



Facility Name & ID Number Good Samaritan Home - Flanagan

# 0009241 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,960	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	60	TOTALS	60	21,960	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	10,678	8,419	1,640	20,737	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,678	8,419	1,640	20,737	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.43%

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)

Peace Meals

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  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 12/01/68

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 60 and days of care provided 1,488

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  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 Home - Flanagan # 0009241 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
	<b>A. General Services</b>										
1	Dietary	234,799	11,905	4,910	251,614		251,614		251,614		1
2	Food Purchase		135,445		135,445		135,445	(33,406)	102,039		2
3	Housekeeping	113,137	14,937		128,074		128,074		128,074		3
4	Laundry	49,857	3,489		53,346		53,346		53,346		4
5	Heat and Other Utilities			101,200	101,200		101,200		101,200		5
6	Maintenance	66,922	17,164	46,337	130,423		130,423		130,423		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>464,715</b>	<b>182,940</b>	<b>152,447</b>	<b>800,102</b>		<b>800,102</b>	<b>(33,406)</b>	<b>766,696</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,101,289	49,111	59,417	1,209,817		1,209,817		1,209,817		10
10a	Therapy			135,733	135,733		135,733		135,733		10a
11	Activities	84,000	2,966	12,466	99,432		99,432		99,432		11
12	Social Services	21,527	33	642	22,202		22,202		22,202		12
13	CNA Training	500	147		647		647		647		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,207,316</b>	<b>52,257</b>	<b>214,258</b>	<b>1,473,831</b>		<b>1,473,831</b>		<b>1,473,831</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	59,041			59,041		59,041		59,041		17
18	Directors Fees										18
19	Professional Services			83,424	83,424		83,424		83,424		19
20	Dues, Fees, Subscriptions & Promotions			13,062	13,062		13,062	(235)	12,827		20
21	Clerical & General Office Expenses	156,496	13,047	26,834	196,377		196,377	(5,971)	190,406		21
22	Employee Benefits & Payroll Taxes			494,862	494,862		494,862	14,259	509,121		22
23	Inservice Training & Education			9,658	9,658		9,658		9,658		23
24	Travel and Seminar			1,417	1,417		1,417		1,417		24
25	Other Admin. Staff Transportation			7,907	7,907		7,907		7,907		25
26	Insurance-Prop.Liab.Malpractice			69,979	69,979		69,979		69,979		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>215,537</b>	<b>13,047</b>	<b>707,143</b>	<b>935,727</b>		<b>935,727</b>	<b>8,053</b>	<b>943,780</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,887,568</b>	<b>248,244</b>	<b>1,073,848</b>	<b>3,209,660</b>		<b>3,209,660</b>	<b>(25,353)</b>	<b>3,184,307</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Good Samaritan Home - Flanagan

#0009241

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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	
	<b>D. Ownership</b>											
30	Depreciation			128,225	128,225		128,225	71,143	199,368			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,440	31,440		31,440	(20,701)	10,739			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,000	3,000		3,000		3,000			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			162,665	162,665		162,665	50,442	213,107			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,213		44,213		44,213		44,213			39
40	Barber and Beauty Shops		10,003		10,003		10,003		10,003			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* <b>Non-allowable cost</b>	82,706		505,445	588,151		588,151	(588,151)				43
44	<b>TOTAL Special Cost Centers</b>	82,706	54,216	538,295	675,217		675,217	(588,151)	87,066			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,970,274	302,460	1,774,808	4,047,542		4,047,542	(563,062)	3,484,480			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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	(19,147)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,820)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	71,143	30		9
10	Interest and Other Investment Income	(20,701)	32		10
11	Discounts, Allowances, Rebates & Refunds				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	(535)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,024)	43		24
25	Fund Raising, Advertising and Promotional	(53,800)	43		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 See Pg. 5A	(494,178)	Vari.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (563,062)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (563,062)		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 Shops		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

