

Facility Name & ID Number Good Samaritan Home# 0009258 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

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	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,312	3
4		Intermediate/DD			4
5	97	Sheltered Care (SC)	97	35,502	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	93,330	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	2,247	1,019	5,508	8,774	8
9	SNF/PED					9
10	ICF	18,190	57,700		75,890	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,437	58,719	5,508	84,664	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.71%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 ClassesF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 2/22/57

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 17 and days of care provided 5,508Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year YES NO Tax Year: 9/30/2008 Fiscal Year: 09/30/2008

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

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Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

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	935,278	53,547	18,678	1,007,503		1,007,503		1,007,503		1
2	Food Purchase		786,088		786,088		786,088	(29,967)	756,121		2
3	Housekeeping	268,770	48,389	33,832	350,991		350,991	(2,825)	348,166		3
4	Laundry	143,138		16,256	159,394		159,394		159,394		4
5	Heat and Other Utilities			483,210	483,210		483,210		483,210		5
6	Maintenance	290,226	76,251	149,104	515,581		515,581	(394)	515,187		6
7	Other (specify):*										7
8	TOTAL General Services	1,637,412	964,275	701,080	3,302,767		3,302,767	(33,186)	3,269,581		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	4,559,950	267,554	22,640	4,850,144		4,850,144		4,850,144		10
10a	Therapy		2,677	555,005	557,682		557,682		557,682		10a
11	Activities	161,955	3,168	11,386	176,509		176,509		176,509		11
12	Social Services	149,515	514	2,004	152,033		152,033		152,033		12
13	CNA Training			4,817	4,817		4,817		4,817		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,871,420	273,913	599,452	5,744,785		5,744,785		5,744,785		16
	C. General Administration										
17	Administrative	211,828			211,828		211,828		211,828		17
18	Directors Fees										18
19	Professional Services			33,005	33,005		33,005		33,005		19
20	Dues, Fees, Subscriptions & Promotion			51,559	51,559		51,559	(1,002)	50,557		20
21	Clerical & General Office Expense	417,439	77,254	119,976	614,669		614,669	(49,354)	565,315		21
22	Employee Benefits & Payroll Tax			1,442,097	1,442,097		1,442,097		1,442,097		22
23	Inservice Training & Education			1,156	1,156		1,156		1,156		23
24	Travel and Seminars			15,370	15,370		15,370	(303)	15,067		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			148,696	148,696		148,696		148,696		26
27	Other (specify):*										27
28	TOTAL General Administration	629,267	77,254	1,811,859	2,518,380		2,518,380	(50,659)	2,467,721		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,138,099	1,315,442	3,112,391	11,565,932		11,565,932	(83,845)	11,482,087		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: 10/01/2007 Ending: 09/30/2008

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			502,037	502,037		502,037	(4,977)	497,060			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			502,037	502,037		502,037	(4,977)	497,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		175,159		175,159		175,159		175,159			39
40	Barber and Beauty Shops	69,191	5,015	484	74,690		74,690		74,690			40
41	Coffee and Gift Shop:	21,952	29,393		51,345		51,345		51,345			41
42	Provider Participation Fee			97,722	97,722		97,722		97,722			42
43	Other (specify): ³ Non-allowable cost	72,557		852,421	924,978		924,978	(924,978)				43
44	TOTAL Special Cost Centers	163,700	209,567	950,627	1,323,894		1,323,894	(924,978)	398,916			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,301,799	1,525,009	4,565,055	13,391,863		13,391,863	(1,013,800)	12,378,063			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: 10/01/2007

Ending:

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	(29,967)	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 Depreciation	(1,407)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,822)	43		13
14	Non-Care Related Interest				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 Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(54,867)	43		24
25	Fund Raising, Advertising and Promotions				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(925,737)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,013,800)		\$	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)	\$ (1,013,800)		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						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

