

Facility Name & ID Number Good Samaritan Home-Flanagan

0009241 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	10,557	6,668	2,204	19,429	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,557	6,668	2,204	19,429	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.72%

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

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

Peace Meals

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
 Date started 12/01/68

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

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 60 and days of care provided 1,855

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Good Samaritan Home-Flanagan # 0009241 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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
	A. General Services										
1	Dietary	195,317	13,923	2,785	212,025		212,025		212,025		1
2	Food Purchase		150,019		150,019		150,019	(33,654)	116,365		2
3	Housekeeping	79,184	10,503		89,687		89,687		89,687		3
4	Laundry	48,570	6,629		55,199		55,199		55,199		4
5	Heat and Other Utilities			100,114	100,114		100,114		100,114		5
6	Maintenance	60,634	16,821	41,385	118,840		118,840		118,840		6
7	Other (specify):*										7
8	TOTAL General Services	383,705	197,895	144,284	725,884		725,884	(33,654)	692,230		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	991,434	60,414	54,891	1,106,739		1,106,739		1,106,739		10
10a	Therapy			151,370	151,370		151,370		151,370		10a
11	Activities	75,823	2,684	9,893	88,400		88,400		88,400		11
12	Social Services	19,392		516	19,908		19,908		19,908		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,086,649	63,098	222,670	1,372,417		1,372,417		1,372,417		16
	C. General Administration										
17	Administrative	37,432			37,432		37,432		37,432		17
18	Directors Fees										18
19	Professional Services			101,055	101,055		101,055		101,055		19
20	Dues, Fees, Subscriptions & Promotions			12,681	12,681		12,681		12,681		20
21	Clerical & General Office Expenses	124,048	13,003	28,995	166,046		166,046	(5,366)	160,680		21
22	Employee Benefits & Payroll Taxes			511,583	511,583		511,583	18,247	529,830		22
23	Inservice Training & Education			9,169	9,169		9,169		9,169		23
24	Travel and Seminar			1,828	1,828		1,828		1,828		24
25	Other Admin. Staff Transportation			16,192	16,192		16,192		16,192		25
26	Insurance-Prop.Liab.Malpractice			72,255	72,255		72,255		72,255		26
27	Other (specify):*										27
28	TOTAL General Administration	161,480	13,003	753,758	928,241		928,241	12,881	941,122		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,631,834	273,996	1,120,712	3,026,542		3,026,542	(20,773)	3,005,769		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			115,209	115,209		115,209	85,349	200,558			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,192	27,192		27,192	(7,566)	19,626			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,400	2,400		2,400		2,400			35
36	Other (specify):*											36
37	TOTAL Ownership			144,801	144,801		144,801	77,783	222,584			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,612		39,612		39,612		39,612			39
40	Barber and Beauty Shops		11,573		11,573		11,573		11,573			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,410	49,410		49,410		49,410			42
43	Other (specify):* Non-allowable cost	225,789		564,566	790,355		790,355	(790,355)				43
44	TOTAL Special Cost Centers	225,789	51,185	613,976	890,950		890,950	(790,355)	100,595			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,857,623	325,181	1,879,489	4,062,293		4,062,293	(733,345)	3,328,948			45

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

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,407)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,160)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	85,349	30		9
10	Interest and Other Investment Income	(7,566)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(292)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,623)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(776,646)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (733,345)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (733,345)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Good Samaritan Home-FlanaganID# 0009241Report Period Beginning: 1/1/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow nonallowable independent living exp	\$		1
2	Apartments	(59,509)	43	2
3	Duplexes	(146,861)	43	3
4	Misc Expense	9,202	43	4
5	Ancillary laboratory expenses	(5,714)	43	5
6	Ancillary X-Ray expenses	(1,682)	43	6
7	Newsletter expense	(4,494)	43	7
8	Flowers expense	(1,350)	43	8
9	Resident expense	(1,987)	43	9
10	Volunteer appreciation	(112)	43	10
11	Summerfest expense	(131)	43	11
12	Strategic Consulting	(201,531)	43	12
13	To offset Misc Income against related Expenses	(5,366)	43	13
14	Other Non Allowable Salary	(225,789)	43.1	14
15	PR Relations	(3,273)	43	15
16	Marketing	(47,188)	43	16
17	MED Cash Fee	(66,861)	43	17
18	Remainder Interest in Real Estate Taxex	(14,000)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(776,646)		49

