



Facility Name & ID Number GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIEW

# 0012955 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	10,313	11,172	2,178	23,663	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	10,313	11,172	2,178	23,663	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.61%

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

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

OUTPATIENT THERAPY

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 09/20/1967

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 70 and days of care provided 2,235

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/01/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number **GOOD SAMARITAN SOCIETY- PROPHE1** # **0012955** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**

**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	199,381	13,364	6,672	219,417		219,417	(252)	219,165		1
2	Food Purchase		153,744		153,744		153,744	(8,592)	145,152		2
3	Housekeeping	56,196	13,765		69,961		69,961	(274)	69,687		3
4	Laundry	54,000	12,617		66,617		66,617	(271)	66,346		4
5	Heat and Other Utilities			84,667	84,667		84,667		84,667		5
6	Maintenance	114,582	7,333	46,401	168,316		168,316	(6,689)	161,627		6
7	Other (specify):*			1,494	1,494		1,494	(423)	1,071		7
8	<b>TOTAL General Services</b>	<b>424,159</b>	<b>200,823</b>	<b>139,234</b>	<b>764,216</b>		<b>764,216</b>	<b>(16,501)</b>	<b>747,715</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,351,923	169,465	5,984	1,527,372		1,527,372	(85,542)	1,441,830		10
10a	Therapy	10,100	421	315,672	326,193		326,193	(115,508)	210,685		10a
11	Activities	93,961	4,322	11,368	109,651		109,651	(8,344)	101,307		11
12	Social Services	48,776	339	388	49,503		49,503	(7)	49,496		12
13	CNA Training										13
14	Program Transportation			2,617	2,617		2,617		2,617		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,504,760</b>	<b>174,547</b>	<b>336,029</b>	<b>2,015,336</b>		<b>2,015,336</b>	<b>(209,401)</b>	<b>1,805,935</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	82,230		157,387	239,617		239,617	37,108	276,725		17
18	Directors Fees										18
19	Professional Services			23,736	23,736		23,736		23,736		19
20	Dues, Fees, Subscriptions & Promotions			25,370	25,370		25,370	(19,682)	5,688		20
21	Clerical & General Office Expenses	82,035	23,825	37,388	143,248		143,248	2,230	145,478		21
22	Employee Benefits & Payroll Taxes			426,398	426,398		426,398	(6,661)	419,737		22
23	Inservice Training & Education			13,538	13,538		13,538		13,538		23
24	Travel and Seminar			3,785	3,785		3,785	(120)	3,665		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,038	29,038		29,038	20,076	49,114		26
27	Other (specify):*	21,198		4,691	25,889		25,889	(21,818)	4,071		27
28	<b>TOTAL General Administration</b>	<b>185,463</b>	<b>23,825</b>	<b>721,331</b>	<b>930,619</b>		<b>930,619</b>	<b>11,133</b>	<b>941,752</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,114,382</b>	<b>399,195</b>	<b>1,196,594</b>	<b>3,710,171</b>		<b>3,710,171</b>	<b>(214,769)</b>	<b>3,495,402</b>		<b>29</b>

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

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 SOCIETY- PROPHETS RIVERVIEW #0012955

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			152,606	152,606		152,606		152,606			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122	122		122	(122)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,676	8,676		8,676		8,676			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			161,404	161,404		161,404	(122)	161,282			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		80	3,568	3,648		3,648	(80)	3,568			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,798	38,798		38,798		38,798			42
43	Other (specify):*			9,072	9,072		9,072	(9,072)				43
44	<b>TOTAL Special Cost Centers</b>		80	51,438	51,518		51,518	(9,152)	42,366			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,114,382	399,275	1,409,436	3,923,093		3,923,093	(224,043)	3,699,050			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,592)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,230	21		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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	(217,681)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (224,043)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (224,043)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

**GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIEW**

ID# 0012955

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	See attached schedule	\$ (252)	1	1
2	See attached schedule	(115,508)	10a	2
3	See attached schedule		2	3
4	See attached schedule	(274)	3	4
5	See attached schedule	(271)	4	5
6	See attached schedule		5	6
7	See attached schedule	(6,689)	6	7
8	See attached schedule	(423)	7	8
9	See attached schedule		8	9
10	See attached schedule		9	10
11	See attached schedule	(85,542)	10	11
12	See attached schedule	(8,344)	11	12
13	See attached schedule	(7)	12	13
14	See attached schedule		13	14
15	See attached schedule		14	15
16	See attached schedule		15	16
17	See attached schedule		16	17
18	See attached schedule		17	18
19	See attached schedule		18	19
20	See attached schedule		19	20
21	See attached schedule	(19,682)	20	21
22	See attached schedule		21	22
23	See attached schedule	(1,560)	22	23
24	See attached schedule		23	24
25	See attached schedule	(120)	24	25
26	See attached schedule		25	26
27	See attached schedule		26	27
28	See attached schedule	(21,818)	27	28
29	See attached schedule		28	29
30	See attached schedule		29	30
31	See attached schedule		30	31
32	See attached schedule		31	32
33	See attached schedule	(122)	32	33
34	See attached schedule		33	34
35	See attached schedule		34	35
36	See attached schedule		35	36
37	See attached schedule		36	37
38	See attached schedule		37	38
39	See attached schedule		38	39
40	See attached schedule		39	40
41	See attached schedule	(80)	40	41
42	See attached schedule		41	42
43	See attached schedule		42	43
44	See attached schedule	(9,072)	43	44
45	See attached schedule		44	45
46	See attached schedule		45	46
47	See attached schedule		46	47
48	See attached schedule		47	48
49	<b>Total</b>	(269,764)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIEW# 0012955

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(252)	0	0	0	0	0	0	0	0	0	0	(252)	1
2	Food Purchase	(8,592)	0	0	0	0	0	0	0	0	0	0	(8,592)	2
3	Housekeeping	(274)	0	0	0	0	0	0	0	0	0	0	(274)	3
4	Laundry	(271)	0	0	0	0	0	0	0	0	0	0	(271)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,689)	0	0	0	0	0	0	0	0	0	0	(6,689)	6
7	Other (specify):*	(423)	0	0	0	0	0	0	0	0	0	0	(423)	7
8	<b>TOTAL General Services</b>	<b>(16,501)</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>(16,501)</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	(85,542)	0	0	0	0	0	0	0	0	0	0	(85,542)	10
10a	Therapy	(115,508)	0	0	0	0	0	0	0	0	0	0	(115,508)	10a
11	Activities	(8,344)	0	0	0	0	0	0	0	0	0	0	(8,344)	11
12	Social Services	(7)	0	0	0	0	0	0	0	0	0	0	(7)	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>(209,401)</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>(209,401)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	37,108	0	0	0	0	0	0	0	0	0	37,108	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	(19,682)	0	0	0	0	0	0	0	0	0	0	(19,682)	20
21	Clerical & General Office Expenses	2,230	0	0	0	0	0	0	0	0	0	0	2,230	21
22	Employee Benefits & Payroll Taxes	(1,560)	(5,101)	0	0	0	0	0	0	0	0	0	(6,661)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(120)	0	0	0	0	0	0	0	0	0	0	(120)	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	20,076	0	0	0	0	0	0	0	0	0	20,076	26
27	Other (specify):*	(21,818)	0	0	0	0	0	0	0	0	0	0	(21,818)	27
28	<b>TOTAL General Administration</b>	<b>(40,950)</b>	<b>52,083</b>	<b>0</b>	<b>11,133</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(266,852)</b>	<b>52,083</b>	<b>0</b>	<b>(214,769)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIE# 0012955

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

## 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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(122)	0	0	0	0	0	0	0	0	0	0	(122)	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>(122)</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>(122)</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	(80)	0	0	0	0	0	0	0	0	0	0	(80)	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):*	(9,072)	0	0	0	0	0	0	0	0	0	0	(9,072)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(9,152)</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>(9,152)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(276,126)</b>	<b>52,083</b>	<b>0</b>	<b>(224,043)</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
Good Samartain Society	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Admin/Acting	\$ 157,387	The Evangelical Lutheran Good Samaritan Society	100.00%	\$ 194,495	\$ 37,108	1
2	V	22 Workers Comp	50,921			87,769	36,848	2
3	V	22 Unemployment	24,001			24,974	973	3
4	V	26 Insurance	29,038			49,114	20,076	4
5	V	22 Group Health Insurance	151,855			108,933	(42,922)	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		\$ 413,202			\$ 465,285	\$ * 52,083	14

