - Other Revenue (specify):	<u><u>44,028</u></u>

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

0009258

Report Period Beginning: **10/01/2006**

Ending:

09/30/2007

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	1,776	2,088	\$ 83,421	\$ 39.95	1
2	Assistant Director of Nursing	1,965	2,357	63,742	27.04	2
3	Registered Nurses	11,935	13,231	274,799	20.77	3
4	Licensed Practical Nurses	76,580	83,700	1,347,801	16.10	4
5	CNAs & Orderlies	192,089	207,477	2,233,875	10.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,642	16,836	178,677	10.61	8
9	Activity Director	1,912	2,080	31,905	15.34	9
10	Activity Assistants	12,507	13,908	127,187	9.14	10
11	Social Service Worker	12,842	14,194	142,331	10.03	11
12	Dietician					12
13	Food Service Supervisor	7,829	8,542	143,383	16.79	13
14	Head Cook	9,303	10,187	108,547	10.66	14
15	Cook Helpers/Assistants	58,550	64,110	572,026	8.92	15
16	Dishwashers	6,764	7,328	65,670	8.96	16
17	Maintenance Worker	24,079	26,302	284,674	10.82	17
18	Housekeepers	25,771	28,115	260,643	9.27	18
19	Laundry	13,173	14,401	146,092	10.14	19
20	Administrator	1,808	2,080	117,425	56.45	20
21	Assistant Administrator	1,800	2,080	95,693	46.01	21
22	Other Administrative	7,827	8,751	168,012	19.20	22
23	Office Manager					23
24	Clerical	18,975	20,999	274,654	13.08	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	1,885	2,126	32,327	15.21	31
32	Other Health C: Sch 20A	13,981	15,457	168,312	10.89	32
33	Other(specify) Sch 20A	13,119	14,240	156,460	10.99	33
34	TOTAL (lines 1 - 33)	531,112	580,589	\$ 7,077,656 *	\$ 12.19	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	407	\$ 14,943	L 1 C 3	35
36	Medical Director	Monthly	3,600	L 9 C 3	36
37	Medical Records Consultant	Quarterly	1,720	L 10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L 10 C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	611	L 11 C 3	44
45	Social Service Consultant	10	643	L 12 C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	425	\$ 31,561		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
09/30/2007

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Nursing Secretary	9,440	10,502	100,115	9.53
Medical Supply Clerk	2,301	2,537	26,359	10.39
Staff Coord.	2,240	2,418	41,838	17.30
Total Line 32 - Other	13,981	15,457	\$ 168,312	\$ 10.89

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	6,020	6,575	\$ 71,169	10.82
Beauty Shop	4,641	5,065	62,918	12.42
General Store	2,458	2,600	22,373	8.61
Total Line 33 - Other	13,119	14,240	\$ 156,460	\$ 10.99

Good Samaritan Home
Provider #: 0009258
10/01/2006 to 09/30/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	33,683
Out of Period Cost for Legal	(1,204)
Total (agree to Schedule V, line 19, column 8)	<u><u>32,479</u></u>

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2006Ending: 09/30/2007**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 \$15,570 CHHS\$7,746
- (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? 7.73 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 75,755 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
-
- (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 \$ 22,846
- (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 N/A
- (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