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Good Samaritan Home-Flanagan

0009241

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	See Attached Schedule 7A	Board Members	Administrative	0.00	N/A	1hr each	2% each	N/A	N/A	N/A
4										4
5	No members of the Board of Directors have ownership in a business that conducts business with the organization									5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home-Flanagan

0009241

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number ()

Fax Number ()

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Good Samaritan Home-Flanagan

0009241

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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			
A. Directly Facility Related																			
Long-Term																			
1	St. Petri Church	X	Mortgage	Interest only	2/26/96	\$ 25,000	\$ 25,000	11/1/11	0.0700	\$ 1,750	1								
2	St. Johns-Graymont St. Bank	X	Mortgage	Interest only	2/26/96	100,000	100,000	11/1/11	0.0439	4,390	2								
3	Flanagan State Bank	X	Mortgage	Int & Principal	4/18/08	361,000	334,866	4/25/13	Various	19,417	3								
4											4								
5											5								
Working Capital																			
6	Flanagan State Bank	X	Operating - LOC	Demand	12/8/08	242,000		2/28/09	0.0725	1,635	6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 728,000	\$ 459,866			\$ 27,192	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13								Interest Income offset		(7,566)	13								
14	TOTAL Non-Facility Related					\$	\$			\$ (7,566)	14								
15	TOTALS (line 9+line14)					\$ 728,000	\$ 459,866			\$ 19,626	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Good Samaritan Home-Flanagan

0009241

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

Independent living facilities - Duplexes and Congregate Living Apartments

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: N/A 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	<u>Facility</u>	<u>14 Acres</u>	<u>1966</u>	<u>\$ 22,917</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	14 Acres		\$ 22,917	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home-Flanagan

0009241

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		1968	1968	\$ 754,053	\$	40	\$	\$	\$ 754,053	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980		49,983		20	584	584	26,201	9
10	Various		1981		4,961		20				10
11	Various		1982		7,246		20				11
12	Various		1991		58,000		20	1,841	1,841	34,907	12
13	Various		1992		49,137		20	2,371	2,371	44,869	13
14	Various		1995		257,361		20	6,599	6,599	94,862	14
15	Various		1996		30,610		20	785	785	10,957	15
16	Various		1997		29,894		20	766	766	9,484	16
17	Various		2000		34,290		20	1,040	1,040	10,151	17
18	Various		2001		150,943		20	15,040	15,040	123,157	18
19	Kitchen & Office Addition		2000		739,459		10	73,946	73,946	595,510	19
20	Painting		2000		2,680		10	268	268	2,122	20
21	None		2000		1,629		10	163	163	1,290	21
22	New Floors		2000		872		10	87	87	668	22
23	Air Conditioner Compressor		2000		6,651		10	665	665	4,988	23
24	Cabling		2003		1,541		10	154	154	988	24
25	Windows		2003		6,350		10	635	635	3,863	25
26	Brass Plaques		2003		884		15	59	59	413	26
27	Dishwasher Rack		2003		160		7	22	22	160	27
28	Kitchen Addition		2003		60,663		7	8,666	8,666	60,662	28
29	Kitchen Addition		2003		6,019		7	860	860	5,948	29
30	Kitchen Addition		2003		113,993		7	16,285	16,285	111,280	30
31	Kitchen Addition		2003		2,086		7	298	298	2,036	31
32	Mini-blinds		2003		616		10	62	62	423	32
33	Mini-blinds		2003		2,236		10	224	224	1,567	33
34	Telephone System		2003		(4,707)		10	(471)	(471)	(3,296)	34
35	Kitchen Addition		2003		60,514		7	8,645	8,645	57,633	35
36	Kitchen Addition		2003		9,492		7	1,356		6,328	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**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	<u>Kitchen Addition</u>	2003	\$ 5,377	\$	7	\$ 768	\$ 768	\$ 4,992	37
38	<u>Mc Cable</u>	2003	589		10	59	59	378	38
39	<u>Kitchen Addition</u>	2003	2,562		7	366	366	2,349	39
40	<u>Wire</u>	2003	2,045		10	205	205	1,280	40
41	<u>Backflow Preventer</u>	2003	398		10	40	40	266	41
42	<u>HVAC</u>	2003	865		10	87	87	572	42
43	<u>Kitchen & Office Addition</u>	2003	480		20	24	24	146	43
44	<u>Phone Switch</u>	2003	150		10	15	15	76	44
45	<u>Paint Rooms</u>	2004	1,120		10	112	112	546	45
46	<u>Amp Carad for Boiler</u>	2004	816		10	81	81	399	46
47	<u>Door Alarm Service</u>	2004	597		5	68	68	597	47
48	<u>Repair South Chiller/Fans</u>	2004	440		5	44	44	440	48
49	<u>Blacktop-Home</u>	2005	1,176		20	59	59	262	49
50	<u>Painting</u>	2005	2,200		10	220	220	1,063	50
51	<u>Nurses Station</u>	2005	5,000		20	250	250	1,042	51
52									52
53	<u>Nurses Station Upgrade</u>	2006	1,279		20	32	32	128	53
54	<u>General Project Parts-Nurses Station</u>	2006	1,127		20	28	28	112	54
55	<u>Fire Safety System Additions</u>	2006	2,977		20	74	74	296	55
56	<u>Phone Lines</u>	2006	344		10	17	17	68	56
57	<u>Annunciaiton Panel</u>	2006	5,554		10	278	278	1,112	57
58	<u>Entryway Flooring, Wallcovering, and Countertop Replace</u>	2007	6,024		10	409	409	1,227	58
59	<u>Water Heater Install & Plumbing</u>	2007	10,500		10	788	788	2,364	59
60	<u>Doorlock System</u>	2007	13,986		10	466	466	1,398	60
61	<u>Water Heater Replacement</u>	2007	18,612		10	1,396	1,396	4,188	61
62	<u>Land Scaping - Painting & Patch work</u>	2008	3,332		10	333	333	666	62
63	<u>Heat Pump</u>	2009	6,478		10	324	324	324	63
64	<u>Fire Alarm Upgrade</u>	2009	15,977		15	532	532	532	64
65									65
66									66
67	<u>Financial statement depreciation booked</u>			62,535			(62,535)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,547,621	\$ 62,535		\$ 148,025	\$ 84,134	\$ 1,988,047	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Good Samaritan Home-Flanagan