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY- PROPHE # 0012955 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIE # 0012955 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

**GOOD SAMARITAN SOCIETY- PROPHET**

# **0012955**

Report Period Beginning:

**01/01/2010**

Ending:

**12/31/2010**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	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>					\$	\$			\$	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>					\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2009 report.

\$ 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ 2

3. Under or (over) accrual (line 2 minus line 1).

\$ 3

4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2005	8
2006	9
2007	10
2008	11
2009	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

# 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

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

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1967	1967	\$ 347,118	\$		\$	\$	\$ 347,118	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9			1967		1,223		15			1,223	9
10			1973		669	17		17		622	10
11			1974		483	12		12		440	11
12			1975		33,671	758		758		30,641	12
13			1977		4,676					4,676	13
14			1978		2,854					2,854	14
15			1979		10,205					10,205	15
16			1980		2,114	9		9		2,035	16
17			1981		60,747	1,404		1,404		45,635	17
18			1982		10,416					10,416	18
19			1983		16,071					16,071	19
20			1984		8,772					8,772	20
21			1985		17,007					17,007	21
22			1986		3,134					3,134	22
23			1987		78,081					78,081	23
24			1988		47,917	430		430		46,771	24
25			1989		90,335					90,335	25
26			1990		805,403	12,008		12,008		805,403	26
27			1991		8,759					8,708	27
28			1992		28,408	214		214		28,023	28
29			1993		6,447	130		130		6,162	29
30			994		44,592	404		404		43,373	30
31			1995		32,831	571		571		31,642	31
32			1996		40,289	1,265		1,265		34,486	32
33			1997		58,092	2,292		2,292		39,621	33
34			1998		26,516	959		959		22,420	34
35			1999		18,382	327		327		16,939	35
36			2000		16,758	899		899		16,304	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

