

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL# 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,943</u>	<u>9,290</u>	<u>2,061</u>	<u>25,294</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,943</u>	<u>9,290</u>	<u>2,061</u>	<u>25,294</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.25%

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)

MEALS ON WHEELSF. Does the facility maintain a daily midnight census? YES

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

YES NO

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

YES NO

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

Date started 01/01/1970

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 72 and days of care provided _____Medicare Intermediary NORIDIAN

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARR # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	180,047	14,447	6,065	200,559		200,559	(832)	199,727			1
2	Food Purchase		140,372		140,372		140,372	(11,248)	129,124			2
3	Housekeeping	77,004	14,295		91,299		91,299	(826)	90,473			3
4	Laundry	47,821	10,897		58,718		58,718	(652)	58,066			4
5	Heat and Other Utilities			91,235	91,235		91,235		91,235			5
6	Maintenance	56,356	11,899	54,168	122,423		122,423	(2,533)	119,890			6
7	Other (specify):*			6,233	6,233		6,233		6,233			7
8	TOTAL General Services	361,228	191,910	157,701	710,839		710,839	(16,091)	694,748			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,269,122	127,636	3,388	1,400,146		1,400,146	(65,024)	1,335,122			10
10a	Therapy		62	148,486	148,548		148,548	(28,630)	119,918			10a
11	Activities	64,093	1,707	11,254	77,054		77,054	(7,306)	69,748			11
12	Social Services	29,776	23	2,098	31,897		31,897	(1)	31,896			12
13	CNA Training											13
14	Program Transportation			5,393	5,393		5,393		5,393			14
15	Other (specify):*	11,589			11,589		11,589		11,589			15
16	TOTAL Health Care and Programs	1,374,580	129,428	170,619	1,674,627		1,674,627	(100,961)	1,573,666			16
	C. General Administration											
17	Administrative	62,346		143,683	206,029		206,029	45,963	251,992			17
18	Directors Fees											18
19	Professional Services			8,199	8,199		8,199	(940)	7,259			19
20	Dues, Fees, Subscriptions & Promotions			21,251	21,251		21,251	(15,397)	5,854			20
21	Clerical & General Office Expenses	103,341	14,575	40,828	158,744		158,744	(261)	158,483			21
22	Employee Benefits & Payroll Taxes			428,038	428,038		428,038	(19,644)	408,394			22
23	Inservice Training & Education			15,056	15,056		15,056	(1,280)	13,776			23
24	Travel and Seminar			2,829	2,829		2,829	(2,240)	589			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,413	18,413		18,413	10,154	28,567			26
27	Other (specify):*	14,097			14,097		14,097	(14,097)				27
28	TOTAL General Administration	179,784	14,575	678,297	872,656		872,656	2,258	874,914			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,915,592	335,913	1,006,617	3,258,122		3,258,122	(114,794)	3,143,328			29

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL #0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			183,089	183,089		183,089	183,089			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,184	3,184		3,184	3,184			35
36	Other (specify):*										36
37	TOTAL Ownership			186,273	186,273		186,273	186,273			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			39,420	39,420		39,420	39,420			42
43	Other (specify):*			5,202	5,202		5,202	(5,202)			43
44	TOTAL Special Cost Centers			44,622	44,622		44,622	(5,202)	39,420		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,915,592	335,913	1,237,512	3,489,017		3,489,017	(119,996)	3,369,021		45

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning: 01/01/08

Ending: 12/31/08

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,248)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,204)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	6,380	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(145,428)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (157,500)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	37,504		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,504		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (119,996)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