ID# 0009258

Report Period Beginning: 10/01/2007

Ending: 09/30/2008

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

Good Samaritan Home

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09/30/2008

Schedule

Schedule 5A

VI. ADJUSTMENT DETAIL

NON-ALLOWABLE EXPENSES

LINE 29 - Other

Description	Amount	Schedule V Reference
Resident Cable Expense	(54,846)	43
To disallow Rotary Club and Chamber of Commerce Dues	(1,002)	20
To disallow non-allowable Administrative Expenses	(1,838)	21
To disallow radio station expense	(640)	43
To disallow X-Ray expense	(7,416)	43
To disallow Lab expense	(14,307)	43
To disallow investment consultants	(301,820)	43
To disallow out of period seminar cost	(2,073)	24
To disallow out of state over fifty miles seminar cost		24
To record last year out of period cost for seminars that related to this y	1,770	24
To offset guest room income	(3,570)	30
To disallow cottage service income	(2,825)	3
To offset miscellaneous income	(1,194)	21
To offset discount earned income	(6,921)	21
To offset discount earned income	(186)	6
To offset discount earned income	(208)	6
To disallow Property Taxes	5,374	43
To disallow rental property expenses	(13,432)	43
To disallow radio station depreciation	(107)	43
To disallow cottage expenses	(481,095)	43
To disallow Public Relation Wages	(39,401)	21
	<hr/>	
Total	(925,737)	

5A

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2007

Ending:

09/30/2008

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	(29,967)	0	0	0	0	0	0	0	0	0	0	(29,967)	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	(29,967)	0	0	0	0	0	0	0	0	0	0	(29,967)	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)	(29,967)	0	0	0	0	0	0	0	0	0	0	(29,967)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2007 Ending:09/30/2008

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):*	(56,689)	0	0	0	0	0	0	0	0	0	0	(56,689) 43
44	TOTAL Special Cost Centers	(56,689)	0	0	0	0	0	0	0	0	0	0	(56,689) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(88,063)	0	0	0	0	0	0	0	0	0	0	(88,063) 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			N/A				4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2007 Ending: 09/30/2008

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 10/01/2007 Ending: 9/30/2008

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:

10/01/2007

Ending:

09/30/2008

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. \$ _____ Line # _____

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2007 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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 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:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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

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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	<u>1,219,680</u>		<u>\$ 128,278</u>	<u>3</u>

Facility Name & ID Number Good Samaritan Home

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

1	2	3	4	5	6	7	8	9		
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		1,468,393	6
7	75		1984	1,953,541	48,839	40	48,839		1,200,617	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		135,510	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	415,756	425	Various	425		413,454	19
20	Land Improvements		1985	2,601		20			2,601	20
21	Building Improvements		1985	250,935	6,273	40	6,273		145,963	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		89,750	24
25	Building Service Equipment		1986	137,391	2,514	Various	2,514		130,322	25
26	Building Improvements		1987	19,089	500	Various	500		10,467	26
27	Building Service Equipment		1987	21,221	29	20	29		21,221	27
28	Building Service Equipment		1988	14,400	42	Various	42		14,200	28
29	Building Improvements		1989	174,123	4,421	Various	4,421		130,450	29
30	Building Service Equipment		1989	6,469		Various			6,469	30
31	Garage Additions		1990	78,563	2,619	30	2,619		48,883	31
32	New Roof - North Wing		1990	43,980	2,199	20	2,199		40,498	32
33	Phones		1990	600		10			600	33
34	Hall Renovations		1991	20,616	1,031	20	1,031		18,125	34
35	Building Improvements State Audit Adjustments 10881+30372		1991	511,992	18,441	30	17,066	(1,375)	295,758	35
36	Ceiling/partitions		1991	37,276	1,243	30	1,243		21,538	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.