## 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		2001	\$ 42,137	\$ 1,928		\$ 1,928		\$ 25,711	37
38		2002	149,332	9,861		9,861		90,259	38
39		2003	63,243	4,216		4,216		33,621	39
40		2004	68,785	6,518		6,518		44,404	40
41		2005	218,729	17,819		17,819		95,723	41
42		2006	206,296	13,806		13,806		63,412	42
43	Fire Sprinkler System	2007	98,579	3,943	25	3,943		15,115	43
44	Repair Hot Water System	2007	3,832	766	5	766		2,810	44
45	Ceiling Tile	2007	34,380	4,297	8	4,297		15,399	45
46	Building-Outpatient clinic	2007	29,877	1,195	25	1,195		4,282	46
47	Roof	2007	24,956	1,248	20	1,248		4,471	47
48	Landscaping 30 0wing	2007	47,363	4,736	10	4,736		14,998	48
49	Dining Conference room Shades	2008	2,009	201	10	201		586	49
50	Drain Tile	2008	3,543	177	20	177		502	50
51	Carpet Floor covering replace	2008	32,057	6,411	5	6,411		17,631	51
52	Vinyl Floor Covering Replace	2008	8,090	809	10	809		2,225	52
53	Preen Mulch around Building	2008	4,218	703	2	703		4,218	53
54	Door Openers	2008	9,193	460	20	460		1,226	54
55	AC Compressor	2008	2,153	215	10	215		556	55
56	Shrubs and Sugar Maple	2008	2,774	139	20	139		347	56
57	New Signage	2008	6,940	694	10	694		1,504	57
58	Sidewalk	2008	2,820	188	15	188		407	58
59	handrail	2009	4,112	274	15	274		548	59
60	Building-Outpatient clinic	2009	21,034	841	25	841		1,683	60
61	Wallpaper	2009	674	135	5	135		270	61
62	Mulch, preen Labor Landscaping	2009	5,806	581	10	581		968	62
63	Radiator repair generator	2009	2,239	224	10	224		336	63
64	King Maple Tree	2009	800	80	10	80		113	64
65	100 Wing Handicap door	2009	6,303	420	15	420		595	65
66	Trees, Plants, Mulch	2009	2,800	280	10	280		350	66
67	Duct Work	2009	192	10	20	10		11	67
68	Carpet - Room Remodel	2009	1,752	350	5	350		409	68
69	Drapes - Room Remodel	2009	85	17	5	17		20	69
70	TOTAL (lines 4 thru 69)		\$ 2,929,073	\$ 105,241		\$ 105,241		\$ 2,213,827	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 2,929,073	\$ 105,241		\$ 105,241	\$	\$ 2,213,827	37
38	2009	92	18		18		21	38
39	2009	4,633	309		309		360	39
40	2009	12,399	496		496		579	40
41	2009	9,275	464		464		541	41
42	2010	2,601	130		130		130	42
43	2010	1,946	130		130		130	43
44	2010	4,858	324		324		324	44
45	2010	4,846	323		323		323	45
46	2010	1,215	81		81		81	46
47	2010	4,704	274		274		274	47
48	2010	4,956	289		289		289	48
49	2010	869	101		101		101	49
50	2010	3,629	363		363		363	50
51	2010	1,100	24		24		24	51
52	2010	719	24		24		24	52
53	2010	4,215	703		703		703	53
54	2010	53,823	673		673		673	54
55	2010	1,177	20		20		20	55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 3,046,130	\$ 109,987		\$ 109,987	\$	\$ 2,218,787	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 337,093	\$ 34,753	\$ 34,753	\$		\$ 206,483	71
72	Current Year Purchases	44,075	2,771	2,771			2,771	72
73	Fully Depreciated Assets	500,689	2,220	2,220			500,689	73
74								74
75	TOTALS	\$ 881,857	\$ 39,744	\$ 39,744	\$		\$ 709,943	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 use	Van and License	1992	\$ 35,985	\$	\$			\$ 35,985	76
77	Resident use	2002 Olds Mini Van	2004	16,850	1,875	1,875			16,850	77
78	Resident use	1995 Chrysler Van	2008	3,000	1,000	1,000			2,417	78
79										79
80	TOTALS			\$ 55,835	\$ 2,875	\$ 2,875	\$		\$ 55,252	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)	\$ 3,998,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,606	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 152,606	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,983,982	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building & Land Improvements	\$ 2,348,261	\$ 113,277	\$ 346,183	86
87	FFE	121,657	11,651	34,655	87
88	Care Assets Allocation to 01 Equip	(28,708)	(5,742)	(12,284)	88
89					89
90					90
91	TOTALS	\$ 2,441,210	\$ 119,186	\$ 368,554	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

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

16. Rental Amount for movable equipment: \$ 8,676 Description: Computer Lease, Companion Pump, Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2011 \$ \_\_\_\_\_

13. \_\_\_\_\_/2012 \$ \_\_\_\_\_

14. \_\_\_\_\_/2013 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<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	Ln 10a,Col 3	hrs	\$	7,308	\$ 109,624	\$	7,308	\$ 109,624	1
2	Licensed Speech and Language Development Therapist	Ln 10a,Col 3	hrs		2,865	42,975		2,865	42,975	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a,Col 3	hrs		10,872	163,073		10,872	163,073	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	21,045	\$ 315,672	\$	21,045	\$ 315,672	14

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

Facility Name & ID Number **GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIEW# 0012955**Report Period Beginning: **01/01/2010**Ending: **12/31/2010****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2010** (last day of reporting year)**This report must be completed even if financial statements are attached.**