STATE OF ILLINOIS
GOOD SAMARITAN SOCIETY-MT CARROLL

ID# 0007344

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Uniform	\$ (3,466)	21	1
2	Administration/Postage	(426)	21	2
3	O/P Nursing and Med Sply PVT	(63)	10	3
4	Transportation	(3,370)	6	4
5	Telephone	(17)	21	5
6	Int Inc Pst Due Accts	(295)	21	6
7	Employee relations Inc	(1,178)	21	7
8	Deferred Maint Cost -2006	1,142	6	8
9	Adv/Promo	(250)	20	9
10	Public Rel Reimb	(821)	20	10
11	Dues-nonreimb	(75)	20	11
12	Bank charges/Employment Garnishment Fees	(41)	21	12
13	Prof Services Legal	(940)	19	13
14	Prescr Drugs Reimb	(58,674)	10	14
15	Inoculations	(1,254)	10	15
16	Supplies Marketing	(546)	21	16
17	Staff Developing/Marketing	(122)	23	17
18	Adv/Promo Marketing	(646)	20	18
19	Advertising Newspaper	(4,713)	20	19
20	Advertising Outdoors Marketing	(455)	20	20
21	Advertising Newsletter Marketing	(2,310)	20	21
22	Inter-Center Reimbursement	(1,713)	20	22
23	Advertising Radio	(1,636)	20	23
24	Advertising Yellow Pages	(1,500)	20	24
25	Advertising Phone	(120)	20	25
26	Advertising Signage	(946)	20	26
27	Salaries Resource Development	(13,474)	27	27
28	Vac Resource Development	(623)	27	28
29	FICA Resouce Development	(1,031)	22	29
30	Supplies Resource Dev	(122)	21	30
31	Travel Resource Dev	-88	24	31
32	Adv/Promo Res Dev	-212	20	32
33	Staff Development Res Dev	-1158	23	33
34	Purch Serv Radiology Mdre	-2692	43	34
35	Lab Fees	-150	43	35
36	Therapy Offset	-28615	10a	36
37	Purch Serv Lab Mdcrc	-2360	43	37
38	Med Supplies Part B	-1932	10	38
39	Out of State travel	-2152	24	39
40	Supplies admin	-550	21	40
41	Supplies Nursing	-3101	10	41
42	Supplies Therapy	-15	10a	42
43	Supplies Activities	-102	11	43
44	Supplies Social Service	-1	12	44
45	Supplies Laundry	-652	4	45
46	Supplies Housekeeping	-826	3	46
47	Supplies Dietary	-832	1	47
48	Supplies Operations/ Maintance	-305	6	48
49	Total	(145,428)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	(832)	0	0	0	0	0	0	0	0	0	0	(832)	1
2	Food Purchase	(11,248)	0	0	0	0	0	0	0	0	0	0	(11,248)	2
3	Housekeeping	(826)	0	0	0	0	0	0	0	0	0	0	(826)	3
4	Laundry	(652)	0	0	0	0	0	0	0	0	0	0	(652)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,533)	0	0	0	0	0	0	0	0	0	0	(2,533)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,091)	0	0	0	0	0	0	0	0	0	0	(16,091)	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	(65,024)	0	0	0	0	0	0	0	0	0	0	(65,024)	10
10a	Therapy	(28,630)	0	0	0	0	0	0	0	0	0	0	(28,630)	10a
11	Activities	(7,306)	0	0	0	0	0	0	0	0	0	0	(7,306)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(100,961)	0	0	0	0	0	0	0	0	0	0	(100,961)	16
	C. General Administration													
17	Administrative	0	45,963	0	0	0	0	0	0	0	0	0	45,963	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(940)	0	0	0	0	0	0	0	0	0	0	(940)	19
20	Fees, Subscriptions & Promotions	(15,397)	0	0	0	0	0	0	0	0	0	0	(15,397)	20
21	Clerical & General Office Expenses	(261)	0	0	0	0	0	0	0	0	0	0	(261)	21
22	Employee Benefits & Payroll Taxes	(1,031)	(18,613)	0	0	0	0	0	0	0	0	0	(19,644)	22
23	Inservice Training & Education	(1,280)	0	0	0	0	0	0	0	0	0	0	(1,280)	23
24	Travel and Seminar	(2,240)	0	0	0	0	0	0	0	0	0	0	(2,240)	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	10,154	0	0	0	0	0	0	0	0	0	10,154	26
27	Other (specify):*	(14,097)	0	0	0	0	0	0	0	0	0	0	(14,097)	27
28	TOTAL General Administration	(35,246)	37,504	0	2,258	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(152,298)	37,504	0	(114,794)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY		
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS		
		(to Sch V, col.7)													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	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	0	32
33	Real Estate Taxes	0	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	0	34
35	Rent-Equipment & Vehicles	0	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	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense														
	E. Special Cost Centers														
38	Medically Necessary Transportation	0	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	0	39
40	Barber and Beauty Shops	0	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	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,202)	0	0	0	0	0	0	0	0	0	0	(5,202)	43	
44	TOTAL Special Cost Centers	(5,202)	0	0	0	0	0	0	0	0	0	0	(5,202)	44	
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(157,500)	37,504	0	(119,996)	45									