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 Office Entrance	1991	\$ 14,768	\$ 738	20	\$ 738		\$ 13,291		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		3,192		39
40 Building Services Equipment	1992	2,706		10			2,706		40
41 Parking Lot	1992	46,071	2,304	20	2,304		35,897		41
42 Kitchen/Dining Room	1993	310,412	7,760	40	7,760		118,991		42
43 Building Services Equipment	1993	20,910	238	various	238		18,554		43
44 Parking Lot	1994	87,827	5,855	15	5,855		86,364		44
45 Manhole/Sewer	1994	2,859	191	15	191		2,796		45
46 Sidewalk	1994	7,875	525	15	525		7,394		46
47 West Nursing	1994	66,876	3,344	20	3,344		46,814		47
48 Dining Room	1994	6,990	315	various	315		5,414		48
49 Building Services Equipment	1994	134,323	2,791	various	2,791		119,673		49
50 West Nursing	1995	128,327	6,416	20	6,416		87,155		50
51 West Nursing	1995	3,151	157	20	157		1,969		51
52 Building Services Equipment	1995	22,482	812	various	812		21,332		52
53 Gas Line	1996	3,062	153	20	153		1,914		53
54 Gutters	1996	10,817	541	20	541		6,761		54
55 Eber Wing Improvement	1996	20,335	1,017	20	1,017		12,710		55
56 Roof	1996	9,016	451	20	451		5,635		56
57 Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		42,185		57
58 Building Services Equipment	1996	46,663	2,128	various	2,128		34,823		58
59 Lights/Front Land Improvement	1997	5,360	357	15	357		4,199		59
60 Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		24,024		60
61 Freezer Floor	1997	4,394	258	17	258		3,102		61
62 Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		13,564		62
63 Sprinkling System	1997	3,354	168	10	168		3,354		63
64 Tamper Detectors	1997	2,818	141	10	141		2,818		64
65 Compressor - Eber	1997	2,039	136	15	136		1,540		65
66 Compressor - East	1997	11,808	787	15	787		8,856		66
67 Sprinkler System	1997	102,875	5,144	20	5,144		57,010		67
68 Air Exchange -Pool Area State Audit adjustment 481	1997	8,092	571	15	539	(32)	6,064		68
69 Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		12,552		69
70 TOTAL (lines 4 thru 69)		\$ 8,554,488	\$ 190,822		\$ 189,415	\$ (1,407)	\$ 6,579,697		70

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 8,554,488	\$ 190,822		\$ 189,415	\$ (1,407)	\$ 6,579,697		1
2	Elevator Doors - Dietary	1998 1,095	55	10	55		1,095		2
3	Remodeling -Anna Brow Wing Walls, Ceiling, Floors,Light	1999 199,131	4,978	39	4,978		45,842		3
4	Remodeling -Anna Brow Wing - Duct Detector:	1999 1,444		5			1,444		4
5	Remodeling -Anna Brow Wing - Carpeting	1999 2,966	296	10	296		2,817		5
6	Remodeling -Anna Brow Wing - Fire Damper	1999 21,915	548	39	548		5,136		6
7	Chapel Roof	1999 21,515	538	39	538		5,312		7
8	Fire Damper Alarm	1999 5,490		5			5,490		8
9	Eber Parking Lot Lights	1999 5,495	366	15	366		3,480		9
10	Stainless Steel D/W Exhaust	1999 1,659	166	10	166		1,576		10
11	Wiring Chapel Roof	1999 332	33	10	33		316		11
12	HVAC Chapel	1999 23,760	1,584	15	1,584		15,048		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		21,428		14
15	Elevator Upgrade - Special Care	1999 5,970	597	10	597		5,672		15
16	Fire Protection A/B	1999 4,500	450	10	450		4,275		16
17	Condensor Unit	1999 22,945	1,530	15	1,530		14,532		17
18	Fire Protection Pool Area	1999 776	78	10	78		737		18
19	Damper Duct Work	1999 5,602	373	15	373		3,548		19
20	Lighting- Special Care	1999 2,075	138	15	138		1,314		20
21	Chapel Remodeling - Fire Damper	2000 3,196	213	15	213		1,811		21
22	Chapel Remodeling - Sign	2000 77		5			77		22
23	Chapel Remodeling - Painting	2000 4,751	119	39	119		956		23
24	Chapel Remodeling - Carpeting	2000 3,073	205	15	205		1,741		24
25	Chapel Remodeling - Unity & Pews	2000 14,760	369	39	369		2,967		25
26	Kitchen Remodeling - Skv Roof Flashing	2000 3,086	206	15	206		1,749		26
27	Kitchen Remodeling - Sidewalls	2000 3,485	232	15	232		1,975		27
28	Kitchen Remodeling - Galvanized Wall Divide	2000 2,601	173	15	173		1,474		28
29	East Nursing Remodeling - Walls, Ceilings, Floors	2000 26,757	669	39	669		5,547		29
30	Eber Wing Smoke Damper	2000 16,485	1,099	15	1,099		9,342		30
31	Special Care Lighting	2000 14,290	953	15	953		8,098		31
32	HVAC Rehab Eber Wing	2000 305,419	20,361	15	20,361		173,071		32
33	3 Ton Rooftop Unit A/C West Dining	2000 2,776	185	15	185		1,573		33
34	TOTAL (lines 1 thru 33)	\$ 9,366,455	\$ 229,592		\$ 228,185	\$ (1,407)	\$ 6,991,125		34