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 95,842	\$	1
2	Cash-Patient Deposits	2,559		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (17,506) )	113,743		3
4	Supply Inventory (priced at )	15,818		4
5	Short-Term Investments	1,490,403		5
6	Prepaid Insurance	3,712		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,722,076	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	4,964,927		14
15	Leasehold Improvements, at Historical Cost	429,469		15
16	Equipment, at Historical Cost	1,030,636		16
17	Accumulated Depreciation (book methods)	(3,352,536)		17
18	Deferred Charges	35,604		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,022		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,126,122	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,848,198	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 61,800	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,559		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,706		30
31	Accrued Taxes Payable (excluding real estate taxes)	(15,415)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,774		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Security Deposits</u>	7,741		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 220,165	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,579,959		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>	\$ 1,579,959	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,800,124	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,048,074	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,848,198	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,093,381</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Apartments</b>	<b>26,109</b>	<b>3</b>
<b>4</b>	<b>Dnr Ret Prop/Oper Gift Cash</b>	<b>4,855</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>3,124,345</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>165,447</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>165,447</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Reserve Fund Assessment NC</b>	<b>(84,753)</b>	<b>18</b>
<b>19</b>	<b>Technology User Assessment NC</b>	<b>(19,404)</b>	<b>19</b>
<b>20</b>	<b>Senior Living</b>	<b>(137,561)</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>(241,718)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,048,074</b>	<b>24</b> *

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY- PROPHETS RIV # 0012955 Report Period Beginning: 01/01/2010Ending: 12/31/2010

**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	\$ 3,514,500	1
2	Discounts and Allowances for all Levels	(727,850)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,786,650</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	54,476	5
6	Therapy	956,017	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,010,493</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		12
13	Barber and Beauty Care	2,798	13
14	Non-Patient Meals	8,592	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	160,553	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,759	19
20	Radiology and X-Ray	2,059	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 178,761</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	55,224	24
25	Interest and Other Investment Income***	12,508	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 67,732</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Nursing and Medical Supplies	45,674	28
28a	Misc Income/Bad Debt/Other	(770)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 44,904</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,088,540</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	764,216	31
32	Health Care	2,015,336	32
33	General Administration	930,620	33
<b>B. Capital Expense</b>			
34	Ownership	161,403	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	38,798	36
<b>D. Other Expenses (specify):</b>			
37	Barber Beauty shop	3,648	37
38	Other	9,072	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,923,093</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>165,447</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>\$ 165,447</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? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

Facility Name & ID Number **GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIE**

# **0012955**

Report Period Beginning: **01/01/2010**

Ending:

**12/31/2010**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,087	1,927	\$ 64,675	\$ 33.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,615	11,511	299,218	25.99	3
4	Licensed Practical Nurses	12,424	11,461	252,387	22.02	4
5	CNAs & Orderlies	61,254	56,184	704,588	12.54	5
6	CNA Trainees					6
7	Licensed Therapist	211	185	5,050	27.30	7
8	Rehab/Therapy Aides	211	185	5,050	27.30	8
9	Activity Director	2,066	1,856	34,703	18.70	9
10	Activity Assistants	5,304	4,783	59,258	12.39	10
11	Social Service Workers	2,372	2,156	48,776	22.62	11
12	Dietician					12
13	Food Service Supervisor	1,799	1,542	32,995	21.40	13
14	Head Cook	6,008	5,572	73,750	13.24	14
15	Cook Helpers/Assistants	9,450	8,608	92,636	10.76	15
16	Dishwashers					16
17	Maintenance Workers	8,146	7,627	114,582	15.02	17
18	Housekeepers	5,697	5,354	56,196	10.50	18
19	Laundry	5,423	4,938	54,000	10.94	19
20	Administrator	2,559	1,855	82,230	44.33	20
21	Assistant Administrator					21
22	Other Administrative	8,933	8,003	103,233	12.90	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,092	1,838	31,055	16.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,651	135,585	\$ 2,114,382 *	\$ 15.59	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	145	\$ 6,533	Ln 1 Col 3	35
36	Medical Director		3,600	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,484	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	2	63	Ln 11 Col 3	44
45	Social Service Consultant	7	388	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 13,068		49

**C. CONTRACT NURSES**

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





Facility Name &amp; ID Number GOOD SAMARITAN SOCIETY- PROPHETS RIVERVIEW

# 0012955

Report Period Beginning: 01/01/2010

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. LSN\$3711
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,545 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? \_\_\_\_\_  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,798  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? YES Indicate the amount. \$ 8,592
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 28%  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? \_\_\_\_\_  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: LARSON ALLEN LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.