0009241

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 604,042	\$	\$ 46,945	\$ 46,945	10	\$ 587,510	71
72	Current Year Purchases	4,146		431	431	10	431	72
73	Fully Depreciated Assets	363,162					363,162	73
74	Current Booked Depr.		45,296		(45,296)			74
75	TOTALS	\$ 971,350	\$ 45,296	\$ 47,376	\$ 2,080		\$ 951,103	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	Ford E450	1998	\$ 48,859	\$	\$	\$	4	\$ 48,859	76
77	Resident care	Brake repairs-Ford E-450	2006	1,792		448	448	4	1,353	77
78	Resident care	Dodge Sprinter Van	2007	47,092	7,378	4,709	(2,669)	10	14,464	78
79										79
80	TOTALS			\$ 97,743	\$ 7,378	\$ 5,157	\$ (2,221)		\$ 64,676	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)	\$ 3,639,631	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 115,209	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,558	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 85,349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,003,826	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments and Improvements	\$ 1,358,309	\$ 37,813	\$ 483,478	86
87	Duplexes and Improvements	1,569,977	41,457	720,645	87
88					88
89					89
90					90
91	TOTALS	\$ 2,928,286	\$ 79,270	\$ 1,204,123	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 2,400 Description: Rental Shed - \$2,400

(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			\$ N/A	\$	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?</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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	832	\$ 59,939	\$	832	\$ 59,939	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		120	8,618		120	8,618	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,150	82,813		1,150	82,813	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				36,868		36,868	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____	39(2)					2,744		2,744	13
14	TOTAL			\$	2,102	\$ 151,370	\$ 39,612	2,102	\$ 190,982	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home-Flanagan# 0009241Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 375,650	\$ 375,650	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>-0-</u>)	505,856	505,856	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	108,200	108,200	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,082	15,082	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,004,788	\$ 1,004,788	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	191,000	191,000	12
13	Land	22,917	22,917	13
14	Buildings, at Historical Cost	2,611,256	754,053	14
15	Leasehold Improvements, at Historical Cost	104,555	1,793,568	15
16	Equipment, at Historical Cost	1,046,605	1,069,093	16
17	Accumulated Depreciation (book methods)	(2,357,117)	(3,003,826)	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 <u>Apt/Duplex, net</u>)	1,724,163	1,724,163	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,343,379	\$ 2,550,968	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,348,167	\$ 3,555,756	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 347,227	\$ 347,227	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	141,919	141,919	29
30	Accrued Salaries Payable	54,829	54,829	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,647	42,647	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	261,980	261,980	36
37	<u>See Sch 17A</u>	842,246	842,246	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,690,848	\$ 1,690,848	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	317,947	317,947	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Support</u>	777,384	777,384	43
44	<u>Non Interest Leases</u>	10,400	10,400	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,105,731	\$ 1,105,731	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,796,579	\$ 2,796,579	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,551,588	\$ 759,177	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,348,167	\$ 3,555,756	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Good Samaritan Home
Provider #: 0009241
1/1/2009 to 12/31/2009 Schedule 17A