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
Good Samartain Society	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	17 Admin/Accting	\$ 143,683	The Evangelical Lutheran Good Samaritan Society	100.00%	\$ 189,646	\$ 45,963 1
2	V	22 Workers Comp	62,175			64,292	2,117 2
3	V	22 Unemployment					3
4	V	26 Insurance	18,411			28,565	10,154 4
5	V	22 Group Health Insurance	176,621			155,891	(20,730) 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		\$ 400,890			\$ 438,394	\$ * 37,504 14

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARI # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARR # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN SOCIETY-MT CARROLL COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0007344

CONTACT PERSON REGARDING THIS REPORT _____

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	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			1970	1970	\$ 418,766	\$ 10,469	40	\$ 10,469		\$ 407,424	4
5			1991	1991	912,128	34,430	20	34,430		829,478	5
6											6
7											7
8											8
	Improvement Type**										
9			1971		382	10	40	10		357	9
10			1976		3,352					3,352	10
11			1979		5,570					5,570	11
12			1980		1,419					1,419	12
13			1981		33,937					33,627	13
14			1982		29,187					29,188	14
15			1983		8,193					8,193	15
16			1984		1,224					1,224	16
17			1985		14,500					14,500	17
18			1986		11,402					11,402	18
19			1987		15,273					15,273	19
20			1988		14,405	155	20	155		14,405	20
21			1989		5,232	179	20	179		5,158	21
22			1990		24,930	26	20	26		24,891	22
23			1992		600					600	23
24			1993		2,434					2,434	24
25			1994		48,103	962	20	962		44,645	25
26			1995		36,886	137	15	137		36,738	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Compressor Control Board	1996	\$ 2,027	\$ 135	15	\$ 135	\$	\$ 1,757	37
38	Air Conditioning	1996	98,766	6,584	15	6,584		85,597	38
39	Windows	1996	10,350	518	20	518		8,798	39
40	Return Air Duct	1996	1,030	52	20	52		648	40
41	Roof	1996	75,405	3,770	20	3,770		46,500	41
42	Instalation of Annumciator PA	1997	7,151					7,151	42
43	Instalation of New Ambulance	1997	1,924	128	15	128		1,422	43
44	Replace Roof	1997	11,921	596	20	596		6,605	44
45	Handrails	1998	5,049	337	15	337		3,647	45
46	Electric Emergency Panel	1998	4,300	215	20	215		2,365	46
47	Wiring for Network	1998	6,096	305	20	305		3,124	47
48	Repair Roof	1998	1,325	99	10	99		1,325	48
49	Steel Door	1999	2,284	152	15	152		1,510	49
50	Alarm System	1999	20,000	2,000	10	2,000		18,833	50
51	Alarm System	1999	8,080	404	20	404		3,670	51
52	Electric Maint Storage Building	2000	2,100	105	20	105		945	52
53	Maintenance storage building	2000	20,196	505	40	505		4,544	53
54	Water Heater	2000	3,500	350	10	350		3,063	54
55	Water Heater	2000	1,639	164	10	164		1,448	55
56	Piping and Wiring Dishwasher	2000	2,180	218	10	218		1,872	56
57	Painting for Kitchen	2000	2,126					2,126	57
58	Building Interior Renovations	2000	2,800	112	25	112		961	58
59	Paint inteior Renovations	2000	637					637	59
60	Wallpaper interior Renovations	2000	15,389					15,389	60
61	Extentions of Firewall	2000	3,985	199	20	199		1,644	61
62	Carpet Interior Renovations	2000	26,529					26,529	62
63	Oak Doors	2002	3,545	236	15	236		1,595	63
64	Wiring for Call Lights	2002	663	66	10	66		409	64
65	Vertical Blinds	2002	510		5			510	65
66	Restroom Remodeling	2002	385	39	10	39		238	66
67	Window Replacement Resident RM	2002	28,542	1,903	15	1,903		11,734	67
68	Tile	2002	536	54	10	54		326	68
69	Commercial Door	2002	509	34	15	34		209	69
70	TOTAL (lines 4 thru 69)		\$ 1,959,402	\$ 65,648		\$ 65,648	\$	\$ 1,757,009	70