## Good Samaritan Home - Flanagan

ID# 0009241

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow nonallowable independent living exp	\$		1
2	Apartment	(58,049)	43	2
3	Duplexes	(142,925)	43	3
4				4
5	Ancillary laboratory expenses	(4,725)	43	5
6	Ancillary X-Ray expenses	(1,423)	43	6
7	Newsletter expense	(5,699)	43	7
8	Flowers expense	(1,624)	43	8
9	Resident expense	(691)	43	9
10	Volunteer appreciation	(402)	43	10
11	Summerfest expense	(5,671)	43	11
12	Fund Development Manager	(45,071)	43	12
13	Strategic Consulting	(45,166)	43	13
14	To offset Misc Exp related to AP per AJE	(176,526)	43	14
15	Offset miscellaneous expense	(5,971)	21	15
16	Non-allowable dues	(235)	20	16
17	Employee Meal Reclass	(14,259)	2	17
18	Employee Meal Reclass	14,259	22	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	<b>Total</b>	(494,178)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home - Flanagan# 0009241

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	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,259)	0	0	0	0	0	0	0	0	0	0	(14,259)	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	<b>TOTAL General Services</b>	<b>(14,259)</b>	<b>0</b>	<b>(14,259)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(235)	0	0	0	0	0	0	0	0	0	0	(235)	20
21	Clerical & General Office Expenses	(5,971)	0	0	0	0	0	0	0	0	0	0	(5,971)	21
22	Employee Benefits & Payroll Taxes	14,259	0	0	0	0	0	0	0	0	0	0	14,259	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	<b>TOTAL General Administration</b>	<b>8,053</b>	<b>0</b>	<b>8,053</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(6,206)</b>	<b>0</b>	<b>(6,206)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home - Flanagan # 0009241 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	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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):*	(487,972)	0	0	0	0	0	0	0	0	0	0	(487,972) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(487,972)</b>	<b>0</b>	<b>(487,972) 44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(494,178)</b>	<b>0</b>	<b>(494,178) 45</b>									

**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			N/A				3
4	V							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 VI.

Facility Name & ID Number Good Samaritan Home - Flanagan # 0009241 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	See attached Schedule 7A										3
4											4
5	No members of the Board of Directors have ownership in a business that conducts business with the organization										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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home - Flanagan

# 0009241

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

Name of Related Organization N/A

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									3
4			N/A						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Good Samaritan Home - Flanagan

# 0009241

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	St. Petri Church		X	Mortgage	Interest only	2/26/96	\$ 25,000	\$ 25,000	11/1/11	0.0700	\$ 1,750	1								
2	St. Johns-Graymont St. Bank		X	Mortgage	Interest only	2/26/96	100,000	100,000	11/1/11	0.0517	4,400	2								
3	Flanagan State Bank		X	Mortgage	Int & Principal	4/18/08	361,000	352,056	4/25/13	0.0600	15,511	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Flanagan State Bank		X	Operating - LOC	Demand	12/8/08	242,000	242,000	2/28/09	0.0725	9,779	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 728,000	\$ 719,056			\$ 31,440	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13									Interest Income offset		(20,701)	13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (20,701)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 728,000	\$ 719,056			\$ 10,739	15								

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>49,275</b>	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.)	2007	\$	<b>52,557</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,282</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>46,519</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(49,801)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	<b>48,013</b>	10
	2006	<b>50,883</b>	11
	2007	<b>52,557</b>	12

**Real estate taxes applies to duplexes and is eliminated on Sch. V, Line 33, Col 7.**

<b>FOR BHF USE ONLY</b>			
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 filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Home - Flanagan COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0009241

CONTACT PERSON REGARDING THIS REPORT Richard Curtis

TELEPHONE (815) 796-2288 FAX #: (815) 796-2280

**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. <u>13-22-278-009</u>	<u>Duplexes</u>	\$ <u>52,557.00</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>52,557.00</u>	\$ _____

**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?  X  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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home - Flanagan

# 0009241

Report Period Beginning:

01/01/08

Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,700 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories One

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).