XVII. Support Schedule
OTHER CURRENT LIABILITIES

	Account	Description	Operating Amount	Consolidated Amount
Sch XV, L36	22-2220	Accrued Federal Withholding	(5,155)	(5,155)
	22-2230	Accrued FICA Payroll Taxes	(3,969)	(3,969)
	22-2240	Accrued Medicaid Payroll Taxes	(928)	(928)
	22-2250	Accrued State Withholding	(1,888)	(1,888)
	22-2261	Accrued Sick	(49,410)	(49,410)
	22-2265	Accrued Vacation	(79,944)	(79,944)
	22-2270	Accrued 401K	(8,101)	(8,101)
	23-2325	Accrued Uniforms	2,841	2,841
	23-2335	Accrued Garnishment	(1,098)	(1,098)
	23-2410	Accrued Security Deposit	(1,000)	(1,000)
	23-2420	Accrued IPA Provider Assessment	(24,345)	(24,345)
	24-2410	Payable on life lease-current	(88,983)	(88,983)
	Sch XV, L36	Other Current Liabilities	<u>(261,980)</u>	<u>(261,980)</u>
Sch XV, L37	21-0030	Deferred Revenue - Residents	(169,539)	(169,539)
	21-0040	Deferred Revenue - Duplexes	(52,600)	(52,600)
	51-5118	Med Cash liability	(620,107)	(620,107)
	Sch XV, L37	Other Current Liabilities	<u>(842,246)</u>	<u>(842,246)</u>

SEE ACCOUNTANT'S COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,986,148	1
2	Restatements (describe):		2
3	Prior Period Adjustment	4,053	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,990,201	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(438,613)	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)	\$ (438,613)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,551,588	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home-Flanagan# 0009241Report Period Beginning: 1/1/2009Ending: 12/31/2009

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,669,145	1
2	Discounts and Allowances for all Levels	88,674	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,757,819	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	175,031	6
7	Oxygen	2,441	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 177,472	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	10,190	13
14	Non-Patient Meals	15,407	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,071	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,324	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,297	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 73,289	23
D. Non-Operating Revenue			
24	Contributions	76,702	24
25	Interest and Other Investment Income***	7,566	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 84,268	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Sch 19A</u>	530,832	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 530,832	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,623,680	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	725,884	31
32	Health Care	1,372,417	32
33	General Administration	928,241	33
B. Capital Expense			
34	Ownership	144,801	34
C. Ancillary Expense			
35	Special Cost Centers	841,540	35
36	Provider Participation Fee	49,410	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,062,293	40
41	Income before Income Taxes (line 30 minus line 40)**	(438,613)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (438,613)	43

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

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

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

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

Good Samaritan Home
Provider #: 0009241
1/1/2009 to 12/31/2009 Schedule 19A

XIX. Support Schedule
OTHER REVENUE

Account	Description	Operating Amount	Consolidated Amount
30-3038	Incontinent Supplies	(48)	(48)
30-3061	Resident Purchases	(1,669)	(1,669)
30-3063	Chapel Offerings	(6)	(6)
30-3071	Transportation	(2,800)	(2,800)
30-3076	Transportation - Medicaid	(2,975)	(2,975)
30-3080	Apartment Services Fees	(104,838)	(104,838)
30-3081	Duplex Income-Service Fees	(68,593)	(68,593)
30-3082	Duplex Income-Deferred Support	(58,742)	(58,742)
30-3084	Duplex Write-Off	72	72
30-3086	Transportation - Medicare	(3,660)	(3,660)
30-3088	Transportation - HMO	(575)	(575)
30-3091	Transportation - Hospice	(100)	(100)
30-3092	Transportation - Hospice WRI	100	100
30-3200	Management Fee	(230,161)	(230,161)
35-3560	Miscellaneous Income	(21,120)	(15,754)
35-3565	Summerfest Income	8,669	8,669
35-3566	Staff Fund Raiser Income	(114)	(114)
36-3610	Temp Restricted Assets-Roof	(44,272)	(44,272)
	Total	<u>(530,832)</u>	<u>(525,466)</u>