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,959,402	\$ 65,648		\$ 65,648	\$	\$ 1,757,009	1
2	Open Front Toilet Seat	2002	568	28	20	28		175	2
3	Water Heater	2002	3,840	384	10	384		2,304	3
4	Heater Covers	2002	9,000	900	10	900		5,625	4
5	Wing Shower Room Tile	2003	599	60	10	60		329	5
6	Boiler System replacement	2003	49,162	2,458	20	2,458		13,314	6
7	Counter top	2003	1,508	75	20	75		408	7
8	Tile for 300 Wing Shower Room	2003	537	54	10	54		295	8
9	Locks	2003	399	40	10	40		216	9
10	Outside Door for Kitchen	2003	1,326	88	15	88		449	10
11	Smoke Detectors	2003	1,650	165	10	165		743	11
12	Cabinets for Activity	2004	4,368	218	20	218		892	12
13	Window	2005	643	43	15	43		161	13
14	Exterior Door	2005	2,611	174	15	174		624	14
15	Heat/AC Unit	2005	2,975	298	10	298		964	15
16	AC Unit	2005	811	81	10	81		257	16
17	Blinds Resident Room Remodel	2005	656	131	5	131		405	17
18	Building Resident Room Remodel	2005	75,208	3,008	25	3,008		9,276	18
19	Drapes Resident Room Remodel	2005	8,199	1,640	5	1,640		5,056	19
20	Wallpaper Resident Room Remodel	2005	17,523	3,505	5	3,505		10,806	20
21	Wood Blinds	2006	636	64	10	64		185	21
22	Fire Sprinkler System	2006	140,294	5,612	25	5,612		15,900	22
23	Emergency Generator	2006	209,100	10,465	20	10,465		27,711	23
24	Fire Caulk	2006	2,650	265	10	265		685	24
25	Wall and Door Protectors	2006	6,729	673	10	673		1,514	25
26	Heat Pump	2006	685	69	10	69		143	26
27	Building Addition/Remodel	2006	18,692	748	25	748		1,807	27
28	Emergency Generator	2006	5,925	494	12	494		1,193	28
29	Salaries/Benefits	2006	573	23	25	23		55	29
30	Flooring for 5 Resident Rooms	2007	8,700	1,740	5	1,740		2,900	30
31	Double Door West Wing	2007	8,230	549	15	549		914	31
32	Repair Chiller	2007	5,220	522	10	522		740	32
33	Repairs On Screen Porch	2007	5,340	537	10	537		684	33
34	TOTAL (lines 1 thru 33)		\$ 2,553,759	\$ 100,759		\$ 100,759	\$	\$ 1,863,739	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,553,759	\$ 100,759		\$ 100,759	\$	\$ 1,863,739	1
2	Windows for Laundry Room	2007	1,586	106	15	106		106	2
3	Repair Chiller	2007	3,998	400	10	400		566	3
4	Hardware for Doors	2008	2,083	116	15	116		116	4
5	Blinds	2008	3,895	584	5	584		584	5
6	Chiller	2008	43,782	1,703	15	1,703		1,703	6
7	Rooftop AC Unit Replaced	2008	7,943	353	15	353		353	7
8	Adjustable Door Closer	2008	2,066	86	10	86		86	8
9	Doors	2008	3,720	165	15	165		165	9
10	Door and Frame	2008	4,990	111	15	111		111	10
11	ADA Gooseneck Faucet	2008	647	3	20	3		3	11
12									12
13									13
14	Prior year Depreciation (71564)			257		257			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,628,469	\$ 104,643		\$ 104,643	\$	\$ 1,867,532	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 2,628,469	\$ 104,643		\$ 104,643	\$	\$ 1,867,532	1
2	Landscaping Seed Sod	1970	1,703					1,703	2
3	Sidwalks	1970	2,000					2,000	3
4	Cement Labor John Flynn	1975	1,986					1,986	4
5	Trees Memorial B Carpenter	1977	185					185	5
6	Misc	1979	466					466	6
7	Landscaping	1980	140					140	7
8	Plant Corner WindBreak Porch	1986	3,061					3,061	8
9	Excavation for Parking Lot	1988	3,474					3,474	9
10	Landscaping Plants	1989	1,419					1,419	10
11	Landscape	1991	10,002					9,780	11
12	Parking	1991	6,500					6,500	12
13	Parking Lot	1991	81,652					81,652	13
14	Sealing of Expansion Joints	1993	2,560					2,560	14
15	Teltra Pond Liner	1994	350					350	15
16	Gss Sign w/Logo	1994	8,841					8,841	16
17	Fencing	1994	2,716	181	15	181		2,565	17
18	Sidwalk west of building	1994	8,601	573	15	573		8,123	18
19	Seal cost Driveways and Parking	1997	3,050	153	20	153		1,754	19
20	Paving additional Parking	1999	6,640	332	20	332		3,099	20
21	Lumber for Raising Garden	2000	330	33	10	33		284	21
22	Garden Bed	2000	1,650	110	15	110		935	22
23	Shrubs	2000	677	68	10	68		570	23
24	Driveway repair	2000	4,455	446	10	446		3,713	24
25	Landscaping	2000	392	26	15	26		218	25
26	Repair Sidewalk	2002	4,270	427	10	427		2,740	26
27	Gazebo	2003	4,006	200	20	200		1,152	27
28	Fencing	2003	732	73	10	73		409	28
29	Stripping Repair Parking Lot	2004	5,865	1,172	5	1,172		5,279	29
30	Concrete Work	2004	3,335	221	15	221		963	30
31	Shed	2005	398	40	10	40		153	31
32	Logo Sign	2008	9,000	674	10	674		675	32
33	Concrete Parking Lot/Curb/Gutter	2008	74,006	2,055	15	2,055		2,056	33
34	TOTAL (lines 1 thru 33)		\$ 2,882,931	\$ 111,427		\$ 111,427	\$	\$ 2,026,337	34

