



Facility Name & ID Number Good Samaritan Home

# 0009258 Report Period Beginning: 10/01/2008 Ending: 9/30/2009

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	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,180	3
4		Intermediate/DD			4
5	97	Sheltered Care (SC)	97	35,405	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	1,292	1,125	5,299	7,716	8	
9	SNF/PED					9	
10	ICF	21,691	31,327		53,018	10	
11	ICF/DD					11	
12	SC		23,590		23,590	12	
13	DD 16 OR LESS					13	
14	TOTALS	22,983	56,042	5,299	84,324	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.01%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Outpatient Therapy - Pool Exercise Classes

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 02/22/1957

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 17 and days of care provided 5,299

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: 09/30/2009 Fiscal Year: 09/30/09

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2008 Ending: 9/30/2009

**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	980,039	56,081	21,571	1,057,691		1,057,691		1,057,691		1
2	Food Purchase		816,233		816,233		816,233	(49,924)	766,309		2
3	Housekeeping	278,269	54,058	31,386	363,713		363,713	(2,600)	361,113		3
4	Laundry	155,678		12,429	168,107		168,107		168,107		4
5	Heat and Other Utilities			477,738	477,738		477,738		477,738		5
6	Maintenance	292,177	57,133	167,621	516,931		516,931	(674)	516,257		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,706,163	983,505	710,745	3,400,413		3,400,413	(53,198)	3,347,215		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	4,655,426	245,900	14,284	4,915,610		4,915,610		4,915,610		10
10a	Therapy		3,760	590,546	594,306		594,306		594,306		10a
11	Activities	169,769	3,535	10,365	183,669		183,669		183,669		11
12	Social Services	155,168	482	989	156,639		156,639		156,639		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,980,363	253,677	619,784	5,853,824		5,853,824		5,853,824		16
	<b>C. General Administration</b>										
17	Administrative	237,756			237,756		237,756		237,756		17
18	Directors Fees										18
19	Professional Services			50,302	50,302		50,302	(9,288)	41,014		19
20	Dues, Fees, Subscriptions & Promotions			49,159	49,159		49,159	(1,735)	47,424		20
21	Clerical & General Office Expenses	468,191	77,865	131,138	677,194		677,194	(55,720)	621,474		21
22	Employee Benefits & Payroll Taxes			1,844,528	1,844,528		1,844,528		1,844,528		22
23	Inservice Training & Education			2,044	2,044		2,044		2,044		23
24	Travel and Seminar			15,675	15,675		15,675	1,293	16,968		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			117,421	117,421		117,421		117,421		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	705,947	77,865	2,210,267	2,994,079		2,994,079	(65,450)	2,928,629		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,392,473	1,315,047	3,540,796	12,248,316		12,248,316	(118,648)	12,129,668		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 &amp; ID Number

Good Samaritan Home

#0009258

Report Period Beginning:

10/01/2008

Ending:

9/30/2009

## 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			500,974	500,974		500,974	(6,007)	494,967			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											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			500,974	500,974		500,974	(6,007)	494,967			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,662		175,662		175,662		175,662			39
40	Barber and Beauty Shops	69,870	5,062	602	75,534		75,534		75,534			40
41	Coffee and Gift Shops	23,639	37,049		60,688		60,688		60,688			41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):* <b>Non-allowable cost</b>	73,044		756,089	829,133		829,133	(829,133)				43
44	<b>TOTAL Special Cost Centers</b>	166,553	217,773	854,146	1,238,472		1,238,472	(829,133)	409,339			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,559,026	1,532,820	4,895,916	13,987,762		13,987,762	(953,788)	13,033,974			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.



Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/2008

Ending: 9/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

**Good Samaritan Home**

0009258

9/30/2009

Schedule 5A

Schedule 5A

VI. ADJUSTMENT DETAIL

NON-ALLOWABLE EXPENSES

LINE 29 - Other

Description	Amount	Schedule V
		Reference
Resident Cable Expense	(52,460)	43
To disallow Rotary Club and Chamber of Commerce Dues	(1,735)	20
To disallow non-allowable Administrative Expenses	(650)	21
To disallow radio station expense	(1,264)	43
To disallow X-Ray expense	(5,994)	43
To disallow Lab expense	(8,621)	43
To disallow investment consultants	(231,915)	43
To disallow out of period seminar cost	(780)	24
To disallow out of state over fifty miles seminar cost	0	24
To record last year out of period cost for seminars that related to this yea	2,073	24
To offset guest room income	(3,450)	30
To disallow cottage service income	(2,600)	3
To offset miscellaneous income	(367)	21
To offset miscellaneous income	(308)	6
To offset the income from adjustment	(420)	21
To offset discount earned income	(111)	21
To offset discount earned income	(143)	6
To offset discount earned income	(223)	6
To offset discount earned income	(7,587)	1
To offset income from sale of equipment	(1,150)	30
To disallow Property Taxes	(15,495)	43
To disallow rental property expenses	(13,252)	43
To disallow radio station depreciation	(88)	43
To disallow cottage expenses	(469,474)	43
To disallow Public Relation Wages	(54,172)	21
To disallow the Architect fee that should be CIP	(9,288)	19
<b>Total</b>	<b>(879,474)</b>	

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2008

Ending:

9/30/2009

## 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	(42,337)	0	0	0	0	0	0	0	0	0	0	(42,337)	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>(42,337)</b>	<b>0</b>	<b>(42,337)</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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</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>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(42,337)</b>	<b>0</b>	<b>(42,337)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2008 Ending:

9/30/2009

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(1,407)	0	0	0	0	0	0	0	0	0	0	(1,407)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,407)</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>(1,407)</b>	<b>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):*	(30,570)	0	0	0	0	0	0	0	0	0	0	(30,570)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(30,570)</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>(30,570)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(74,314)</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>(74,314)</b>	<b>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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Good Samaritan Home

# 0009258

Report Period Beginning:

10/01/2008

Ending:

9/30/2009

## 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	N/A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Good Samaritan Home

# 0009258

Report Period Beginning:

10/01/2008

Ending: 1/30/2009

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		N/A							6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Good Samaritan Home

# 0009258

Report Period Beginning:

10/01/2008

Ending:

9/30/2009

**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										
										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	First Bankers Trust		x	New Construction		9/30/08	\$ 6,700,545	\$ 4,709,318	9/30/2010	0.0538	\$	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 6,700,545	\$ 4,709,318			\$	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 6,700,545	\$ 4,709,318			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      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.)





