

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955 Report Period Beginning: 01/01/09 Ending: 01/01/09

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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	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	10,960	10,907	2,254	24,121	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,960	10,907	2,254	24,121	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.41%

D. How many bed-hold days during this year were paid by the Department? _____ (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 TherapyF. 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 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 09/20/1967J. 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 70 and days of care provided 2,235Medicare Intermediary Noridian

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview # 0012955 Report Period Beginning: 01/01/09 Ending: 01/01/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	198,834	14,235	6,982	220,051		220,051	(187)	219,864		1
2	Food Purchase		150,423		150,423		150,423	(8,912)	141,511		2
3	Housekeeping	51,490	15,745		67,235		67,235	(283)	66,952		3
4	Laundry	48,960	13,059		62,019		62,019	(234)	61,785		4
5	Heat and Other Utilities			79,378	79,378		79,378		79,378		5
6	Maintenance	102,541	7,425	31,195	141,161		141,161	(10,338)	130,823		6
7	Other (specify):*			1,676	1,676		1,676	(15)	1,661		7
8	TOTAL General Services	401,825	200,887	119,231	721,943		721,943	(19,969)	701,974		8
	B. Health Care and Programs										
9	Medical Director	1,259,140	159,699	10,802	1,429,641		1,429,641		1,429,641		9
10	Nursing and Medical Records		1,419	363,537	364,956		364,956	(77,837)	287,119		10
10a	Therapy	89,767	3,991	10,177	103,935		103,935	(148,527)	(44,592)		10a
11	Activities	44,259	306	119	44,684		44,684	(7,632)	37,052		11
12	Social Services							(5)	(5)		12
13	CNA Training										13
14	Program Transportation			2,262	2,262		2,262		2,262		14
15	Other (specify):*	9,886			9,886		9,886		9,886		15
16	TOTAL Health Care and Programs	1,403,052	165,415	386,897	1,955,364		1,955,364	(234,001)	1,721,363		16
	C. General Administration										
17	Administrative	64,525		162,236	226,761		226,761	30,185	256,946		17
18	Directors Fees										18
19	Professional Services			1,770	1,770		1,770		1,770		19
20	Dues, Fees, Subscriptions & Promotions			7,688	7,688		7,688	(2,468)	5,220		20
21	Clerical & General Office Expenses	91,570	14,694	60,294	166,558		166,558	(19,510)	147,048		21
22	Employee Benefits & Payroll Taxes			381,862	381,862		381,862	11,517	393,379		22
23	Inservice Training & Education			8,792	8,792		8,792	(273)	8,519		23
24	Travel and Seminar			3,323	3,323		3,323	(3,184)	139		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			25,745	25,745		25,745	3,148	28,893		26
27	Other (specify):*	2,315		5,693	8,008		8,008	(8,007)	1		27
28	TOTAL General Administration	158,410	14,694	657,403	830,507		830,507	11,408	841,915		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,963,287	380,996	1,163,531	3,507,814		3,507,814	(242,562)	3,265,252		29

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

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview #0012955 Report Period Beginning: 01/01/09 Ending: 01/01/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			184,003	184,003		184,003		184,003			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,499	7,499		7,499		7,499			35
36	Other (specify):*											36
37	TOTAL Ownership			191,502	191,502		191,502		191,502			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	60	162	3,169	3,391		3,391	(3,391)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,404	38,404		38,404		38,404			42
43	Other (specify):*			7,711	7,711		7,711	(7,711)				43
44	TOTAL Special Cost Centers	60	162	49,284	49,506		49,506	(11,102)	38,404			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,963,347	381,158	1,404,317	3,748,822		3,748,822	(253,664)	3,495,158			45