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,366,455	\$ 229,592		\$ 228,185	\$ (1,407)	\$ 6,991,125	1
2	Telephone Unit	2000	323		7			324	2
3	Elevator Up Grade East Wing	2000	12,776	852	15	852		7,240	3
4	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		624	4
5	Entrance Codelock Special Car	2000	1,848	123	15	123		1,048	5
6	Life Safety Code Sprinkler Drain	2000	7,000	467	15	467		3,967	6
7	Land Improvement New Sidewall	2000	1,200	60	20	60		450	7
8	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		66,535	8
9	Exterior Painting	2001	14,347	956	15	956		7,174	9
10	Painting Kitchen	2001	2,550	170	15	170		1,275	10
11	Chapel Renovation	2000	2,001	50	39	50		394	11
12	Kitchen Electrical Work	2000	611	41	15	41		305	12
13	HVAC Rehab Eber Wing	2000	5,584	372	15	372		2,792	13
14	Sprinklers	2000	4,151	277	15	277		2,076	14
15	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		1,847	15
16	Electrical Work	2001	1,609	107	15	107		805	16
17	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		25,368	17
18	Air Compressor Anna Brown Wing	2001	10,911	727	15	727		5,456	18
19	3D Detectors in Elevators	2001	4,916	344	10	344		2,564	19
20	Compensators	2001	2,724	191	10	191		1,421	20
21	33 Lever Passage Locks	2002	2,904	203	10	203		1,514	21
22	Exit Lights and Hold Opens	2002	966	68	10	68		504	22
23	16 Lever Passage Locks	2002	1,408	99	10	99		734	23
24	48 Lockouts	2002	985	69	10	69		514	24
25	Water Piping	2001	4,600	115	39	115		791	25
26	New Curb & Driveway	2002	16,118	607	20	607		4,582	26
27	Buffet in Dining Area	2003	2,977	199	15	199		1,127	27
28	Door - code alert and keypad	2003	2,489	249	10	249		1,410	28
29	Fire Collars	2003	3,619	362	10	362		2,034	29
30	Main Breaker	2003	3,291	219	15	219		1,115	30
31	Elevator Master Door Operator	2003	4,278	428	10	428		2,317	31
32	Training Room Drainage	2003	731	19	39	19		103	32
33	Dietary - Floor Drain	2003	223	6	39	6		31	33
34	TOTAL (lines 1 thru 33)		\$ 9,908,339	\$ 249,903		\$ 248,496	\$ (1,407)	\$ 7,139,566	34