Facility Name & ID Number Good Samaritan Home

# 0009258

Report Period Beginning:

10/01/2008 Ending:

9/30/2009

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).  
Residential Cottage Apartments 160 Units for 174,278 square feet

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>1,219,680</u>	<u>1956-1999</u>	<u>\$ 128,278</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>1,219,680</b>		<b>\$ 128,278</b>	<b>3</b>

Facility Name &amp; ID Number Good Samaritan Home

# 0009258

Report Period Beginning:

10/01/2008

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	30			1957	\$ 358,309	\$	40	\$	\$	\$ 358,309	4
5	75			1962	683,823		40			683,823	5
6	99			1973	1,683,761	42,094	40	42,094		1,510,488	6
7	75			1984	1,953,541	48,839	40	48,839		1,249,456	7
8											8
	<b>Improvement Type**</b>										
9		Building Improvements		1974	89,670		30			89,670	9
10		Building Improvements		1976	9,414		20			9,414	10
11		Building Improvements		1977	3,107		20			3,107	11
12		Building Service Equipment		1978	5,714		15			5,714	12
13		Building Service Equipment		1979	9,188		Various			9,188	13
14		Building Service Equipment		1980	324		Various			324	14
15		Building Improvements		1982	151,081	4,556	Various	4,556		140,066	15
16		Building Service Equipment		1982	17,350		Various			17,350	16
17		Building Service Equipment		1983	10,058		20			10,058	17
18		Land Improvements		1984	49,187		15			49,187	18
19		Building Service Equipment		1984	415,756	425	Various	425		413,879	19
20		Land Improvements		1985	2,601		20			2,601	20
21		Building Improvements		1985	250,935	6,273	40	6,273		152,237	21
22		Building Service Equipment		1985	179,735		Various			179,735	22
23		Land Improvements		1986	72,453		20			72,453	23
24		Building Improvements		1986	161,531	4,038	40	4,038		93,789	24
25		Building Service Equipment		1986	137,391	2,514	Various	2,514		132,836	25
26		Building Improvements		1987	19,089	500	Various	500		10,967	26
27		Building Service Equipment		1987	21,221		20			21,221	27
28		Building Service Equipment		1988	14,400	42	Various	42		14,242	28
29		Building Improvements		1989	174,123	4,421	Various	4,421		134,871	29
30		Building Service Equipment		1989	6,469		Various			6,469	30
31		Garage Additions		1990	78,563	2,619	30	2,619		51,502	31
32		New Roof - North Wing		1990	43,980	2,199	20	2,199		42,697	32
33		Phones		1990	600		10			600	33
34		Hall Renovations		1991	20,616	1,031	20	1,031		19,156	34
35		Building Improvements State Audit Adjustments 10881+30372		1991	511,992	18,441	30	17,066	(1,375)	312,824	35
36		Ceiling/partitions		1991	37,276	1,243	30	1,243		22,780	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 Home# 0009258

Report Period Beginning:

10/01/2008 Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Office Entrance	1991	\$ 14,768	\$ 738	20	\$ 738		\$ 14,030	37
38	Building Services Equipment State Aduit Adjustment of 359	1991	83,893		various			83,893	38
39	Parking Lot	1992	4,257	213	20	213		3,405	39
40	Building Services Equipment	1992	2,706		10			2,706	40
41	Parking Lot	1992	46,071	2,304	20	2,304		38,201	41
42	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		126,751	42
43	Building Services Equipment	1993	20,910	238	various	238		18,791	43
44	Parking Lot	1994	87,827	1,464	15	1,464		87,827	44
45	Manhole/Sewer	1994	2,859	64	15	64		2,859	45
46	Sidewalk	1994	7,875	481	15	481		7,875	46
47	West Nursing	1994	66,876	3,344	20	3,344		50,158	47
48	Dining Room	1994	6,990	315	various	315		5,729	48
49	Building Services Equipment	1994	134,323	2,791	various	2,791		122,463	49
50	West Nursing	1995	128,327	6,416	20	6,416		93,572	50
51	West Nursing	1995	3,151	158	20	158		2,127	51
52	Building Services Equipment	1995	22,482	812	various	812		22,144	52
53	Gas Line	1996	3,062	153	20	153		2,067	53
54	Gutters	1996	10,817	541	20	541		7,302	54
55	Eber Wing Improvements	1996	20,335	1,017	20	1,017		13,726	55
56	Roof	1996	9,016	451	20	451		6,086	56
57	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		45,725	57
58	Building Services Equipment	1996	46,663	2,128	various	2,128		36,950	58
59	Lights/Front Land Improvements	1997	5,360	357	15	357		4,556	59
60	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		26,113	60
61	Freezer Floor	1997	4,394	258	17	258		3,360	61
62	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		14,814	62
63	Sprinkling System	1997	3,354		10			3,354	63
64	Tamper Detectors	1997	2,818		10			2,818	64
65	Compressor - Eber	1997	2,039	136	15	136		1,676	65
66	Compressor - East	1997	11,808	787	15	787		9,643	66
67	Sprinkler System	1997	102,875	5,144	20	5,144		62,154	67
68	Air Exchange -Pool Area State Audit adjustment 480	1997	8,092	571	15	539	(32)	6,603	68
69	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		13,719	69
70	TOTAL (lines 4 thru 69)		\$ 8,554,488	\$ 185,923		\$ 184,516	\$ (1,407)	\$ 6,764,210	70