Independent living facilities - Duplexes and Congregate Living Apartments

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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>14 Acres</u>	<u>1966</u>	<u>\$ 22,917</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>14 Acres</b>		<b>\$ 22,917</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Good Samaritan Home - Flanagan

# 0009241

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60	1968	1968	\$ 754,053	\$	40	\$	\$	\$ 754,053	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1980	49,983		20	584	584	25,617	9
10	Various		1981	4,961		20				10
11	Various		1982	7,246		20				11
12	Various		1991	58,000		20	1,841	1,841	33,066	12
13	Various		1992	49,137		20	2,371	2,371	42,498	13
14	Various		1995	257,361		20	6,599	6,599	88,263	14
15	Various		1996	30,610		20	785	785	10,172	15
16	Various		1997	29,894		20	766	766	8,718	16
17	Various		2000	34,290		20	1,040	1,040	9,111	17
18	Various		2001	150,943		20	15,040	15,040	108,117	18
19	Kitchen & Office Addition		2000	739,459		10	73,946	73,946	518,835	19
20	Painting		2000	2,680		10	268	268	1,854	20
21	None		2000	1,629		10	163	163	1,127	21
22	New Floors		2000	872		10	87	87	581	22
23	Air Conditioner Compressor		2000	6,651		10	665	665	4,323	23
24	Cabling		2003	1,541		10	154	154	834	24
25	Windows		2003	6,350		10	635	635	3,228	25
26	Brass Plaques		2003	884		15	59	59	354	26
27	Dishwasher Rack		2003	160		7	23	23	138	27
28	Kitchen Addition		2003	60,663		7	8,666	8,666	51,996	28
29	Kitchen Addition		2003	6,019		7	860	860	5,088	29
30	Kitchen Addition		2003	113,993		7	16,285	16,285	94,995	30
31	Kitchen Addition		2003	2,086		7	298	298	1,738	31
32	Mini-blinds		2003	616		10	62	62	361	32
33	Mini-blinds		2003	2,236		10	224	224	1,343	33
34	Telephone System		2003	(4,707)		10	(471)	(471)	(2,825)	34
35	Kitchen Addition		2003	60,514		7	8,645	8,645	48,988	35
36	Kitchen Addition		2003	9,492		7	1,356	1,356	7,684	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Good Samaritan Home - Flanagan

# 0009241

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		
37	Kitchen Addition	2003	\$ 5,377	\$	7	\$ 768	\$ 768	\$ 4,224	37
38	Mc Cable	2003	589		10	59	59	319	38
39	Kitchen Addition	2003	2,562		7	366	366	1,983	39
40	Wire	2003	2,045		10	205	205	1,075	40
41	Backflow Preventer	2003	398		10	40	40	226	41
42	HVAC	2003	865		10	87	87	485	42
43	Kitchen & Office Addition	2003	480		20	24	24	122	43
44	Phone Switch	2003	150		10	15	15	61	44
45	Paint Rooms	2004	1,120		10	112	112	434	45
46	Amp Carad for Boiler	2004	816		10	81	81	318	46
47	Door Alarm Service	2004	597		5	119	119	546	47
48	Repair South Chiller/Fans	2004	440		5	88	88	396	48
49	Blacktop-Home	2005	1,176		20	59	59	203	49
50	Painting	2005	2,200		10	220	220	843	50
51	Nurses Station	2005	5,000		20	250	250	792	51
52									52
53	Nurses Station Upgrade	2006	1,279		20	32	32	96	53
54	General Project Parts-Nurses Station	2006	1,127		20	28	28	84	54
55	Fire Safety System Additions	2006	2,977		20	74	74	222	55
56	Phone Lines	2006	344		10	17	17	51	56
57	Annunciaiton Panel	2006	5,554		10	278	278	834	57
58	Entryway Flooring, Wallcovering, and Countertop Replace	2007	6,024		10	409	409	818	58
59	Water Heater Install & Plumbing	2007	10,500		10	788	788	1,576	59
60	Doorlock System	2007	13,986		10	466	466	932	60
61	Water Heater Replacement	2007	18,612		10	1,396	1,396	2,792	61
62	Land Scaping - Painting & Patch work	2008	3,332		10	333	333	333	62
63									63
64									64
65									65
66									66
67	Financial statement depreciation booked			75,046			(75,046)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,525,166	\$ 75,046		\$ 147,265	\$ 72,219	\$ 1,840,022	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Good Samaritan Home - Flanagan