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

Good Samaritan Society - Prophets Riverview

ID# 0012955

Report Period Beginning: 01/01/09

Ending: 01/01/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Uniform	\$ (112)	21	1
2	Administration	(589)	21	2
3	Employee Garnishment	(125)	21	3
4	Wandergard	(1,200)	10	4
5	Postage	(20)	21	5
6	Transportation	(10,269)	6	6
7	Int Inc Past Due Accounts	(3,139)	21	7
8	Adv Promo	58	20	8
9	Public Rel Reimb	(2,406)	20	9
10	Dues Nonreimb	(120)	20	10
11	Prescr Drugs Reim	(73,530)	10	11
12	Pharm Inoculations Resi	(755)	10	12
13	Barber/Beauty Expenses	(3,391)	40	13
14	Shrd Empl Benes Res Dev	(1,238)	22	14
15	Credit Card	(4)	21	15
16	Contract Services	(12)	27	16
17	C/Serv Shared Empl	(5,681)	27	17
18	Marketing Expense	(17,732)	21	18
19	FICA Marketing	(168)	22	19
20	Travel Marketing	(21)	24	20
21	Staff Dev Marketing	(273)	23	21
22	Therapy Offset	(148,521)	10a	22
23	Purch Svc Lab	(3,882)	43	23
24	Purch Svc Rad	(3,829)	43	24
25	Med Supplies	(997)	10	25
26	Less Out of State Travel	(3,163)	24	26
27	Admin Supplies	(194)	21	27
28	Nursing Supplies	(1,346)	10	28
29	Therapy Supplies	(6)	10a	29
30	Admin Supplies	(9)	10	30
31	Activities Supplies	-72	11	31
32	SS Supplies	-5	12	32
33	Laundry Supplies	-234	4	33
34	HSK Supplies	-283	3	34
35	Dietary Supplies	-187	1	35
36	Plant Supplies	-69	6	36
37	Marketing - Vacation Accrual	-123	27	37
38	Marketing Salaries	-2191	27	38
39	Cable TV	-7560	11	39
40	Resident Supplies	-15	7	40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(293,413)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(187)	0	0	0	0	0	0	0	0	0	0	(187)	1
2	Food Purchase	(8,912)	0	0	0	0	0	0	0	0	0	0	(8,912)	2
3	Housekeeping	(283)	0	0	0	0	0	0	0	0	0	0	(283)	3
4	Laundry	(234)	0	0	0	0	0	0	0	0	0	0	(234)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(10,338)	0	0	0	0	0	0	0	0	0	0	(10,338)	6
7	Other (specify):*	(15)	0	0	0	0	0	0	0	0	0	0	(15)	7
8	TOTAL General Services	(19,969)	0	0	0	0	0	0	0	0	0	0	(19,969)	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	(77,837)	0	0	0	0	0	0	0	0	0	0	(77,837)	10
10a	Therapy	(148,527)	0	0	0	0	0	0	0	0	0	0	(148,527)	10a
11	Activities	(7,632)	0	0	0	0	0	0	0	0	0	0	(7,632)	11
12	Social Services	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(234,001)	0	0	0	0	0	0	0	0	0	0	(234,001)	16
	C. General Administration													
17	Administrative	0	30,185	0	0	0	0	0	0	0	0	0	30,185	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	(2,468)	0	0	0	0	0	0	0	0	0	0	(2,468)	20
21	Clerical & General Office Expenses	(19,510)	0	0	0	0	0	0	0	0	0	0	(19,510)	21
22	Employee Benefits & Payroll Taxes	(1,406)	12,923	0	0	0	0	0	0	0	0	0	11,517	22
23	Inservice Training & Education	(273)	0	0	0	0	0	0	0	0	0	0	(273)	23
24	Travel and Seminar	(3,184)	0	0	0	0	0	0	0	0	0	0	(3,184)	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	3,148	0	0	0	0	0	0	0	0	0	3,148	26
27	Other (specify):*	(8,007)	0	0	0	0	0	0	0	0	0	0	(8,007)	27
28	TOTAL General Administration	(34,848)	46,256	0	11,408	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(288,818)	46,256	0	(242,562)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09