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

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,908,339	\$ 249,903		\$ 248,496	\$ (1,407)	\$ 7,139,566	1
2	Handicap Accessible Entrance and Sidewall	2003	3,200	160	20	160		800	2
3	Annunciators	2004	51,494	5,149	10	5,149		23,172	3
4	Sewer Lines	2003	5,801	387	15	387		1,901	4
5	Smoke Damper - Eber	2003	698	47	15	47		225	5
6	Beauty Shop Wiring	2003	2,272	152	15	152		720	6
7	Dietary Doors	2004	3,801	253	15	253		1,182	7
8	Roof	2004	4,028	268	15	268		1,209	8
9	Remote Annunciator	2004	4,650	465	10	465		2,015	9
10	Cooler Expansion	2004	6,120	408	15	408		1,768	10
11	Parking Lot	2004	6,800	453	15	453		1,927	11
12	Ambulance Garage Door	2004	1,070	107	10	107		446	12
13	Kitchen Remodel	2004	6,425	642	10	642		2,570	13
14	Plumbing work in Eber/South	2004	5,147	343	15	343		1,315	14
15	Water Softener System	2004	15,642	1,564	10	1,564		5,866	15
16	Storage Tank Replacement	2004	2,454	245	10	245		920	16
17	Air Handler in East Circle	2005	1,297	130	10	130		443	17
18	Parking Lot Off-Street	2005	68,884	4,592	15	4,592		15,308	18
19	Kitchen Electrical Work	2004	247	12	20	12		49	19
20	Kitchen Remodel	2004	1,248	62	20	62		244	20
21	Sprinkler System	2004	980	49	20	49		188	21
22	Sprinkler System	2005	2,373	119	20	119		435	22
23	Tunnel Closure	2005	1,888	126	15	126		462	23
24	Perry Suite Renovations	2005	2,470	165	15	165		590	24
25	Water Heater	2006	13,003	1,300	10	1,300		3,217	25
26	Telephone System	2006	65,476	4,613	various	4,613		11,730	26
27	Sprinkler System Pipes	2006	1,645	142	various	142		308	27
28	Overhead Door	2005	1,400	140	10	140		408	28
29	Concrete Work	2005	9,936	662	15	662		1,877	29
30	Fire Walls	2006	14,948	747	20	747		1,744	30
31	Fire Alarm System	2006	23,500	1,567	15	1,567		4,178	31
32	Life Safety Code Renovations	2006	1,905	190	10	190		492	32
33	Renovations to Building Front Entrance	2006	38,611	1,931	20	1,931		4,505	33
34	TOTAL (lines 1 thru 33)		\$ 10,277,752	\$ 277,093		\$ 275,686	\$ (1,407)	\$ 7,231,780	34

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

Facility Name & ID Number Good Samaritan Home

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 10,277,752	\$ 277,093		\$ 275,686	\$ (1,407)	\$ 7,231,780		1
2	Telephone System Wiring	2006 35,781	3,578	10	3,578		7,473		2
3	Pool Area Renovations	2006 98,370	4,919	20	4,919		11,886		3
4	Concrete Work	2006 3,850	257	15	257		620		4
5	Lighting in the Hallway	2006 7,872	394	20	394		886		5
6	Laundry Renovations- Air Systen	2006 9,841	492	20	492		1,107		6
7	Smoke/Fire Dampers Special Care Area	2006 14,683	734	20	734		1,652		7
8	Eber Elevator Remodel	2006 12,769	851	15	851		1,632		8
9	Sprinkler System Head	2006 20,456	1,364	15	1,364		2,387		9
10	South Wing Fiber Service	2007 2,526	168	15	168		295		10
11	Smoke/Fire Detectors	2007 10,431	1,043	10	1,043		1,739		11
12	Repairs to Boiler Motor	2007 954	95	10	95		159		12
13	Smoke/Fire Dampers	2007 1,125	113	10	113		188		13
14	CO Detectors	2007 1,483	148	10	148		173		14
15	Call Lights - Dining Hall	2007 823	82	10	82		89		15
16	Hot Water Tank	2007 2,588	259	10	259		302		16
17	Repairs to Hot Water Shower Area	2007 1,113	113	10	113		111		17
18	Compressor - Walk in	2007 2,922	292	10	292		292		18
19	Repairs to Wiring in Chapel Area	2007 14,516	968	15	968		968		19
20	HVAC Controllers	2007 11,952	797	15	797		797		20
21	Physical Therapy Ductwork Repair	2006 2,254	150	15	150		288		21
22	Alarm Stations Repairs	2006 27,685	1,846	15	1,846		3,230		22
23	Dining Hall Electric	2007 890	59	15	59		104		23
24	Chapel Roof Repair	2007 3,528	235	15	235		412		24
25	Special Care Area Door	2007 3,038	304	10	304		506		25
26	Dining Hall Paint	2007 7,401	740	10	740		1,172		26
27	Special Care Area Bathroom Repair	2007 4,106	274	15	274		411		27
28	Pool Area Renovations	2007 5,108	341	15	341		511		28
29	Dinning Hall Roof Repairs	2007 573	38	15	38		57		29
30	Front Hall Area Roof Repair	2007 3,100	207	15	207		310		30
31	Storm Sewer Line	2007 3,459	231	15	231		308		31
32	Dietary Doors	2007 1,485	148	10	148		148		32
33	Alarm System at Stations	2007 4,450	371	10	371		371		33
34	TOTAL (lines 1 thru 33)	\$ 10,598,884	\$ 298,704		\$ 297,297	\$ (1,407)	\$ 7,272,364		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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,598,884	\$ 298,704		\$ 297,297	\$ (1,407)	\$ 7,272,364	1
2	Roof South Eber	2007	9,587	533	15	533		533	2
3	B&G Series 1510- 2 Pump	2008	7,597		10				3
4	Fiber Projest Improvements	2008	10,646	355	15	355		355	4
5	Door Closers	2008	10,180		10				5
6	Pine Doors	2008	1,714	57	10	57		57	6
7	Evevator Renovator	2008	122,827	2,729	15	2,729		2,729	7
8	Wanderer Alert Svsyten	2008	1,968	98	10	98		98	8
9	CO System Detectors	2008	1,395	58	10	58		58	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	Guest Room Income Offset					(3,570)	(3,570)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,764,798	\$ 302,534		\$ 297,557	\$ (4,977)	\$ 7,276,194	34