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	889,626	53,375	17,131	960,132	0	960,132	0	960,132
2. Food Purchase	0	713,284	0	713,284	0	713,284	-22,846	690,438
3. Housekeeping	260,643	44,212	29,668	334,523	0	334,523	-3,150	331,373
4. Laundry	146,092	0	17,355	163,447	0	163,447	0	163,447
5. Heat and Other Utilities	0	0	401,633	401,633	0	401,633	0	401,633
6. Maintenance	284,674	51,820	154,668	491,162	0	491,162	0	491,162
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,581,035	862,691	620,455	3,064,181	0	3,064,181	-25,996	3,038,185
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	4,382,954	268,822	21,956	4,673,732	0	4,673,732	0	4,673,732
10a. Therapy	0	1,949	577,913	579,862	0	579,862	0	579,862
11. Activities	159,092	3,602	30,972	193,666	0	193,666	0	193,666
12. Social Services	142,331	1,409	643	144,383	0	144,383	0	144,383
13. Nurse Aide Training	0	0	6,051	6,051	0	6,051	0	6,051
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	4,684,377	275,782	641,135	5,601,294	0	5,601,294	0	5,601,294
17. Administrative	213,118	0	0	213,118	0	213,118	0	213,118
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	33,683	33,683	0	33,683	-1,204	32,479
20. Fees, Subscriptions & Promotion	0	0	37,817	37,817	0	37,817	-1,251	36,566
21. Clerical & General Office	442,666	76,657	116,095	635,418	0	635,418	-52,975	582,443
22. Employee Benefits & Payroll	0	0	1,489,801	1,489,801	0	1,489,801	0	1,489,801
23. Inservice Training & Education	0	0	262	262	0	262	0	262
24. Travel and Seminar	0	0	17,193	17,193	0	17,193	-59	17,134
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	159,451	159,451	0	159,451	0	159,451
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	655,784	76,657	1,854,302	2,586,743	0	2,586,743	-55,489	2,531,254
29. Total General Administrative	6,921,196	1,215,130	3,115,892	11,252,218	0	11,252,218	-81,485	11,170,733
30. Depreciation	0	0	481,142	481,142	0	481,142	-4,647	476,495
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	481,142	481,142	0	481,142	-4,647	476,495
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	157,393	0	157,393	0	157,393	0	157,393
40. Barber and Beauty Shop	62,918	4,347	158	67,423	0	67,423	0	67,423
41. Coffee and Gift Shops	22,373	32,776	0	55,149	0	55,149	0	55,149
42	0	0	97,455	97,455	0	97,455	0	97,455
43. Other (specify):*	71,169	0	781,783	852,952	0	852,952	-852,952	0
44. Total Special Cost Ce	156,460	194,516	879,396	1,230,372	0	1,230,372	-852,952	377,420
45. Grand Total	7,077,656	1,409,646	4,476,430	12,963,732	0	12,963,732	-939,084	12,024,648

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	141,351	141,351
2. Cash - Patient Deposits	18,789	18,789
3. Accounts & Notes Recievable	1,903,058	1,903,058
4. Supply Inventory	0	0
5. Short-Term Investments	1,989,266	1,989,266
6. Prepaid Insurance	132,709	132,709
7. Other Prepaid Expenses	1,229	1,229
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	31,311	31,311
10. Total current assets	4,217,713	4,217,713
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	32,341,967	32,341,967
13. Land	128,278	128,278
14. Buildings, at Historical Cost	10,935,236	10,636,694
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,748,790	2,755,489
17. Accumulated Depreciation (book methods)	-9,185,276	-8,912,317
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):	573,352	573,352
23. other (specify):	3,732,897	3,732,897
24. Total Long-Term Assets	41,275,244	41,256,360
25. Total Assets	45,492,957	45,474,073
CURRENT LIABILITIES		
26. Accounts Payable	178,626	178,626
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	18,789	18,789
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	479,971	479,971
31. Accrued Taxes Payable	2,287	2,287
32. Accrued Real Estate Taxes	28,702	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):	106,704	106,704
37. Other Current Liabilities (specify):	743,988	743,988
38. Total Current Liabilities	1,559,067	1,530,365
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	1,559,067	1,530,365
47. Total Equity	43,933,890	43,943,708
48. Total Liabilities and Equity	45,492,957	45,474,073

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,723,289
2. Discounts and Allowances for all Levels	-1,385,055
Subtotal - Inpatient Care	9,338,234
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	971,701
7. Oxygen	5,736
Subtotal - Ancillary Revenue	977,437
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	35,928
13. Barber and Beauty Care	56,166
14. Non-Patient Meals	22,846
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	301,100
18. Sale of Supplies to Non-Patients	0
19. Laboratory	20,369
20. Radiology and X-Ray	8,490
21. Other Medical Services	141,617
22. Laundry	0
Subtotal - Other Operating Revenue	586,516
24. Contributions	63,885
25. Interest and Other Investments Income	5,251,159
Subtotal - Non-Operating Revenue	5,315,044
27. Other Revenue (specify):	44,028
28. Other Revenue (specify):	1,369,530
Subtotal - Other Revenue	1,413,558
30. Total Revenue	17,630,789
31. General Services	2,933,542
32. Health Care	5,782,295
33. General Administration	2,541,467
34. Ownership	468,364
35. Special Cost Centers	1,086,322
35. Provider Participation Fee	97,455
37. Other	0
40. Total Expenses	12,909,445
41. Income Before Income Taxes	4,721,344
42. Income Taxes	0
43. Net Income or Loss for the Year	4,721,344