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	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	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(3,391)	0	0	0	0	0	0	0	0	0	0	(3,391)	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):*	(7,711)	0	0	0	0	0	0	0	0	0	0	(7,711)	43
44	TOTAL Special Cost Centers	(11,102)	0	0	0	0	0	0	0	0	0	0	(11,102)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(299,920)	46,256	0	0	0	0	0	0	0	0	0	(253,664)	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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Admin/Acctg	\$ 162,236	Evangelical Lutheran Good Samaritan Society	100.00%	\$ 192,421	\$ 30,185	1
2	V	22 Unemployment	3,224			3,367	143	2
3	V	22 Workers Comp	50,540			75,896	25,356	3
4	V	26 Insurance	25,745			28,893	3,148	4
5	V	22 Health Insurance	141,777			129,201	(12,576)	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		\$ 383,522			\$ 429,778	\$ * 46,256	14

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

Facility Name & ID Number Good Samaritan Society - Prophets Rivervie # 0012955 Report Period Beginning: 01/01/09 Ending: 01/01/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview

0012955

Report Period Beginning:

01/01/09

Ending: 01/01/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Good Samaritan Society - Prophets Riverview

0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09

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						\$				\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,259 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			1966	\$ 15,000	1
2					2
3	TOTALS			\$ 15,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4			1967	\$ 347,118	\$	40	\$	\$	\$ 347,118
5									
6									
7									
8									
Improvement Type**									
9			1973	669	17	40	17		605
10			1974	483	12	40	12		428
11			1975	30,308	758	40	758	0	26,520
12			1977	4,676					4,676
13			1979	7,265					7,265
14			1980	2,113	9	40	9		2,026
15			1981	58,599	1,404	40	1,404		42,084
16			1982	7,924					7,924
17			1983	14,821					14,821
18			1984	8,772					8,772
19			1985	17,007					17,007
20			1986	3,134					3,134
21			1987	78,081		20			78,105
22			1988	47,917	430	25	430		46,338
23			1989	90,366	2	20	2		90,362
24			1990	803,954	36,023	20	36,023	0	791,946
25			1991	4,791					4,785
26			1992	24,226	214	20	214		23,628
27			1993	6,019	234	20	234		5,604
28			1994	43,542	781	20	781	0	41,902
29			1995	27,180	693	20	693		25,420
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09**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	Floor covering for Maint RM	1996	\$ 605	\$	20	\$	\$	\$ 605	37
38	10 Bath Cabnites for Residents	1996	784	39	15	39		549	38
39	FRP Board and supplies For 200	1996	205	14	25	14		190	39
40	Replace water lines from broiler	1996	6,000	240	10	240		3,300	40
41	Sanitizing room 1/2 down payemnt	1996	5,497		20			5,497	41
42	Install Kemlite in 200 Wing	1996	453	23	20	23		314	42
43	Counter top Dining room	1996	365	18	20	18		249	43
44	Lavatory Water Closet Tank Fau	1996	445	22	15	22		304	44
45	York A/C Foof Unit for 300 Window	1996	7,100	473	15	473		6,390	45
46	Isolation valves on Circulation	1996	1,300		15			1,300	46
47	Remove and replace counter	1996	600	40		40		537	47
48	AT and Partner Sys Configuration	1996	8,646		20			8,226	48
49	Steel Fire Doors	1996	2,857	143		143		1,917	49
50	Air Compressor for air handler	1996	511		15			488	50
51	Install windows and screens	1996	420	28	20	28		373	51
52	Water system	1996	4,500	225	15	225		2,981	52
53	Six Birch Doors	1997	590	39	10	39		505	53
54	Amplifier intercom	1997	618		10			618	54
55	Green Louvered Shutters	1997	475		10			475	55
56	Install new Booster Heater	1997	1,286		10			1,286	56
57	Replace Motor Coupling	1997	1,559		10			1,559	57
58	Reconfigured Water Heat Loop	1997	1,800		15			1,800	58
59	18 room/Closet Doors Complet	1997	6,320	421	15	421		5,267	59
60	Outdoor Signage	1997		50		50			60
61	36" Door Fram Guards/Contact	1997	1,127	75	10	75		945	61
62									62
63	Remodel Bath/Clean and soiled utility room	1997	33,471	1,339	20	1,339		17,182	63
64	Plumbing remodel 100 wing	1997	504	25	15	25		323	64
65	Cabinets	1998	858	57	15	57		672	65
66	Counter tops	1998	2,326	155	20	155		1,822	66
67	Lavatory Foucet with pop up	1998	362	18		18		211	67
68	plastering walls	1998	2,500		10			2,500	68
69	Labor Material for wallpaper	1998	3,966					3,966	69
70	TOTAL (lines 4 thru 69)		\$ 1,727,017	\$ 44,020		\$ 44,021	\$ 1	\$ 1,662,820	70