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

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 8,554,488	\$ 185,923		\$ 184,516	\$ (1,407)	\$ 6,764,210	1
2	Elevator Doors - Dietary	1998	1,095		10			1,095	2
3	Remodeling -Anna Brow Wing Walls, Celing, Floors,Lights	1999	199,131	4,978	39	4,978		50,820	3
4	Remodeling -Anna Brow Wing - Duct Detectors	1999	1,444		5			1,444	4
5	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	148	10	148		2,965	5
6	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	549	39	549		5,684	6
7	Chapel Roof	1999	21,515	538	39	538		5,849	7
8	Fire Damper Alarm	1999	5,490		5			5,490	8
9	Eber Parking Lot Lights	1999	5,495	366	15	366		3,846	9
10	Stainless Steel D/W Exhaust	1999	1,659	83	10	83		1,659	10
11	Wiring Chapel Roof	1999	332	17	10	17		332	11
12	HVAC Chapel	1999	23,760	1,584	15	1,584		16,632	12
13	Code Alert System	1999	61,985		5			61,985	13
14	Elevator Upgrade A/B East	1999	22,556	1,128	10	1,128		22,556	14
15	Elevator Upgrade - Special Care	1999	5,970	299	10	299		5,970	15
16	Fire Protection A/B	1999	4,500	225	10	225		4,500	16
17	Condensor Unit	1999	22,945	1,530	15	1,530		16,062	17
18	Fire Protection Pool Area	1999	776	39	10	39		776	18
19	Damper Duct Work	1999	5,602	373	15	373		3,921	19
20	Lighting- Special Care	1999	2,075	138	15	138		1,453	20
21	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		2,024	21
22	Chapel Remodeling - Sign	2000	77		5			77	22
23	Chapel Remodeling - Painting	2000	4,751	119	39	119		1,075	23
24	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		1,946	24
25	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		3,336	25
26	Kitchen Remodeling - Sky Roof Flashing	2000	3,086	206	15	206		1,954	26
27	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		2,207	27
28	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601	173	15	173		1,647	28
29	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		6,216	29
30	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		10,441	30
31	Special Care Lighting	2000	14,290	953	15	953		9,050	31
32	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		193,432	32
33	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		1,758	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,366,455	\$ 222,702		\$ 221,295	\$ (1,407)	\$ 7,212,412	34

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

Facility Name &amp; ID Number Good Samaritan Home

# 0009258

Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 9,366,455	\$ 222,702		\$ 221,295	\$ (1,407)	\$ 7,212,412	1
2	Telephone Unit	2000	323		7			323	2
3	Elevator Up Grade East Wing	2000	12,776	852	15	852		8,091	3
4	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		697	4
5	Entrance Code Lock Special Care	2000	1,848	123	15	123		1,171	5
6	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		4,433	6
7	Land Improvement New Sidewalk	2000	1,200	60	20	60		510	7
8	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		75,766	8
9	Exterior Painting	2001	14,347	956	15	956		8,130	9
10	Painting Kitchen	2001	2,550	170	15	170		1,445	10
11	Chapel Renovation	2000	2,001	50	39	50		444	11
12	Kitchen Electrical Work	2000	611	41	15	41		346	12
13	HVAC Rehab Eber Wing	2000	5,584	372	15	372		3,164	13
14	Sprinklers	2000	4,151	277	15	277		2,352	14
15	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		2,094	15
16	Electrical Work	2001	1,609	107	15	107		912	16
17	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		28,750	17
18	Air Compressor Anna Brown Wing	2001	10,911	727	15	727		6,183	18
19	3D Detectors in Elevators	2001	4,916	344	10	344		2,908	19
20	Compensators	2001	2,724	191	10	191		1,611	20
21	33 Lever Passage Locks	2002	2,904	203	10	203		1,718	21
22	Exit Lights and Hold Opens	2002	966	68	10	68		571	22
23	16 Lever Passage Locks	2002	1,408	99	10	99		833	23
24	48 Lockouts	2002	985	69	10	69		583	24
25	Water Piping	2001	4,600	115	39	115		906	25
26	New Curb & Driveway	2002	16,118	577	20	577		5,158	26
27	Buffet in Dining Area	2003	2,977	198	15	198		1,326	27
28	Door - code alert and keypad	2003	2,489	249	10	249		1,659	28
29	Fire Collars	2003	3,619	362	10	362		2,395	29
30	Main Breaker	2003	3,291	219	15	219		1,335	30
31	Elevator Master Door Operator	2003	4,278	428	10	428		2,745	31
32	Training Room Drainage	2003	731	19	39	19		122	32
33	Dietary - Floor Drain	2003	223	6	39	6		37	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,908,339	\$ 242,982		\$ 241,575	\$ (1,407)	\$ 7,381,130	34