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

Facility Name & ID Number: Good Samaritan Hom # 0009258 Report Period Beginning: 10/01/2007 Ending: 09/30/2008
 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	\$ 1,387,019	\$ 156,693	\$ 156,693	\$	3-20 yrs	\$ 787,453	71
72	Current Year Purchases	116,095	9,704	9,704		5-10 yrs	9,704	72
73	Fully Depreciated Assets	1,040,920				3-20 yrs	1,040,920	73
74								74
75	TOTALS	\$ 2,544,034	\$ 166,397	\$ 166,397	\$		\$ 1,838,077	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	33,106	33,106		5-10 yrs	129,374	79
80	TOTALS			\$ 320,849	\$ 33,106	\$ 33,106	\$		\$ 248,229	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)	\$ 13,757,959	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 502,037	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 497,060	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,977)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,362,500	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	8,361,514	184,685	5,322,536	88
89	Rental Property Fixed Assets	371,077	13,432	90,169	89
90	Radio Station	15,038	107	14,300	90
91	TOTALS	\$ 9,030,738	\$ 198,224	\$ 5,427,005	91

G. Construction-in-Progress

	Description	Cost	
92	Building Construction	\$ 1,949,813	92
93			93
94			94
95		\$ 1,949,813	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	\$ 0	\$ 0	\$ 0	5 yrs	\$ 710	42
43	Maintenance	Chevy S-10 98	2002	7,508	0	0	0	5 yrs	6,457	43
44	Facility	Toro mower	2003	7,139	714	714	0	5 yrs	7,139	44
44a	Facility	Ford/Goshen Bus (2)	2004	98,532	19,706	19,706	0	5 yrs	83,752	44a
44b	Facility	Lift for Van	2005	1,500	300	300	0	5 yrs	1,025	44b
44c	Facility	Toto mower	2005	9,792	1,958	1,958	0	5 yrs	6,691	44c
44d	Facility	2005 Chrysler Town	2005	21,931	4,386	4,386	0	5 yrs	13,158	44d
44e	Facility	1999 Chevy Van	2005	5,648	1,130	1,130	0	5 yrs	3,200	
44f	Facility	Kubota L3430	2006	18,895	1,890	1,890	0	10 yrs	3,464	
44g	Facility	Ford F350	2007	30,224	3,022	3,022	0	10 yrs	3,778	
44h	Facility									
45							0			45
46	TOTALS			\$ 201,994	\$ 33,106	\$ 33,106	\$ 0		\$ 129,374	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.	<u>/2009</u>	\$ <u>N/A</u>
13.	<u>/2010</u>	\$ <u>N/A</u>
14.	<u>/2011</u>	\$ <u>N/A</u>

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 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.