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,727,017	\$ 44,020		\$ 44,021	\$ 1	\$ 1,662,820	1
2									2
3									3
4	Dining room Doors	1998		296		296			4
5	Toilet and Tank	1998	373		10			373	5
6					15				6
7	Nurses Station	1998	6,401	427	15	427		4,801	7
8									8
9									9
10	Material and Labor to Cable BU	1998	6,033	302	20	302		3,419	10
11	Staff entrance Hall Flooring	1998	1,151					1,151	11
12	Plumbing repair	1999	2,644		10			2,644	12
13	Door on 300 Wing	1999		30		30			13
14									14
15	Grease trap	1999	626		10			626	15
16	Lavatory Faucets	1999	732	37	20	37		400	16
17	Entrance door on 300 wing	1999		30	15	30			17
18	Pulled Stool Flange	1999	443	11	10	11		443	18
19	Boiler	1999	694	23	10	23		694	19
20	Gutter Replacements	1999	8,260	344	10	344		8,260	20
21	Rebuilt Coner Overhead Porch	1999	560	28	10	28		560	21
22	Faucets	1999	1,070	54	20	54		562	22
23	Toilet Tanks	1999	1,628	81	20	81		855	23
24	Water heaters	2000	4,981	498	10	498		4,939	24
25	Flooring	2000	1,338					1,338	25
26	AM Standard Faucets	2000	953	48	20	48		451	26
27	Generator Repair	2000	965	96	10	96		901	27
28	Vinyl Floor Finish Resident room	2000	7,427	743	10	743		6,746	28
29	Vinyl Floor	2001	477	48	10	48		430	29
30	Lockset	2001	1,314	88	15	88		789	30
31	Door Locks	2001	1,825	122	15	122		1,095	31
32	Toilet	2001	353	18	20	18		156	32
33	Fire Alarm Panel	2001	395	25	15	25		242	33
34	TOTAL (lines 1 thru 33)		\$ 1,777,660	\$ 47,369		\$ 47,370	\$ 1	\$ 1,704,695	34

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09**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		\$ 1,777,660	\$ 47,369		\$ 47,370	\$ 1	\$ 1,704,695	1
2									2
3									3
4	<u>Toilets</u>	2001	353	18	20	18		156	4
5	<u>Air Conditioner</u>	2001	708					708	5
6	<u>Ceiling Dining Room</u>	2001	1,394	93	15	93		767	6
7	<u>Wall Unit Panels Priv Screen</u>	2001	968	64	15	64		543	7
8	<u>Ventilation</u>	2002	143,372	9,558	15	9,558		76,465	8
9	<u>Corner Gards Res rooms</u>	2001	162	16	10	16		131	9
10	<u>Doors Res Rooms</u>	2001	1,770	118	15	118		954	10
11	<u>Duct work res room</u>	2001	2,139	107	20	107		865	11
12	<u>Interior Partitions Rs Rm</u>	2001	844	56	15	56		455	12
13	<u>Paint resident Room Remodel</u>	2001	181					181	13
14	<u>Corner Guards Rs Room</u>	2001	558	56	10	56		451	14
15	<u>Wall Paper res room remodel</u>	2001	6,694					6,694	15
16	<u>Carpet</u>	2002	1,107		5			1,107	16
17	<u>Cabinet Window Kitchen</u>	2002	1,726	173	10	173		1,309	17
18	<u>Blinds Remodel 8 Rooms</u>	2002	217		5			217	18
19	<u>Building remodel 8 rooms</u>	2002	924	37	25	37		262	19
20	<u>Corner Guards Remodel 8 rooms</u>	2002	138	14	10	14		98	20
21	<u>Drapes remodel 8 rooms</u>	2002	14		5			14	21
22	<u>Duct work remodel 8 rooms</u>	2002	1,115	56	20	56		395	22
23	<u>Plumbing remodel 8 rooms</u>	2002	354	24	15	24		167	23
24	<u>Shades</u>	2002	364		60			364	24
25	<u>Garage/Storage Bulding</u>	2003	60,774	4,052	15	4,052		28,361	25
26	<u>Dining Room Counter Top and Base</u>	2003	509	34	15	34		238	26
27	<u>Water Softner</u>	2002		524	10	524			27
28	<u>Dietary Entrance Door</u>	2003	1,960	131	15	131		806	28
29	<u>Toilet Bowl Tank Sink</u>	2004	1,693	85	20	85		476	29
30	<u>Floor for room 108</u>	2004	1,897	190	10	190		1,091	30
31	<u>Fire Alarm System</u>	2004	59,225	5,923	10	5,923		34,548	31
32	<u>Wood Floor Beauty Shop</u>	2004	4,969	248	20	248		1,387	32
33	<u>Shower Unit</u>	2004	445	44	10	44		241	33
34	TOTAL (lines 1 thru 33)		\$ 2,074,234	\$ 68,990		\$ 68,991	\$ 1	\$ 1,864,146	34