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

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Report Period Beginning:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 9,908,339	\$ 242,982		\$ 241,575	\$ (1,407)	\$ 7,381,130	1
2	Handicap Accessible Entrance and Sidewalk	2003	3,200	160	20	160		960	2
3	Annunciators	2004	51,494	5,149	10	5,149		28,322	3
4	Sewer Lines	2003	5,801	387	15	387		2,288	4
5	Smoke Damper - Eber	2003	698	46	15	46		271	5
6	Beauty Shop Wiring	2003	2,272	151	15	151		871	6
7	Dietary Doors	2004	3,801	253	15	253		1,436	7
8	Roof	2004	4,028	269	15	269		1,477	8
9	Remote Annunciator	2004	4,650	465	10	465		2,480	9
10	Cooler Expansion	2004	6,120	408	15	408		2,176	10
11	Parking Lot	2004	6,800	453	15	453		2,380	11
12	Ambulance Garage Doors	2004	1,070	107	10	107		553	12
13	Kitchen Remodel	2004	6,425	643	10	643		3,213	13
14	Plumbing wok in Eber/South	2004	5,147	343	15	343		1,658	14
15	Water Softener System	2004	15,642	1,564	10	1,564		7,430	15
16	Storage Tank Replacement	2004	2,454	245	10	245		1,165	16
17	Air Handler in East Circle	2005	1,297	130	10	130		573	17
18	Parking Lot Off-Street	2005	68,884	4,592	15	4,592		19,900	18
19	Kitchen Electrical Work	2004	247	12	20	12		62	19
20	Kitchen Remodel	2004	1,248	62	20	62		307	20
21	Sprinkler System	2004	980	49	20	49		237	21
22	Sprinkler System	2005	2,373	119	20	119		554	22
23	Tunnel Closure	2005	1,888	126	15	126		587	23
24	Perry Suite Renovations	2005	2,470	165	15	165		755	24
25	Water Heater	2006	13,003	1,300	10	1,300		4,527	25
26	Telephone System	2006	65,476	4,613	various	4,613		16,343	26
27	Sprinkler System Pipes	2006	1,645	142	various	142		451	27
28	Overhead Door	2005	1,400	140	10	140		548	28
29	Concrete Work	2005	9,936	662	15	662		2,539	29
30	Fire Walls	2006	14,948	747	20	747		2,491	30
31	Fire Alarm System	2006	23,500	1,567	15	1,567		5,744	31
32	Life Safety Code Renovations	2006	1,905	190	10	190		683	32
33	Renovations to Building Front Entrance	2006	38,611	1,931	20	1,931		6,435	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,277,752	\$ 270,172		\$ 268,765	\$ (1,407)	\$ 7,500,546	34

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

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Report Period Beginning:

10/01/2008 Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 10,277,752	\$ 270,172		\$ 268,765	\$ (1,407)	\$ 7,500,546	1
2	Telephone System Wiring	2006	35,781	3,578	10	3,578		11,051	2
3	Pool Area Renovations	2006	98,370	4,919	20	4,919		16,805	3
4	Concrete Work	2006	3,850	257	15	257		877	4
5	Lighting in the Hallway	2006	7,872	394	20	394		1,279	5
6	Laundry Renovations- Air System	2006	9,841	492	20	492		1,599	6
7	Smoke/Fire Dampers Special Care Area	2006	14,683	734	20	734		2,386	7
8	Eber Elevator Remodel	2006	12,769	851	15	851		2,483	8
9	Sprinkler System Heads	2006	20,456	1,364	15	1,364		3,750	9
10	South Wing Fiber Server	2007	2,526	168	15	168		463	10
11	Smoke/Fire Detectors	2007	10,431	1,043	10	1,043		2,782	11
12	Repairs to Boiler Motor	2007	954	95	10	95		254	12
13	Smoke/Fire Dampers	2007	1,125	113	10	113		300	13
14	CO Detectors	2007	1,483	148	10	148		321	14
15	Call Lights - Dining Hall	2007	823	82	10	82		171	15
16	Hot Water Tank	2007	2,588	259	10	259		561	16
17	Repairs to Hot Water Shower Area	2007	1,113	111	10	111		223	17
18	Compressor - Walk in	2007	2,922	292	10	292		584	18
19	Repairs to Wiring in Chapel Area	2007	14,516	968	15	968		1,936	19
20	HVAC Controllers	2007	11,952	797	15	797		1,594	20
21	Physical Therapy Ductwork Repairs	2006	2,254	150	15	150		438	21
22	Alarm Stations Repairs	2006	27,685	1,846	15	1,846		5,075	22
23	Dining Hall Electric	2007	890	59	15	59		163	23
24	Chapel Roof Repair	2007	3,528	235	15	235		647	24
25	Special Care Area Door	2007	3,038	304	10	304		810	25
26	Dining Hall Paint	2007	7,401	740	10	740		1,912	26
27	Special Care Area Bathroom Repairs	2007	4,106	274	15	274		684	27
28	Pool Area Renovations	2007	5,108	341	15	341		851	28
29	Dinning Hall Roof Repairs	2007	573	38	15	38		96	29
30	Front Hall Area Roof Repair	2007	3,100	207	15	207		517	30
31	Storm Sewer Line	2007	3,459	231	15	231		538	31
32	Dietary Doors	2007	1,485	148	10	148		297	32
33	Alarm System at Stations	2007	4,450	445	10	445		816	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,598,884	\$ 291,855		\$ 290,448	\$ (1,407)	\$ 7,562,809	34

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

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Report Period Beginning:

10/01/2008 Ending:

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,598,884	\$ 291,855		\$ 290,448	\$ (1,407)	\$ 7,562,809	1
2	Roof South Eber	2007	9,587	639	15	639		1,172	2
3	B&G Series 1510- 2 Pump	2008	7,597	760	10	760		760	3
4	Fiber Projest Improvements	2008	10,646	710	15	710		1,065	4
5	Door Closers	2008	10,180	1,018	10	1,018		1,018	5
6	Pine Doors	2008	1,714	171	10	171		229	6
7	Evevator Renovation	2008	122,827	8,188	15	8,188		10,918	7
8	Wanderer Alert System	2008	1,968	197	10	197		295	8
9	CO Systrem Detectors	2008	1,395	140	10	140		198	9
10	Improvements Fire Protection	2009	35,300	1,569	15	1,569		1,569	10
11	New Doors Alarm	2008	8,704	326	20	326		326	11
12	Improvements to Elevator	2008	27,518	1,682	15	1,682		1,682	12
13	Improvement to Alarms	2009	14,985	437	20	437		437	13
14	Eber Water Project	2009	3,795	95	20	95		95	14
15	Improvements Fire Protection	2009	1,640	7	20	7		7	15
16	Hot Water Heater	2009	5,577	279	10	279		279	16
17	Improvements to Heater in Pool	2009	14,325	597	10	597		597	17
18	Run Fiber - Anna Brown to switch in Maint. For Phone Sys.	2009	1,040	35	5	35		35	18
19	IDCS 500 Release - Wiring & Cabinet for Phone System	2009	7,099	118	5	118		118	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Guest Room Income Offset					(3,450)	(3,450)		31
32	Income from sale of equipment					(1,150)	(1,150)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,884,781	\$ 308,823		\$ 302,816	\$ (6,007)	\$ 7,583,609	34

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2008

Ending:

9/30/2009

## 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	\$ 1,391,732	\$ 156,781	\$ 156,781	\$	3-20 yrs	\$ 842,554	71
72	Current Year Purchases	105,530	6,342	6,342			6,342	72
73	Fully Depreciated Assets	745,721				3-20 yrs	745,721	73
74								74
75	TOTALS	\$ 2,242,983	\$ 163,123	\$ 163,123	\$		\$ 1,594,617	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	Various	Various	\$ 74,241	\$	\$	\$	3-5 yrs	\$ 74,241	76
77	Maintenance	Various	Various	40,426				5 yrs	40,426	77
78	Maintenance	Various	Various	1,219				3 yrs	1,219	78
79	See Attach Sch 13A	Various	Various	219,869	29,028	29,028		5-10 yrs	158,403	79
80	TOTALS			\$ 335,755	\$ 29,028	\$ 29,028	\$		\$ 274,289	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)	\$ 13,591,797	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 500,974	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 494,967	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,007)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,452,515	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage Land	\$ 207,379	\$	\$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,115,337	182,364	5,195,881	88
89	Rental Property Fixed Assets	367,490	13,252	99,834	89
90	Radio Station	15,038	88	14,387	90
91	TOTALS	\$ 8,780,974	\$ 195,704	\$ 5,310,102	91

## G. Construction-in-Progress

	Description	Cost	
92	Building Construction	\$ 10,025,840	92
93			93
94			94
95		\$ 10,025,840	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.

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$ 0		\$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Toro 2001	2001	\$ 825	\$ 0	\$ 0	\$ 0	5 yrs	\$ 710	42
43	Maintenance	Chevy S-10 98	2002	7,508	0	0	0	5 yrs	6,457	43
44	Facility	Toro mower	2003	7,139			0	5 yrs	7,139	44
44a	Facility	Ford/Goshen Bus (2)	2004	98,532	14,780	14,780	0	5 yrs	98,532	44a
44b	Facility	Lift for Van	2005	1,500	300	300	0	5 yrs	1,325	44b
44c	Facility	Toro mower	2005	9,792	1,958	1,958	0	5 yrs	8,650	44c
44d	Facility	2005 Chrysler Town	2005	21,931	4,386	4,386	0	5 yrs	17,544	44d
44e	Facility	1999 Chevy Van	2005	5,648	1,130	1,130	0	5 yrs	4,330	44e
44f	Facility	Kubota L3430	2006	18,895	1,889	1,889	0	10 yrs	5,353	44f
44g	Facility	Ford F350	2007	30,224	3,022	3,022	0	10 yrs	6,800	44g
44h	Facility	Toro Mower	2009	7,000	350	350	0	5 yrs	350	44h
44i	Facility	Toro mower	2009	9,000	900	900	0	5 yrs	900	44i
44j	Facility	Truck Plow 84 Rear	2008	675	113	113	0	5 yrs	113	44j
44k	Facility	Golf Cart	2008	1,200	200	200	0	5 yrs	200	44k
44l	Facility									44l
45							0			45
46	TOTALS			\$ 219,869	\$ 29,028	\$ 29,028	\$ 0		\$ 158,403	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		<u>N/A</u>						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 N/A  
by the length of the lease N/A.

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

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

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

16. Rental Amount for movable equipment: \$ 0 Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

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 \$ N/A

13. /2011 \$ N/A

14. /2012 \$ N/A

\* 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 type="checkbox"/> YES      <input checked="" 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 type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10a C 3	hrs	\$	3,178	\$ 190,676	\$	3,178	\$ 190,676	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		202	12,146		202	12,146	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 3	hrs		6,462	387,724	3,760	6,462	391,484	4
5	Physician Care		visits							5
6	Dental Care	L. 10 C 2,3	visits		12	2,400		12	2,400	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C 2	# of prescrpts				175,662		175,662	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	<b>TOTAL</b>			\$	9,854	\$ 592,946	\$ 179,422	9,854	\$ 772,368	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 Home# 0009258Report Period Beginning: 10/01/2008Ending: 9/30/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 279,580	\$ 279,580	1
2	Cash-Patient Deposits	20,994	20,994	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,922,220	1,922,220	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,667,046	1,667,046	5
6	Prepaid Insurance	106,264	106,264	6
7	Other Prepaid Expenses	13,429	13,429	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Application Fee Repurchase</u>	33,451	33,451	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,042,984	\$ 4,042,984	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	26,186,315	26,186,315	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	11,137,456	10,884,781	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,578,738	2,578,738	16
17	Accumulated Depreciation (book methods)	(9,689,124)	(9,452,515)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP)	10,025,840	10,025,840	22
23	Other(specify): <u>Cottage &amp; Rental Property</u>	3,470,872	3,470,872	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 43,838,375	\$ 43,822,309	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 47,881,359	\$ 47,865,293	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,009,891	\$ 1,009,891	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,994	20,994	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	554,254	554,254	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,964	5,964	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,865		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>See Attached Sch 17C</u>	79,779	79,779	36
37	<u>Prepaid Resident Rent</u>	785,011	785,011	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,466,758	\$ 2,455,893	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,709,318	4,709,318	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,709,318	\$ 4,709,318	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,176,076	\$ 7,165,211	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 40,705,283	\$ 40,700,082	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 47,881,359	\$ 47,865,293	48