SEE ACCOUNTANT'S COMPILATION REPORT

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

0009241

Report Period Beginning: **1/1/2009**

Ending:

12/31/2009

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	1,773	2,060	\$ 53,939	\$ 26.18	1
2	Assistant Director of Nursing	1,701	2,022	47,963	23.72	2
3	Registered Nurses	5,538	5,979	137,648	23.02	3
4	Licensed Practical Nurses	8,205	9,067	185,444	20.45	4
5	CNAs & Orderlies	43,591	48,068	476,642	9.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,150	3,642	38,484	10.57	8
9	Activity Director	1,762	2,059	27,590	13.40	9
10	Activity Assistants	5,303	5,961	48,233	8.09	10
11	Social Service Workers	1,711	1,842	19,392	10.53	11
12	Dietician					12
13	Food Service Supervisor	1,846	1,935	27,012	13.96	13
14	Head Cook	4,093	5,266	51,131	9.71	14
15	Cook Helpers/Assistants	1,125	12,955	117,174	9.04	15
16	Dishwashers					16
17	Maintenance Workers	4,387	4,759	60,634	12.74	17
18	Housekeepers	7,218	8,828	79,184	8.97	18
19	Laundry	4,434	5,291	48,570	9.18	19
20	Administrator	1,915	2,072	37,432	18.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,229	7,952	124,048	15.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,948	2,082	51,314	24.65	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Non Care Wages	15,143	17,489	225,789	12.91	33
34	TOTAL (lines 1 - 33)	122,072	149,329	\$ 1,857,623 *	\$ 12.44	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	70	\$ 2,785	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	Monthly	2,902	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,530	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	516	11(3)	44
45	Social Service Consultant	9	516	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	187	\$ 18,249		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	141	\$ 6,007	10(3)	50
51	Licensed Practical Nurses	138	5,695	10(3)	51
52	Certified Nurse Assistants/Aides	1,492	34,757	10(3)	52
53	TOTAL (lines 50 - 52)	1,771	\$ 46,459		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Richard Curtis	Administrator	0	\$ 37,432	Workers' Compensation Insurance	\$ 101,391	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	6,817	Advertising: Employee Recruitment	1,700	
				FICA Taxes	134,357	Health Care Worker Background Check		
				Employee Health Insurance	246,384	(Indicate # of checks performed)	880	
				Employee Meals	18,247	Patient Background Checks	608	
				Illinois Municipal Retirement Fund (IMRF)*	0	Life Services Network	907	
				Employee Pension Plan	11,081	Miscellaneous License & Fees	2,050	
				Benefits Administration Fee	5,390	Miscellaneous Dues & Subscriptions	565	
				Uniforms	(2,899)	Printed Materials	3,981	
				Employee Screening & Physicals	2,922			
				Employee Morale & Motivation	6,140	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 37,432				\$ 529,830			\$ 12,681	
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
N/A	\$			N/A		\$	Out-of-State Travel	\$
							In-State Travel	1,828
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$				\$			()	
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V, line 24, col. 8)	
See Sch 21A		\$ 101,055					TOTAL	\$ 1,828
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 101,055				\$				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Good Samaritan Home

Provider #: 0009241

1/1/2009 to 12/31/2009

Schedule 21A

XIX. Support Schedule

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Hartweg, Turner & Wood P.C	Legal	3,250
ADP Resource	Accounting	31,051
Frost Ruttenberg & Rothblatt	Accounting	2,622
Revere Healthcare	Accounting	28,349
Collaborative Fiscal	Accounting	1,115
Insurance Program MA	Other Professional Services	3,612
McGladrey & Pullen, LLP	Accounting	31,056
Total (agree to Schedule V, Line 19, Column 3)		<u>101,055</u>
Total (agree to Schedule V, Line 19, Column 8)		<u><u>101,055</u></u>

SEE ACCOUNTANT'S COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3		N/A						N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home-Flanagan# 0009241Report Period Beginning: 1/1/2009Ending: 12/31/2009**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 - \$907
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,880 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,410
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,247 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 15,407
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? No
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT