

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning: 10/01/2009 Ending: 9/30/2010

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 5/01/2010

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	72	20,768	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	131	48,027	3
4		Intermediate/DD			4
5	97	Sheltered Care (SC)	54	28,826	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	257	97,621	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,740	1,285	5,134	8,159	8
9	SNF/PED					9
10	ICF	23,713	33,423		57,136	10
11	ICF/DD					11
12	SC		16,540		16,540	12
13	DD 16 OR LESS					13
14	TOTALS	25,453	51,248	5,134	81,835	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.83%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Outpatient Therapy - Pool Exercise Classes

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 02/22/1957

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number

of beds certified 17 and days of care provided 4,942

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2010 Fiscal Year: 9/30/2010

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

Facility Name & ID Number

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10/01/2009

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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	1,043,009	67,077	26,441	1,136,527		1,136,527		1,136,527		1
2	Food Purchase		873,175		873,175		873,175	(60,515)	812,660		2
3	Housekeeping	285,453	56,102	25,816	367,371		367,371	(2,125)	365,246		3
4	Laundry	160,190		17,005	177,195		177,195		177,195		4
5	Heat and Other Utilities			456,112	456,112		456,112		456,112		5
6	Maintenance	293,059	76,614	257,022	626,695		626,695	(519)	626,176		6
7	Other (specify):*										7
8	TOTAL General Services	1,781,711	1,072,968	782,396	3,637,075		3,637,075	(63,159)	3,573,916		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	4,846,839	258,391	14,108	5,119,338		5,119,338		5,119,338		10
10a	Therapy		3,053	609,133	612,186		612,186		612,186		10a
11	Activities	185,002	4,743	12,283	202,028		202,028		202,028		11
12	Social Services	147,766	530	809	149,105		149,105		149,105		12
13	CNA Training			10,691	10,691		10,691		10,691		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,179,607	266,717	650,624	6,096,948		6,096,948		6,096,948		16
	C. General Administration										
17	Administrative	223,447			223,447		223,447		223,447		17
18	Directors Fees										18
19	Professional Services			63,172	63,172		63,172	(24,948)	38,224		19
20	Dues, Fees, Subscriptions & Promotions			52,105	52,105		52,105	(1,425)	50,680		20
21	Clerical & General Office Expenses	482,942	76,868	131,633	691,443		691,443	(64,493)	626,950		21
22	Employee Benefits & Payroll Taxes			1,731,518	1,731,518		1,731,518		1,731,518		22
23	Inservice Training & Education			329	329		329		329		23
24	Travel and Seminar			18,093	18,093		18,093	(1,086)	17,007		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			139,507	139,507		139,507		139,507		26
27	Other (specify):*										27
28	TOTAL General Administration	706,389	76,868	2,136,357	2,919,614		2,919,614	(91,952)	2,827,662		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,667,707	1,416,553	3,569,377	12,653,637		12,653,637	(155,111)	12,498,526		29

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

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

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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			633,512	633,512		633,512	(21,623)	611,889			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			520,259	520,259		520,259		520,259			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,153,771	1,153,771		1,153,771	(21,623)	1,132,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		197,654		197,654		197,654		197,654			39
40	Barber and Beauty Shops	70,269	4,423	682	75,374		75,374		75,374			40
41	Coffee and Gift Shops	22,630	37,162		59,792		59,792		59,792			41
42	Provider Participation Fee			100,905	100,905		100,905		100,905			42
43	Other (specify):* Non-Allowable Cos	73,265		851,868	925,133		925,133	(925,133)				43
44	TOTAL Special Cost Centers	166,164	239,239	953,455	1,358,858		1,358,858	(925,133)	433,725			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,833,871	1,655,792	5,676,603	15,166,266		15,166,266	(1,101,867)	14,064,399			45

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

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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	(52,024)	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	(16,891)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,413)	43		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	(22,847)	43		24
25	Fund Raising, Advertising and Promotional	(60,935)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Sch5A</u>	(946,757)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,101,867)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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))	\$ (1,101,867)		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.

		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

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49 Total	0		49

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Schedule 5A

Schedule 5A**VI. ADJUSTMENT DETAIL****NON-ALLOWABLE EXPENSES****LINE 29 - Other**

Description	Amount	Schedule V Reference
Resident Cable Expense	(46,747)	43
To disallow Rotary Club and Chamber of Commerce Dues	(1,425)	20
To disallow non-allowable Administrative Expenses	(5,483)	21
To disallow radio station expense	(811)	43
To disallow X-Ray expense	(7,445)	43
To disallow Lab expense	(10,308)	43
To disallow investment consultants	(234,517)	43
To disallow out of period seminar cost	(1,284)	24
To disallow out of state over fifty miles seminar cost	(582)	24
To record last year out of period cost for seminars that related to this ye	780	24
To offset guest room income	(3,678)	30
To disallow cottage service income	(2,125)	3
To offset miscellaneous income	(23)	21
To offset miscellaneous income	(260)	6
To offset the income from adjustment	0	21
To offset discount earned income	0	21
To offset discount earned income	(233)	6
To offset discount earned income	(26)	6
To offset discount earned income	(8,491)	1
To offset income from sale of equipment	(1,054)	30
To disallow Property Taxes	(15,541)	43
To disallow rental property expenses	(88)	43
To disallow radio station depreciation	(13,252)	43
To disallow cottage expenses	(510,229)	43
To disallow Public Relation Wages	(58,987)	21
To disallow out of period Legal Fees	(3,425)	19
To disallow the Development Cost that relates to the Cottages	(21,523)	19
Total	(946,757)	

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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							3
4	V			N/A				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.