\*(See instructions.)

Good Samaritan Home  
0009258  
9/30/2009

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
ST Disability Payable - Employee	3,478	3,478
United Way Deduction	37	37
Employee Assist Fund Withheld	6,514	6,514
Capital Campaign Pledge - Residents	25	25
Benevolent Fund Payable	6,100	6,100
Flower Fund Payable	(9,360)	(9,360)
Application Fee Payable	26,880	26,880
Medicare Liability		
Medicaid Liability		
Employee Health/Life Liability	46,105	46,105
<b>Total Line 36 - Other Current Liabilities(specify):</b>	<b>79,779</b>	<b>79,779</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>39,301,940</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</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>39,301,940</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,403,345</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>1,403,345</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>	<b>Rounding</b>	<b>(2)</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>(2)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>40,705,283</b>	<b>24</b> *

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

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2008Ending: 9/30/2009

**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	\$ 11,483,754	1
2	Discounts and Allowances for all Levels	(1,578,636)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,905,118</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,060,167	6
7	Oxygen	13,793	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,073,960</b>	<b>8</b>
<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	37,049	12
13	Barber and Beauty Care	63,072	13
14	Non-Patient Meals	42,337	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	333,012	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,387	19
20	Radiology and X-Ray	11,990	20
21	Other Medical Services	112,269	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 617,116</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	34,739	24
25	Interest and Other Investment Income***	2,201,773	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,236,512</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Attached Schedule 19E	45,982	28
28a	Cottage and Rental Property Income	1,512,419	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,558,401</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 15,391,107</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,400,413	31
32	Health Care	5,853,824	32
33	General Administration	2,994,079	33
<b>B. Capital Expense</b>			
34	Ownership	500,974	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,141,017	35
36	Provider Participation Fee	97,455	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 13,987,762</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,403,345</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,403,345</b>	<b>43</b>

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

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

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

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

Good Samaritan Home  
0009258  
9/30/2009

Schedule 19E

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	1,825
Discount Earned Income	8,064
Adjustments	420
Guest Room Income	3,450
Van Transportation	29,623
Cottage Services Income	2,600
Application Fee Income	
<b>Total Line 28 - Other Revenue (specify):</b>	<b><u><u>45,982</u></u></b>

Facility Name & ID Number Good Samaritan Home

# 0009258

Report Period Beginning:

10/01/2008

Ending:

9/30/2009

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	1,884	2,080	\$ 92,969	\$ 44.70	1
2	Assistant Director of Nursing	1,912	2,080	54,455	26.18	2
3	Registered Nurses	14,232	15,604	347,171	22.25	3
4	Licensed Practical Nurses	74,305	80,574	1,383,398	17.17	4
5	CNAs & Orderlies	198,571	215,662	2,395,848	11.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,694	15,317	173,922	11.35	8
9	Activity Director	1,872	2,080	34,826	16.74	9
10	Activity Assistants	12,904	13,956	134,943	9.67	10
11	Social Service Workers	13,356	14,685	155,168	10.57	11
12	Dietician					12
13	Food Service Supervisor	7,734	8,644	151,302	17.50	13
14	Head Cook	9,620	10,614	119,728	11.28	14
15	Cook Helpers/Assistants	61,842	67,431	646,182	9.58	15
16	Dishwashers	5,954	6,434	62,827	9.76	16
17	Maintenance Workers	23,274	25,448	292,177	11.48	17
18	Housekeepers	25,346	27,988	278,269	9.94	18
19	Laundry	13,443	14,714	155,678	10.58	19
20	Administrator	1,846	2,080	132,019	63.47	20
21	Assistant Administrator	1,848	2,080	105,737	50.84	21
22	Other Administrative	5,732	6,448	158,200	24.53	22
23	Office Manager					23
24	Clerical	19,646	21,880	309,991	14.17	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	1,933	2,147	34,658	16.14	31
32	Other Health C: SCH 20A	13,561	14,929	173,005	11.59	32
33	Other(specify) SCH 20A	13,343	14,587	166,553	11.42	33
34	TOTAL (lines 1 - 33)	537,852	587,462	\$ 7,559,026 *	\$ 12.87	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	509	\$ 19,489	L. 1 C3	35
36	Medical Director	Monthly	3,600	L. 9 C3	36
37	Medical Records Consultant	Quarterly	1,840	L. 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L. 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	628	L. 11 C3	44
45	Social Service Consultant	11	989	L. 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	528	\$ 36,590		49

C. CONTRACT NURSES

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

Good Samaritan Home  
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9/30/2009

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Nursing Secretary	9,193	10,205	104,416	10.23
Medical Supply Clerk	2,340	2,560	28,148	11.00
Staff Coord.	2,028	2,164	40,441	18.69
<b>Total Line 32 - Other</b>	<b>13,561</b>	<b>14,929</b>	<b>\$ 173,005</b>	<b>\$ 11.59</b>