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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$ 3,752	\$	\$ 3,752
2	Books and Supplies		915		915
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments:		150		150
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,817	\$	\$ 4,817
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,817		

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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	L. 10a C 3	hrs	\$	2,319	\$	139,153	\$			2,319	\$	139,153	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		221		13,252				221		13,252	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	L. 10a C 3	hrs		6,706		402,386		2,677		6,706		405,063	4
5	Physician Care		visits											5
6	Dental Care	L. 10 C 2,3	visits		12		2,400				12		2,400	6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	L. 39 C 2	# of prescripts						175,159				175,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify): See Sch 16A				2		214				2		214	13
14	TOTAL			\$	9,260	\$	557,405	\$	177,836		9,260	\$	735,241	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

10/01/2007 to 09/30/2008

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>
Respiratory Therapy	L. 10a C 2	2	214	
Total		2	214	0

Good Samaritan Home
0009258
09/30/2008

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
ST Disability Payable - Employee	3,151	3,151
United Way Deduction	62	62
Employee Assist Fund Withheld	9,986	9,986
Benevolent Fund Payable	5,159	5,159
Flower Fund Payable	(6,694)	(6,694)
Application Fee Payable	27,005	27,005
Medicare Liability	13,017	13,017
Medicaid Liability	23	23
Employee Health/Life Liability	20,031	20,031
Total Line 36 - Other Current Liabilities(specify):	71,740	71,740

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 43,933,890	1
2	Restatements (describe):	(3)	2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 43,933,887	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,631,947)	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)	\$ (4,631,947)	17
B. Transfers (Itemize):			
18			18
19			19
20	Rounding		20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 39,301,940	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2007Ending: 09/30/2008**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	\$ 11,027,501	1
2	Discounts and Allowances for all Level	(1,417,083)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,610,418	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	952,093	6
7	Oxygen	8,257	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 960,350	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	33,144	12
13	Barber and Beauty Care	59,450	13
14	Non-Patient Meals	29,967	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	332,100	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	32,754	19
20	Radiology and X-Ray	14,877	20
21	Other Medical Services	121,636	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 623,928	23
D. Non-Operating Revenue			
24	Contributions	45,774	24
25	Interest and Other Investment Income**	(3,972,004)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (3,926,230)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19E	46,869	28
28a	Cottage and Rental Property Income	1,444,581	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,491,450	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,759,916	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,302,767	31
32	Health Care	5,744,785	32
33	General Administrator	2,518,380	33
B. Capital Expense			
34	Ownership	502,037	34
C. Ancillary Expense			
35	Special Cost Centers	1,226,172	35
36	Provider Participation Fee	97,722	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,391,863	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,631,947)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,631,947)	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
09/30/2008

Schedule 19E

XVII. INCOME STATEMENT
Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	1,194
Discount Earned Income	7,315
Adjustments	
Guest Room Income	3,570
Van Transportation	31,965
Cottage Services Income	2,825
Application Fee Income	
Total Line 28 - Other Revenue (specify):	<u><u>46,869</u></u>

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

0009258

Report Period Beginning: **10/01/2007**

Ending:

09/30/2008

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	1,816	2,080	\$ 80,660	\$ 38.78	1
2	Assistant Director of Nursing	1,844	2,156	56,544	26.23	2
3	Registered Nurses	13,809	14,840	321,452	21.66	3
4	Licensed Practical Nurses	74,801	82,277	1,372,075	16.68	4
5	CNAs & Orderlies	197,204	212,228	2,339,349	11.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,628	16,351	181,593	11.11	8
9	Activity Director	1,872	2,080	33,030	15.88	9
10	Activity Assistants	12,682	13,743	128,925	9.38	10
11	Social Service Worker	12,887	14,776	149,515	10.12	11
12	Dietician					12
13	Food Service Supervisor	7,632	8,488	144,782	17.06	13
14	Head Cook	7,872	8,676	96,939	11.17	14
15	Cook Helpers/Assistants	61,404	67,376	626,166	9.29	15
16	Dishwashers	6,531	7,128	67,391	9.45	16
17	Maintenance Worker	23,957	26,167	290,226	11.09	17
18	Housekeepers	25,150	28,092	268,770	9.57	18
19	Laundry	12,724	14,189	143,138	10.09	19
20	Administrator	1,888	2,080	118,458	56.95	20
21	Assistant Administrator	1,868	2,080	93,370	44.89	21
22	Other Administrative	5,918	6,796	140,135	20.62	22
23	Office Manager					23
24	Clerical	18,396	20,480	277,304	13.54	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	1,951	2,164	34,271	15.84	31
32	Other Health C: SCH 20A	13,994	15,440	174,006	11.27	32
33	Other(specify) SCH 20A	13,417	14,706	163,700	11.13	33
34	TOTAL (lines 1 - 33)	534,245	584,393	\$ 7,301,799 *	\$ 12.49	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	424	\$ 15,947	L. 1 C3	35
36	Medical Director	Monthly	3,600	L. 9 C3	36
37	Medical Records Consultant	Quarterly	1,720	L. 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,370	L. 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,398	L. 11 C3	44
45	Social Service Consultant	28	2,004	L. 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	471	\$ 33,039		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
09/30/2008