# 0009241

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	\$ 569,650	\$	\$ 43,506	\$ 43,506	10	\$ 537,126	71
72	Current Year Purchases	34,392		3,439	3,439	10	3,439	72
73	Fully Depreciated Assets	363,162					363,162	73
74	Current Booked Depre		43,849		(43,849)			74
75	TOTALS	\$ 967,204	\$ 43,849	\$ 46,945	\$ 3,096		\$ 903,727	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	Ford E450	1998	\$ 48,859	\$	\$	\$		\$ 48,859	76
77	Resident care	Brake repairs-Ford E-450	2006	1,792		448	448	4	905	77
78	Resident care	Dodge Sprinter Van	2007	47,092	9,330	4,709	(4,621)	10	9,755	78
79										79
80	TOTALS			\$ 97,743	\$ 9,330	\$ 5,157	\$ (4,173)		\$ 59,519	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)	\$ 3,613,030	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 128,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,368	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 71,143	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,803,268	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	Apartments & Improvements	\$ 1,345,110	\$ 39,511	\$ 453,505	86
87	Duplexes & Improvements	1,554,577	45,003	683,013	87
88					88
89					89
90					90
91	TOTALS	\$ 2,899,687	\$ 84,514	\$ 1,136,518	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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				N/A			4
5								5
6								6
7	TOTAL				\$			7

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: \$ 3,000 Description: Rental Shed - \$3,000

(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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

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 \$ \_\_\_\_\_

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

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

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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>390</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>160</u></p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 147	\$	\$ 147
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		500		500
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 647	\$	\$ 647
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	647		

**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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>3</b>

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10A(3)	hrs	\$	833	\$ 49,953	\$	833	\$ 49,953	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		138	8,264		138	8,264	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,291	77,436		1,291	77,436	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				42,054		42,054	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Respiratory Therapy Other (specify): <u>Oxygen</u>	10A(3) 39(2)			1	80	2,159	1	2,159	13
14	TOTAL			\$	2,262	\$ 135,733	\$ 44,213	2,262	\$ 179,866	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Good Samaritan Home - Flanagan

# 0009241

Report 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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 82,215	\$ 82,215	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	666,026	666,026	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments	158,721	158,721	5
6	Prepaid Insurance	3,712	3,712	6
7	Other Prepaid Expenses	15,082	15,082	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>                                    </u>			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 925,756	\$ 925,756	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,917	22,917	13
14	Buildings, at Historical Cost	2,587,858	754,053	14
15	Leasehold Improvements, at Historical Cost	104,555	1,771,113	15
16	Equipment, at Historical Cost	1,047,438	1,064,947	16
17	Accumulated Depreciation (book methods)	(2,239,071)	(2,803,268)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Non-care assets, net</u> )	1,776,236	1,776,236	22
23	Other(specify): <u>Investments-A/R Long-Term</u>	205,000	205,000	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,504,933	\$ 2,790,998	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,430,689	\$ 3,716,754	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 239,374	\$ 239,374	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	383,248	383,248	29
30	Accrued Salaries Payable	64,392	64,392	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,519	46,519	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	211,289	211,289	36
37	<u>Deferred Revenue - Duplexes</u>	199,602	199,602	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,144,424	\$ 1,144,424	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	335,808	335,808	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deferred Support</u>	930,409	930,409	43
44	<u>Non-Interest Leases - Duplexes</u>	33,900	33,900	44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,300,117	\$ 1,300,117	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,444,541	\$ 2,444,541	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,986,148	\$ 1,272,213	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,430,689	\$ 3,716,754	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,421,626</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Reverse P/Y restricted contribution add-on</b>	<b>(7,151)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,414,475</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(428,327)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(428,327)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,986,148</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,886,100	1
2	Discounts and Allowances for all Levels	85,719	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,971,819	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	161,674	6
7	Oxygen	12,623	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 174,297	8
<b>C. Other Operating Revenue</b>			
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	10,843	13
14	Non-Patient Meals	19,147	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,961	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,857	19
20	Radiology and X-Ray		20
21	Other Medical Services	18,344	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 88,152	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	73,323	24
25	Interest and Other Investment Income***	57,185	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 130,508	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	26,885	28
28a	<u>Apartment &amp; Duplex Income &amp; Support</u>	227,554	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 254,439	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,619,215	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	800,102	31
32	Health Care	1,473,831	32
33	General Administration	935,727	33
<b>B. Capital Expense</b>			
34	Ownership	162,665	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	642,367	35
36	Provider Participation Fee	32,850	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,047,542	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(428,327)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (428,327)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Good Samaritan Home - Flanagan  
Provider #: 0009241  
01/01/08 to 12/31/08