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,074,234	\$ 68,990		\$ 68,991	\$ 1	\$ 1,864,146	1
2	Fire Alarm Door	2004	556	28		28		144	2
3	Heritage Green Shutter	2005	936	94		94		437	3
4	Siemens Hipath 3750 Phone Systm	2005	20,546	2,055		2,055		9,246	4
5	Entrance Doors and Auto Openers	2005	8,319	416		416		1,698	5
6	Blinds Remodel Resident Rooms	2005	138	28		28		113	6
7	Building Remodel Resident Rms	2005	17,662	1,766		1,766		7,212	7
8	Corner Guard Rmdl Rs. Rm	2005	88	18		18		71	8
9	Paint Rmdl Rs. Room	2005	390	78		78		318	9
10	Wallpaper Rmdl Res Room	2005	710	142		142		580	10
11	Res Room Flooring	2005	58,123	5,812		5,812		26,640	11
12	Escerior Masonry Restoration	2006	43,228	2,161		2,161		7,745	12
13	Water Heater	2006	3,895	390		390		1,396	13
14	Replacement Ventilation System	2006	75,926	5,062		5,062		20,247	14
15	Gutters Downspout	2006	1,275	85		85		312	15
16	Toilet Bowl	2006	883	44		44		143	16
17	Bldg Rmdl Lounge into Activities	2006	12,134	485		485		1,494	17
18	Cabi Rmdl Lounge into Activity	2006	19,850	1,323		1,323		4,080	18
19	Fan Rmdl Lounge into Activities	2006	326	33		33		101	19
20	Fire Sprinkler System install	2007	98,579	3,943		3,943		11,172	20
21	Ceiling Tile NH	2007	34,380	4,297		4,297		11,102	21
22	Roof	2007	24,956	1,248		1,248		3,223	22
23	Building Outpatient Clinic	2007	29,877	1,195		1,195		3,087	23
24	Repair Hot water system	2007	3,832	766		766		2,044	24
25	Dining, Conf Rm Shades	2008	2,009	201		201		385	25
26	Carpet Floor Covering Replace	2008	32,057	6,411		6,411		11,220	26
27	Vinyl Floor Covering Replace	2008	8,090	809		809		1,416	27
28	Door Openers 300 wing	2008	9,193	460		460		766	28
29	AC Compressor	2008	2,153	215		215		341	29
30	Radiator Repair	2009	2,239	112	10	112		112	30
31	Wing Handicap Door	2009	6,303	175	15	175		175	31
32	Building Room Remodel	2009	12,399	83		83		83	32
33	Carpet Room Remodel	2009	1,752	58	5	58		58	33
34	TOTAL (lines 1 thru 33)		\$ 2,607,038	\$ 108,983		\$ 108,984	\$ 1	\$ 1,991,307	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,607,038	\$ 108,983		\$ 108,984	\$ 1	\$ 1,991,307	1
2	Drapes Room Remodel	2009	85	3	5	3		3	2
3	Duct Work Remodel	2009	192	2	20	2		2	3
4	Paint Remodel	2009	92	3	5	3		3	4
5	Windows Room Remodel	2009	4,633	51	15	51		51	5
6	Building Wall Covering roject	2009	21,034	841		841		841	6
7	Handrail Wall Covering Project	2009	4,112	274	15	274		274	7
8	Wall Paper Wall Covering	2009	674	135	5	135		135	8
9									9
10									10
11									11
12									12
13	Prior year depreciation			66		66			13
14	Diposal of Property			4,040		4,040			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,637,860	\$ 114,398		\$ 114,399	\$ 1	\$ 1,992,616	34