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Maintenance Cottages	5,818	6,362	\$ 73,044	11.48
Beauty Shop	5,003	5,583	69,870	12.51
General Store	2,522	2,642	23,639	8.95
<b>Total Line 33 - Other</b>	<b>13,343</b>	<b>14,587</b>	<b>\$ 166,553</b>	<b>\$ 11.42</b>



**Good Samaritan Home**

**Provider #: 0009258**

**10/01/2008 to 9/30/2009**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 50,302

Disallow Architect Expense that should be capitalize (9,287)  
when project is completed CIP

Total (agree to Schedule V, line 19, column 8) 41,015

Good Samaritan Home

SEMINAR EXPENSE  
 Provider Number 0009258  
 September 30, 2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS	LOCATION	FEE
10/14-15/2008	Illinois Pioneer Coalitaton	5th Annual Pioneer Coalitaton Summit	Annie Hildebrand	Assistant Director of Nursing	Springfield, IL	\$773.32
			Pam DeMoss	Medicare Nurse		
			Cate Laeson	Resident Care Coordinator		
			Marjorie Robinson	C.N.A.		
			Betty Darrow	Assistant Activity Director		
			Sande Jenkins	Activity Aide		
			Steve Disseler	Chaplain		
			Adam Zanger	Social Services Director		
10/21/2008	Blessing Hospital	Fall Wound Conference The Road to Wound Healing	Pam DeMoss	Medicare Nurse	Quincy, IL	50.00
10/23-24/2008	Illinois Activity Professionals Assoc.	2008 IAPA Conference	Sally Hodgson	Activity Director	Springfield, IL	121.70
			Tammy Collins	Activity Aide		
			Angie Brashears	Activity Aide		
10/28-29/2008	Illinois Nursing Home Administrators Assoc.	2008 Annual Convention & Trade Show	Judy Graham	Assoc. Administrator	Springfield, IL	232.80
			Oneta Crowe	Director of Nursing		
11/11/2008	Alzheimer's Assoc.	Illinois Dementia Care Training	Annie Hildebrand	Assistant Director of Nursing	Quincy, IL	220.00
			Adam Zanger	Social Services Director		
12/2/2008	Quincy Area Safety Council	What are your Liabilities as a Supervisor & Employer	Missy Loos	Human Resources	Quincy, IL	100.00
			Mary Ellen Piner	Medical Secretary		
12/11/2008	Illinois CPA Foundation	2008 Springfield Not-for-Profit Conference	Judy Graham	Assoc. Administrator	Springfield, IL	290.00
12/17/2008	SkillPath Seminars	The Quincy Managers & Supervisors Conference	Janet Stoner	Resident Care Coordinator	Quincy, IL	995.00
			Adam Zanger	Social Services Director		

Good Samaritan Home

SEMINAR EXPENSE  
 Provider Number 0009258  
 September 30, 2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS	LOCATION	FEE
			Cate Larensen	Resident Care Coordinator		
			Tina Kroeger	Resident Care Coordinator		
			Evie Rossiter	Evening Nurse Supervisor		
1/29-30/2009	Outcome Services of IL	SSD Basic: Training Course	Adam Zanger	Social Services Director	Carlyle, IL	320.62
2/25/2009	Padgett-Thompson	FMLA Compliance 2009	Missy Loos	Human Resources	Springfield, IL	209.00
1/21/2009	Life Services Network	Psychosocial Adaptation: Are you Missing Out	Sally Hodgson	Activity Director	Quincy, IL	99.00
		on Medicaid Dollars?	Adam Zanger	Social Services Director		
1/15/2009	Cross Country Education	Improving MDS Skills & Performance	Sarah Riggs	Food Service Director	Quincy, IL	187.00
2/18/2009	BRAGG	Low Functioning Activities	Betty Darrow	Assistant Activity Director	Quincy, IL	30.00
			Sande Jenkins	Activity Aide		
			Angela Kill	Activity Aide		
1/28/2009	Pathway Health Services	Qualities of an Effective DON:	Annie Hildebrand	Assistant Director of Nursing	Quincy, IL	59.00
		Is this someone you recognize?				
1/30/2009	Pathway Health Services	Restorative Nursing Building a Program for	Annie Hildebrand	Assistant Director of Nursing	Quincy, IL	59.00
		Healthy Residents & Revenue Enhancement	Oneta Crowe	Director of Nursing		
2/11/2009	Blessing Hospital, IL Veterans Home, Alzheimer's Assoc. John Wood College	Ethical Issues & End of Life Care	Judy Moellingring	Night Nurse Supervisor	Quincy, IL	35.00
3/5-8/2009	United Church of Christ	Our Call to Faithful Advocacy	Michael Duffy	Administrator	St. Louis, MO	2,073.04
			Steve Disseler	Chaplain		

Good Samaritan Home

SEMINAR EXPENSE  
 Provider Number 0009258  
 September 30, 2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS	LOCATION	FEE
			Lanse Tomlinson	Development Director		
2/24/2009	Life Services Network	Did Someone Call or Visit Your Organization	Frances Crabtree	Housekeeping Director	Quincy, IL	100.00
		Today, That Will Never Call or Visit Again,	Oneta Crowe	Director of Nursing		
		Because of How They Feel, They Were Treated?	Steve Disseler	Chaplain		
			Sarah Dolbeare	Admissions		
			Michael Duffy	Administrator		
			Cindy Gilbert	Admissions		
			Annie Hildebrand	Assistant Director of Nursing		
			Judy Graham	Assoc. Administrator		
			Sally Hodgson	Activity Director		
			Missy Loos	Human Resources		
			Barb Lowary	Payroll		
			Jerry Manton	Maintenance Director		
			Lanse Tomlinson	Development Director		
			Adam Zanger	Social Services Director		