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

Facility Name & ID Number **GOOD SAMARITAN SOCIETY-MT CARROLL**

0007344

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,882,931	\$ 111,427		\$ 111,427	\$	\$ 2,026,337	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	TOTAL (lines 1 thru 33)	\$ 2,882,931	\$ 111,427		\$ 111,427	\$	\$ 2,026,337	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 551,573	\$ 56,921	\$ 56,921	\$		\$ 304,171	71
72	Current Year Purchases	104,588	7,846	7,846			6,293	72
73	Fully Depreciated Assets	372,423	1,328	1,328			384,644	73
74								74
75	TOTALS	\$ 1,028,584	\$ 66,095	\$ 66,095	\$		\$ 695,108	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 Use	Bus	2002	\$ 42,763	\$ 1,188	\$ 1,188	\$	6	\$ 42,763	76
77	Resident Use	1994 4X4 Truck	2004	3,500	583	583		4	3,500	77
78	Resident Use	2002 Osmobile Silhouette	2005	15,173	3,793	3,793		4	12,012	78
79										79
80	TOTALS			\$ 61,436	\$ 5,564	\$ 5,564	\$		\$ 58,275	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,978,671	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	183,086	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	183,086	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,779,720	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 13,312	92
93			93
94			94
95		\$ 13,312	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 3,180 Description: GSS Computers, Admin Technicare Nursing

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL # 0007344 Report Period Beginning: 01/01/08 Ending: 12/31/08

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a, col 3	hrs	\$	4,475	\$ 64,208	\$	4,475	\$ 64,208	1
2	Licensed Speech and Language Development Therapist	Ln 10a, col 3	hrs		194	4,384		194	4,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, col 3	hrs		4,944	79,893		4,944	79,893	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,613	\$ 148,485	\$	9,613	\$ 148,485	14

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL# 0007344Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 54,323	\$	1
2	Cash-Patient Deposits	5,764		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	401,195		3
4	Supply Inventory (priced at)	9,488		4
5	Short-Term Investments	1,287,807		5
6	Prepaid Insurance	2,580		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(29,742)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,731,415	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	2,628,471		14
15	Leasehold Improvements, at Historical Cost	254,463		15
16	Equipment, at Historical Cost	1,105,550		16
17	Accumulated Depreciation (book methods)	(2,781,272)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	101,897		21
22	Other Long-Term Assets (spe <u>Asset Management</u>)	7,824		22
23	Other(specify): <u>CIP</u>	13,312		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,335,965	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,067,380	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,486	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,764		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,945		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,719		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 282,914	\$	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)	\$ 282,914	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,784,468	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,067,382	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,952,547	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,952,547	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(71,736)	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) Dnr Rst Prop Gft Cash	41,749	15
16	Other (describe) Dnr Oper Gft Cash	760	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (29,227)	17
B. Transfers (Itemize):			
18	Reserve Fund Assessment Nc	(115,320)	18
19	Technology User Assesment NC	(23,532)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (138,852)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,784,468	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL # 0007344 Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,035,200	1
2	Discounts and Allowances for all Levels	(1,076,337)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,958,863	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	443,410	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 443,410	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	240	13
14	Non-Patient Meals	11,248	14
15	Telephone, Television and Radio	16	15
16	Rental of Facility Space		16
17	Sale of Drugs	164,164	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,590	19
20	Radiology and X-Ray	1,908	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 190,166	23
D. Non-Operating Revenue			
24	Contributions	18,323	24
25	Interest and Other Investment Income***	(275,806)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (257,483)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NS & Med Supplies	61,443	28
28a	Sch Attached	20,883	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 82,326	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,417,282	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	710,839	31
32	Health Care	1,674,597	32
33	General Administration	872,686	33
B. Capital Expense			
34	Ownership	186,273	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	39,420	36
D. Other Expenses (specify):			
37	Lab and Radiology	5,202	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,489,017	40
41	Income before Income Taxes (line 30 minus line 40)**	(71,735)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (71,735)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **GOOD SAMARITAN SOCIETY-MT CARROLL**

0007344

Report Period Beginning: **01/01/08**

Ending:

12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,092	1,880	\$ 52,683	\$ 28.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,860	14,259	375,890	26.36	3
4	Licensed Practical Nurses	5,852	5,316	118,951	22.38	4
5	CNAs & Orderlies	47,007	43,697	495,330	11.34	5
6	CNA Trainees	7,328	6,727	64,116	9.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,831	4,115	60,731	14.76	8
9	Activity Director	2,140	1,944	26,285	13.52	9
10	Activity Assistants	4,592	4,342	37,943	8.74	10
11	Social Service Workers	2,025	1,815	29,795	16.42	11
12	Dietician					12
13	Food Service Supervisor	2,170	1,867	27,311	14.63	13
14	Head Cook	7,012	6,279	66,287	10.56	14
15	Cook Helpers/Assistants	9,670	8,644	86,439	10.00	15
16	Dishwashers					16
17	Maintenance Workers	4,843	4,425	56,018	12.66	17
18	Housekeepers	8,306	7,327	76,954	10.50	18
19	Laundry	5,105	4,616	47,374	10.26	19
20	Administrator	2,098	1,823	61,943	33.98	20
21	Assistant Administrator					21
22	Other Administrative	7,593	6,718	112,452	16.74	22
23	Office Manager					23
24	Clerical	3,938	3,596	63,066	17.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,006	988	13,474	13.64	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,897	1,670	27,878	16.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>HR</u>	109	109	1,748	16.04	33
34	TOTAL (lines 1 - 33)	145,474	132,157	\$ 1,902,668 *	\$ 14.40	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	104	\$ 5,155	Ln 1 Col 3	35
36	Medical Director	16	2,400	Ln10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,469	Ln10 Col 2	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,678	Ln 11 Col 3	44
45	Social Service Consultant	29	1,595	Ln 12 Col 13	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	180	\$ 13,297		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Dunk	Administrator		\$ 61,944	Workers' Compensation Insurance	\$ 64,292	IDPH License Fee	\$	
vacation accrual			402	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	141,129	Health Care Worker Background Check		
				Employee Health Insurance	155,891	(Indicate # of checks performed)		
				Employee Meals		Dues Non Reim	(75)	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	1,451	
				Pension	42,941	Dues Reimb	4,737	
				Taxable Gifts	366	Public Advertising	11,039	
				Admin and Consulting	2,314	Newletter	2,310	
				Work Comp pd direct	1,460	Inter Reim	1,713	
						Less: Public Relations Expense	(1,071)	
						Non-allowable advertising	(12,751)	
						Yellow page advertising	(1,500)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 62,346		\$ 408,393		\$ 5,853	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Admin/Accounting			\$ 143,683			\$	Out-of-State Travel	\$ 2,152
							In-State Travel	677
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	
			\$ 143,683				Out of State	(2,152)
C. Professional Services							Resource Development Travel	
Vendor/Payee	Type		Amount					
National Campus Medicare	Cost report prep		\$ 600					(88)
National Campus Medicaid	Cost report prep		900				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
Contract Services	Admin		5,759					
Richard Johns	Estimate for remodel		940					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	
			\$ 8,199			\$		\$ 589

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MT CARROLL

0007344

Report Period Beginning: 01/01/08

Ending:

12/31/08

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Heating	01/02	\$ 1,738	10	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 174	\$ 172	\$
2	Heating	04/02	1,288	10	129	129	129	129	129	129	129	129	127
3	Heating	01/01	219	10	22	22	22	22	22	21			
4	Plumbing	02/01	910	10	91	91	91	91	91	91			
5	Wallpaper	07/01	230	5	102	102	49						
6	Paint	08/01	390	5	102	102	49						
7	Air Condition	09/01	511	10	51	51	51	51	51	51	51		
8	Air Condition	10/01	1,841	10	184	184	184	184	184	184	184		
9	Air Condition	02/01	901	10	90	90	90	90	90	90	90		
10	Plumbing	04/01	87	10	9	9	9	9	9	9	9		
11	Plumbing	01/01	5,879	10	58	58	58	58	58	58	58		
12	Heating	05/01	152	10	15	15	15	15	15	15	15		
13	Plumbing	08/01	1,402	10	140	140	140	140	140	140	140		
14	Plumbing	01/03	1,787	10	179	179	179	179	179	179	179	179	179
15													
16													
17													
18													
19													
20	TOTALS		\$ 17,335		\$ 1,346	\$ 1,346	\$ 1,240	\$ 1,142	\$ 1,142	\$ 1,141	\$ 1,029	\$ 478	\$ 179

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? 3603
If YES, give association name and amount. Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,963 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 39,420
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? _____ If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,248
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 30%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson Allen LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? _____
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.