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09**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		\$ 2,637,860	\$ 114,398		\$ 114,399	\$ 1	\$ 1,992,616	1
2	Cement	1991	461					461	2
3	Sidewalks 1967	1967	1,223					1,223	3
4	Walks Drives Parking	1975	3,363					3,363	4
5	Blacktop parking lot	1978	2,250					2,250	5
6	Fence Sears	1978	604					604	6
7	Parking Lot Paving	1979	2,940					2,940	7
8	Trees Plants and overall Landscaping	1981	2,147					2,147	8
9	Landscaping	1892	2,492					2,492	9
10	Trees	1983	850					850	10
11	Landscaping	1983	400					400	11
12	Trees Shrubs + Planting Material	1990	560					560	12
13	Flowers topsoil rock for landscape	1990	858					858	13
14	Gate and Fence Construction	1991	726					707	14
15									15
16	Sidewalk	1992	1,200		15			1,200	16
17	Landscaping around sign	1992	536					536	17
18	Landscaping	1992	2,446					2,446	18
19	Concrete and Labor	1991	1,381					1,381	19
20	Field Servey and Peat Prep	1991	1,400					1,374	20
21	Blacktop parking lot	1993	428					428	21
22	Fence Sears	1994	1,049	23	15	23		1,049	22
23	Landscaping for front	1995	4,152					4,152	23
24	1 coat Sealer to Parking Lot	1995	1,500					1,500	24
25	Gazebo and preparation for	1996		121	20	121			25
26	Remove Exisitng Pavement	1997	7,843	392	20	392		4,869	26
27	Seal Coat Front Parking Lot	1997	2,500		10			2,500	27
28	Mulch Edging Fabric Weed	1998	582					582	28
29	Edging Pipedrain Elbow	1998	1,062		10			1,062	29
30	Gutter Screen Retaining Wall	1998	904		10			902	30
31	Perennial Planting Landscape	1999	1,726	155	10	155		1,570	31
32	Landscaping	2000	1,094	109	10	109		1,030	32
33	Parking Lot Overlay	2001	22,000	1,100	20	1,100		9,167	33
34	TOTAL (lines 1 thru 33)		\$ 2,708,536	\$ 116,298		\$ 116,299	\$ 1	\$ 2,047,219	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 12F, Carried Forward		\$ 2,708,536	\$ 116,298		\$ 116,299	\$ 1	\$ 2,047,219	1
2	Landscaping Memorial Gardens	2005	110,518	7,368	15	7,368		31,313	2
3	Trees Memorial Gardent Phase 1	2005	1,300	65	20	65		276	3
4	Black Dirt	2006	1,305	87	15	87		341	4
5	Landscaping Memorial Gardens	2006	3,433	229	15	229		820	5
6	Christ Statue	2006	9,940	497	20	497		1,740	6
7	Bulk Mulch Preen-Landscaping	2006	2,094	209	10	209		785	7
8	Landscaping 200/300 wing	2006	32,006	3,201	10	3,201		10,402	8
9	Landscaping 300 wing	2007	47,363	4,736	10	4,736		10,262	9
10	Drain Tile	2008	3,543	177	20	177		325	10
11	Preen, Mulch Around Building	2008	4,218	2,109	2	2,109		3,515	11
12	Shrubs, & Sugar Maple Tree	2008	2,774	139	20	139		208	12
13	Sidewalk	2008	2,820	188	15	188		219	13
14	New Signage	2008	6,940	694	10	694		810	14
15	Mulch Preen, Labor/ Landscaping	2009	5,806	387	15	387		387	15
16	Crimson King Maple Tree	2009	800	33	10	33		33	16
17	Trees Plants Mulch	2009	2,800	70	10	70		70	17
18	Curb Blacktop/Parking Lot	2009	9,275	77	20	77		77	18
19									19
20	Disposal of Property			1,065		1,065			20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,955,471	\$ 137,629		\$ 137,630	\$ 1	\$ 2,108,802	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See 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	\$ 318,640	\$ 32,340	\$ 32,340	\$		\$ 186,383	71
72	Current Year Purchases	38,376	3,049	3,049			3,049	72
73	Fully Depreciated Assets	480,761	6,319	6,319			480,761	73
74	gain/loss on disposal-depreciation		854	854				74
75	TOTALS	\$ 837,777	\$ 42,562	\$ 42,562	\$		\$ 670,193	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	Van and License	1992	\$ 35,985	\$	\$	\$		\$ 35,985	76
77	Resident Care	2002 Olds Mini Van	2004	16,850	2,812	2,812			14,975	77
78	Resident Care	1995 Chrysler Van	2008	3,000	1,000	1,000			1,417	78
79										79
80	TOTALS			\$ 55,835	\$ 3,812	\$ 3,812	\$		\$ 52,377	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)	\$ 3,864,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,003	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 184,004	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,831,372	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	Building unit 35	\$ 2,188,935	\$ 106,742	\$ 169,610	86
87	Building	75,306	2,236	56,630	87
88	FFE	12,937	348	8,187	88
89	Land Impr	84,020	4,224	6,666	89
90	FFE unit 35	77,678	5,256	8,278	90
91	TOTALS	\$ 2,438,876	\$ 118,806	\$ 249,371	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 54,496	92
93			93
94			94
95		\$ 54,496	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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: \$ 7,499 Description: Computer Lease, Companion Pump, Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a,Col 3	hrs	\$	1,571	\$ 123,538	\$	1,571	\$ 123,538	1
2	Licensed Speech and Language Development Therapist	Ln 10a,Col 3	hrs		573	43,532		573	43,532	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a,Col 3	hrs		1,835	196,465		1,835	196,465	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,979	\$ 363,535	\$	3,979	\$ 363,535	14