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	9,657	10,578	104,225	9.85
Medical Supply Clerk	2,285	2,519	26,900	10.68
Staff Coord.	2,052	2,343	42,881	18.30
Total Line 32 - Other	13,994	15,440	\$ 174,006	\$ 11.27

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Maintenance Cottages	5,989	6,542	\$ 72,557	11.09
Beauty Shop	5,035	5,491	69,191	12.60
General Store	2,393	2,673	21,952	8.21
Total Line 33 - Other	13,417	14,706	\$ 163,700	\$ 11.13

Good Samaritan Home
Provider #: 0009258
10/01/2007 to 09/30/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 33,005

Total (agree to Schedule V, line 19, column 8) 33,005

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2007Ending: 09/30/2008**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 \$15,758 CHHS\$7,986
- (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? 7.68 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 71,277 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. 97,722
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 \$ 29,967
- (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? Firm Name: Dennis G. Koch 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

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	198,448	198,448
2. Cash - Patient Deposits	21,530	21,530
3. Accounts & Notes Recievable	1,790,497	1,790,497
4. Supply Inventory	0	0
5. Short-Term Investments	1,502,089	1,502,089
6. Prepaid Insurance	76,866	76,866
7. Other Prepaid Expenses	14,695	14,695
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	32,826	32,826
10. Total current assets	3,636,951	3,636,951
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	27,527,846	27,527,846
13. Land	128,278	128,278
14. Buildings, at Historical Cost	11,017,474	10,764,798
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,864,883	2,864,883
17. Accumulated Depreciation (book methods)	-9,597,703	-9,362,500
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):	1,949,813	1,949,813
23. other (specify):	3,603,736	3,603,736
24. Total Long-Term Assets	37,494,327	37,476,854
25. Total Assets	41,131,278	41,113,805
CURRENT LIABILITIES		
26. Accounts Payable	451,333	451,333
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	21,530	21,530
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	502,169	502,169
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	9,945	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):	71,740	71,740
37. Other Current Liabilities (specify):	772,621	772,621
38. Total Current Liabilities	1,829,338	1,819,393
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	1,829,338	1,819,393
47. Total Equity	39,301,940	39,294,412
48. Total Liabilities and Equity	41,131,278	41,113,805

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,027,501
2. Discounts and Allowances for all Levels	-1,417,083
Subtotal - Inpatient Care	9,610,418
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	952,093
7. Oxygen	8,257
Subtotal - Ancillary Revenue	960,350
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	33,144
13. Barber and Beauty Care	59,450
14. Non-Patient Meals	29,967
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	332,100
18. Sale of Supplies to Non-Patients	0
19. Laboratory	32,754
20. Radiology and X-Ray	14,877
21. Other Medical Services	121,636
22. Laundry	0
Subtotal - Other Operating Revenue	623,928
24. Contributions	45,774
25. Interest and Other Investments Income	-3,972,004
Subtotal - Non-Operating Revenue	-3,926,230
27. Other Revenue (specify):	46,869
28. Other Revenue (specify):	1,444,581
Subtotal - Other Revenue	1,491,450
30. Total Revenue	8,759,916
31. General Services	3,064,181
32. Health Care	5,601,294
33. General Administration	2,586,743
34. Ownership	481,142
35. Special Cost Centers	1,132,917
35. Provider Participation Fee	97,455
37. Other	0
40. Total Expenses	12,963,732
41. Income Before Income Taxes	-4,203,816
42. Income Taxes	0
43. Net Income or Loss for the Year	-4,203,816