**Schedule 19A**

Schedule XVII - Income Statement

Line 28 - Other Revenue

Resident Purchases	1,894
Craft Income	-
Chapel Offering	1
Miscellaneous Income	5,971
Summerfest Income	13,865
Staff Fund Raisers Income	<u>5,154</u>
Total - Line 28	<u><u>26,885</u></u>

Facility Name & ID Number Good Samaritan Home - Flanagan

# 0009241

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	1,643	2,085	\$ 59,506	\$ 28.54	1
2	Assistant Director of Nursing	1,931	2,217	56,348	25.42	2
3	Registered Nurses	5,547	5,778	143,925	24.91	3
4	Licensed Practical Nurses	7,292	8,188	167,885	20.50	4
5	CNAs & Orderlies	49,637	54,174	580,044	10.71	5
6	CNA Trainees	49	49	500	10.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,183	3,536	39,268	11.11	8
9	Activity Director	1,707	2,080	27,764	13.35	9
10	Activity Assistants	6,037	6,745	56,236	8.34	10
11	Social Service Workers	1,854	2,011	21,527	10.70	11
12	Dietician					12
13	Food Service Supervisor	1,649	1,849	35,971	19.45	13
14	Head Cook	5,170	5,882	61,518	10.46	14
15	Cook Helpers/Assistants	13,219	14,781	137,310	9.29	15
16	Dishwashers	0	0			16
17	Maintenance Workers	5,297	5,701	66,922	11.74	17
18	Housekeepers	10,936	12,611	113,137	8.97	18
19	Laundry	4,707	5,431	49,857	9.18	19
20	Administrator	1,861	2,080	59,041	28.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,936	10,321	156,496	15.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,911	2,115	54,312	25.68	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Indep Living Sal.</u>	5,547	6,406	82,706	12.91	33
34	TOTAL (lines 1 - 33)	138,113	154,040	\$ 1,970,274 *	\$ 12.79	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	123	\$ 4,910	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	959	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	4,613	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	606	11(3)	44
45	Social Service Consultant	9	642	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	\$ 17,730		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	708	\$ 29,661	10(3)	50
51	Licensed Practical Nurses	556	21,529	10(3)	51
52	Certified Nurse Assistants/Aides	95	2,655	10(3)	52
53	TOTAL (lines 50 - 52)	1,358	\$ 53,845		53

SEE ACCOUNTANTS' COMPILATION REPORT

**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		
Richard Curtis	Administrator	0	\$ 59,041	Workers' Compensation Insurance	\$ 63,669	IDPH License Fee	\$ 3,979		
				Unemployment Compensation Insurance	4,552	Advertising: Employee Recruitment			
				FICA Taxes	155,923	Health Care Worker Background Check	1,120		
				Employee Health Insurance	216,742	(Indicate # of checks performed <u>56</u> )	688		
				Employee Meals	14,259	Patient Background Checks	<u>142</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	3,793		
				Employee Pension Plan	37,151	Miscellaneous Dues & Subscriptions	1,982		
				Benefits Administration Fee	2,433	Printed Materials	1,500		
				Uniforms	1,289				
				Employee Screening & Physicals	3,382	Less: Public Relations Expense	(235)		
				Employee Morale & Motivation	9,721	Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,041	TOTAL (agree to Schedule V, line 22, col.8)		\$ 509,121	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,827
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
N/A				N/A			Out-of-State Travel	\$	
							In-State Travel	1,417	
							Seminar Expense		
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,417
C. Professional Services									
Vendor/Payee	Type								
Jerry Pinney & Assoc.	Legal	\$	150						
ADP Resource	Payroll		38,355						
Diaz Sign Art	Misc Consulting		500						
Revere Healthcare	Site Reports		12,353						
McGladrey & Pullen	Accounting		25,881						
R. Russell & Assoc.	Maintenance Consulting		3,238						
Frost Ruttenberg & Rothblatt	Accounting		2,947						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 83,424						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2005					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A						N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home - Flanagan# 0009241

Report Period Beginning:

01/01/08

Ending:

12/31/08**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 - \$3,793
- (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? N/A
- (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? N/A
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,270 Line 10(2)
- (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. \$ 32,850  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ 14,259 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 19,147
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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? N/A  
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? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen 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? No If no, please explain. Audit not yet complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? No
- (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

**SEE ACCOUNTANTS' COMPILATION REPORT**