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

Facility Name & ID Number Good Samaritan Society - Prophets Riverview

0012955

Report Period Beginning: 01/01/09

Ending: 01/01/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/01/09 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 140,080	\$	1
2	Cash-Patient Deposits	3,557		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	337,862		3
4	Supply Inventory (priced at)	13,860		4
5	Short-Term Investments	1,163,863		5
6	Prepaid Insurance	5,809		6
7	Other Prepaid Expenses	(25,781)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,639,250	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	4,902,107		14
15	Leasehold Improvements, at Historical Cost	401,629		15
16	Equipment, at Historical Cost	984,227		16
17	Accumulated Depreciation (book methods)	(3,080,744)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	36,038		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	55,044		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,313,301	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,952,551	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 64,432	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,557		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,759		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,947		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr Interest</u>	424		36
37	<u>Security Deposit</u>	5,092		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 279,211	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,579,959		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,579,959	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,859,170	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,093,381	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,952,551	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,853,093	1
2	Restatements (describe):		2
3	Dnr Rst Prop Gft Cash	250	3
4	Dnr Rst Oper Gft Cash	7,805	4
5	Apartments	20,478	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,881,626	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	435,882	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)	\$ 435,882	17
	B. Transfers (Itemize):		
18	Reserve Fund Assessment NC	(44,254)	18
19	Technology User Assessment NC	(22,536)	19
20	Senior Living	(157,337)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (224,127)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,093,381	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,536,342	1
2	Discounts and Allowances for all Levels	(713,208)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,823,134	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	111,752	5
6	Therapy	920,926	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,032,678	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,895	13
14	Non-Patient Meals	8,912	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	172,093	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,911	19
20	Radiology and X-Ray	3,527	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 192,338	23
D. Non-Operating Revenue			
24	Contributions	7,739	24
25	Interest and Other Investment Income***	79,076	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 86,815	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Ns and Med supplies</u>	46,189	28
28a	<u>Schedule Attached</u>	3,549	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 49,738	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,184,703	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	721,943	31
32	Health Care	1,957,360	32
33	General Administration	828,511	33
B. Capital Expense			
34	Ownership	191,502	34
C. Ancillary Expense			
35	Special Cost Centers	3,391	35
36	Provider Participation Fee	38,403	36
D. Other Expenses (specify):			
37	<u>59010 P/Serv Lab MDCR</u>	3,882	37
38	<u>59020 P/Serv Radiology MDCR</u>	3,829	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,748,821	40
41	Income before Income Taxes (line 30 minus line 40)**	435,882	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 435,882	43