Good Samaritan Home

SEMINAR EXPENSE  
 Provider Number 0009258  
 September 30, 2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS	LOCATION	FEE
3/3/2009	Life Services Network	Did Someone Call or Visit Your Organization	Stacy Arrowsmith	Receptionist	Quincy, IL	100.00
		Today, That Will Never Call or Visit Again,	Frances Crabtree	Housekeeping Director		
		Because of How They Feel, They Were Treated?	Oneta Crowe	Director of Nursing		
			Steve Disseler	Chaplain		
			Sarah Dolbear	Admissions		
			Michael Duffy	Administrator		
			Judy Graham	Assoc. Administrator		
			Annie Hildebrand	Assistant Director of Nursing		
			Jerry Manton	Maintenance Director		
			Dawn Reckers	Admissions		
			Sarah Riggs	Food Service Director		
			Lanse Tomlinson	Development Director		
			Adam Zanger	Social Services Director		
3/24-27/2009	Life Services Network	People & Practices: Transcending the Everyday	Judy Graham	Assoc. Administrator	Chicago, IL	6,169.83
		Annual Meeting	Oneta Crowe	Director of Nursing		
			Missy Loos	Human Resources		
			Cindy Gilbert	Admissions		
			Tammy Collins	Activity Aide		
			Lanse Tomlinson	Development Director		
			Adam Zanger	Social Services Director		
5/12/2009	FR&R Healthcare Consulting, Inc.	Still Confused about Medicare Notices in Your SNF?	Oneta Crowe	Director of Nursing	Quincy, IL	150.00
			Debbie Steinbrecher	Patient Accounts		
			Jill Zwick	Resident Care Coordinator		
			Cindy Gilbert	Admissions		
			Judy Graham	Assoc. Administrator		
			Dawn Reckers	Admissions		

Good Samaritan Home

SEMINAR EXPENSE  
 Provider Number 0009258  
 September 30, 2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS	LOCATION	FEE
5/22/2009	Blessing Hospital Alzheimer's Assoc.	Dimensions of Dementia Accepting the Challenge	Tammy Collins	Activity Aide	Quincy, IL	240.00
			Sande Jenkins	Activity Aide		
			Melinda Meyer	Social Services Aide		
			Kristi Primm	Social Services Aide		
			Debbie Willis	Resident Care Coordinator		
			Shelley Grimsley	Social Services Aide		
5/29/2009	Life Services Network	Fingerprint Background Check Rules	Barb Lowary	Payroll	Quincy, IL	99.00
6/25/2009	FR&R Healthcare Consulting	Preparing for the RAC Auditors	Debbie Steinbrecher	Patient Accounts	Quincy, IL	150.00
	Telspan		Michael Duffy	Administrator		
			Kris Humphrey	Medical Records		
			Annie Hildebrand	Assistant Director of Nursing		
7/15-16/2009	Pathway Health Services	Restorative/Rehabilitation Certification Program	Annie Hildebrand	Assistant Director of Nursing	Springfield, IL	2,021.52
7/21-22/2009		for Licensed Nurses	Veronica Nichols	Night Nurse Supervisor		
7/28-29/2009						
8/4-5/2009						
10/15/2009	Illinois Activity Professionals Assoc.	30th Annual Conference	Sally Hodgson	Activity Director	Springfield, IL	345.00 (B)
		Let Our Stars Shine in 09	Betty Darrow	Assistant Activity Director		
			Angela Kill	Activity Aide		
10/13-14/2009	IL Pioneer Coalition	6th Annual Summit	Mitzi Hultz	Social Services Aide	Springfield, IL	435.00 (B)
		Culture Change: Leading The Way	Angie Brashears	Activity Aide		
			Ashley Manton	Activity Aide		

Good Samaritan Home

SEMINAR EXPENSE  
 Provider Number 0009258  
 September 30, 2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS	LOCATION	FEE
9/23/2009	Continuing Education Institute of IL	18th Annual Multi-Disciplinary Certificate	Oneta Crowe	Director of Nursing	Quincy, IL	10.00
		Program in Geriatrics for Non-Physicians	Judy Graham	Assoc. Administrator		
	<b>TOTAL</b>					<b>15,674.83</b>
				Out of State Seminar over 50 Miles	A	-
				Out of Period Seminar	B	(780.00)
	Add back last year out of period					
10/14-15/08	IL Pioneer Coalition	5th Annual Pioneer Coalition Summit	Annie Hildebrand	Assist Director of Nursing	Springfield, IL	900.00
			Pam DeMoss	Medicare Nurse		
			Cate Larensen	Resident Care Coord		
			Marjorie Robinson	C.N.A.		
			Betty Darrow	Assist Activity Director		
			Sande Jenkins	Activity Aide		
			Steve Disseler	Chaplin		
			Adam Zanger	Social Services Director		
10/21/08	Life Services Network of IL	Insider Secrets to Delivering Red Carpet Customer Service	Judy Graham	Assoc Administrator	Springfield, IL	693.00
			Cindy Gilbert	Admissions		
			Oneta Crowe	Director of Nursing		
			Sarah Dolbeare	Admissions		
			Steve Disseler	Chaplain		
			Annie Hildebrand	Assist Director of Nursing		
			Angie Brashears	Activity Aide		





Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2008Ending: 9/30/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$15,121 CHHS\$7,913
- (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? 6.70 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 77,957 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 97,455  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule 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? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 42,337
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Dennis G. Koch
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.