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

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

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

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

Facility Name & ID Number **Good Samaritan Society - Prophets Riverview**

0012955

Report Period Beginning:

01/01/09

Ending:

01/01/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,088	1,933	\$ 62,516	\$ 32.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,192	13,917	332,873	23.92	3
4	Licensed Practical Nurses	9,571	8,562	183,222	21.40	4
5	CNAs & Orderlies	59,029	54,361	638,306	11.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,070	1,805	33,240	18.42	9
10	Activity Assistants	6,081	5,490	61,874	11.27	10
11	Social Service Workers	2,130	1,912	44,373	23.21	11
12	Dietician					12
13	Food Service Supervisor	1,756	1,557	30,871	19.83	13
14	Head Cook	6,548	6,158	76,874	12.48	14
15	Cook Helpers/Assistants	9,730	8,626	90,950	10.54	15
16	Dishwashers					16
17	Maintenance Workers	7,990	7,285	103,210	14.17	17
18	Housekeepers	6,068	5,373	53,875	10.03	18
19	Laundry	5,150	4,656	48,696	10.46	19
20	Administrator	2,086	1,768	64,416	36.43	20
21	Assistant Administrator					21
22	Other Administrative	5,724	5,204	80,736	15.51	22
23	Office Manager	1,275	1,050	21,320	20.30	23
24	Clerical					24
25	Vocational Instruction					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	2,019	1,774	28,670	16.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hair Stylist</u>			60		33
34	TOTAL (lines 1 - 33)	144,507	131,431	\$ 1,956,082 *	\$ 14.88	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	144	\$ 6,473	Ln 1 Col 3	35
36	Medical Director		3,600	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,028	Ln 10 Col 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	5	269	Ln 11 Col 3	44
45	Social Service Consultant	7	419	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	156	\$ 12,789		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jeanette DeFrieze		100	\$ 64,416	Workers' Compensation Insurance	\$ 75,896	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,207	Advertising: Employee Recruitment		
Vacation Accrual			109	FICA Taxes	145,256	Health Care Worker Background Check		
				Employee Health Insurance	129,201	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Publication Reimb.	719	
				Admin Consultant Savings	2,416	Public Relations Reimb	2,406	
				Staff Pension	36,277	Dues reimbursable	4,394	
				W/Comp Ins pd dir	216	Adver Promotion	228	
				Taxable Gifts	100	Non Reimb Dues/Newletter Marketing	(58)	
				shared Employee	2,058	Less: Public Relations Expense	(2,406)	
				Less FICA Marketing	(1,248)	Non-allowable advertising	(62)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,525	TOTAL (agree to Schedule V, line 22, col.8)	\$ 393,379	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,221	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Admin and Accounting			\$ 162,235			\$	Out-of-State Travel	\$ 3,163
							In-State Travel	160
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 162,235				Seminar Expense	
							Out of State	(3,163)
C. Professional Services							Marketing Travel	(24)
Vendor/Payee	Type		Amount				Entertainment Expense	()
National Campus	Mdcr Cost report Prep		\$ 850				(agree to Sch. V, line 24, col. 8)	
National Campus	Mdcd Cost Report Prep		900				TOTAL	\$ 136
National Campus	Contract Service Admin		20					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,770	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Good Samaritan Society - Prophets Riverview# 0012955Report Period Beginning: 01/01/09Ending: 01/01/09**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. LSN \$3711
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,531 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,403
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? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,912
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 51%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson Allen, LLP
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.