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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	N/A										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

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

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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		X	Construction		9/30/08	\$ 6,700,545	\$	09/30/2010	0.0538	\$	1								
2		X	Mortgage	\$65,550.75	12/01/09	12,000,000	11,871,792	12/01/2039	0.0508		515,641	2							
3		X	Amortization of Loan Cost								4,618	3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related			\$65,550.75		\$ 18,700,545	\$ 11,871,792			\$	520,259	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related					\$	\$			\$		14							
15	TOTALS (line 9+line14)					\$ 18,700,545	\$ 11,871,792			\$	520,259	15							

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

** 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.)	2009	\$	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 Home COUNTY Adams
 FACILITY IDPH LICENSE NUMBER 0009258
 CONTACT PERSON REGARDING THIS REPORT Judy Graham
 TELEPHONE (217) 223-8717 FAX #: (217) 223-6015

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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.**

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X. BUILDING AND GENERAL INFORMATION:A. Square Feet: 124,970 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Residential Cottage Apartments 160 Units for 174,278 square feetF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>1,219,680</u>	<u>1956-2010</u>	<u>\$ 193,553</u>	1
2					2
3	TOTALS	1,219,680		\$ 193,553	3

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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				1957	\$	\$	40	\$	\$	\$	4
5	48			1962	683,823		40			683,823	5
6	94			1973	1,683,761	42,094	40	42,094		1,552,582	6
7	91			1984	1,953,541	48,839	40	48,839		1,298,295	7
8	24			2010	1,695,151	30,486	Various	30,486		30,486	8
	Improvement Type**										
9	Building Improvements - Disposals			1974	59,320		30			59,320	9
10	Building Improvements - Disposals			1976							10
11	Building Improvements - Disposals			1977							11
12	Building Service Equipment - Disposal			1978							12
13	Building Service Equipment - Disposal			1979							13
14	Building Service Equipment - Disposal			1980							14
15	Building Improvements - Disposals			1982		3,417	Various	3,417			15
16	Building Service Equipment - Disposal			1982			Various				16
17	Building Service Equipment			1983	10,058		20			10,058	17
18	Land Improvements			1984	49,187		15			49,187	18
19	Building Service Equipment - Disposal			1984	345,127	425	Various	425		343,675	19
20	Land Improvements			1985	2,601		20			2,601	20
21	Building Improvements			1985	250,935	6,273	40	6,273		158,510	21
22	Building Service Equipment - Disposal			1985	30,300		Various			30,300	22
23	Land Improvements			1986	2,130		20			2,130	23
24	Building Improvements			1986	119,616	3,776	40	3,776		72,764	24
25	Building Service Equipment			1986	137,391	2,514	Various	2,514		135,350	25
26	Building Improvements			1987	19,089	500	Various	500		11,467	26
27	Building Service Equipment - Disposal			1987	10,451		20			10,451	27
28	Building Service Equipment - Disposal			1988	11,876	42	Various	42		11,759	28
29	Building Improvements - Disposals			1989	163,640	4,404	Various	4,404		128,807	29
30	Building Service Equipment			1989							30
31	Garage Additions			1990	78,563	2,619	30	2,619		54,121	31
32	New Roof - North Wing -Disposal			1990		1,283		1,283			32
33	Phones			1990							33
34	Hall Renovations - Disposal			1991		773		773			34
35	Building Improvements State Audit Adjustments 10881+30372			1991	511,992	18,441	30	17,066	(1,375)	329,890	35
36	Ceiling/partitions -Disposals			1991		932		932			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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	Office Entrance - Disposal	1991	\$	\$ 554	20	\$ 554	\$	\$	37			
38	Building Services Equipment State Audit Adjustment of 359	1991		35,381	various			35,381	38			
39	Parking Lot	1992		4,257	20	213		3,618	39			
40	Building Services Equipment	1992		2,706	10			2,706	40			
41	Parking Lot	1992		46,071	20	2,304		40,505	41			
42	Kitchen/Dining Room	1993		310,412	40	7,760		134,512	42			
43	Building Services Equipment - Disposal	1993		12,199	various	238		10,317	43			
44	Parking Lot	1994		87,827	15			87,827	44			
45	Manhole/Sewer	1994		2,859	15			2,859	45			
46	Sidewalk	1994		7,875	15			7,875	46			
47	West Nursing	1994		66,876	20	3,344		53,501	47			
48	Dining Room -Disposal	1994		6,305	various	315		5,359	48			
49	Building Services Equipment - Disposal	1994		75,153	various	2,791		66,084	49			
50	West Nursing	1995		128,327	20	6,416		99,988	50			
51	West Nursing	1995		3,151	20	158		2,284	51			
52	Building Services Equipment - Disposal	1995		12,183	various	338		12,183	52			
53	Gas Line -Disposal	1996			20	77			53			
54	Gutters	1996		10,817	20	541		7,843	54			
55	Eber Wing Improvements	1996		20,335	20	1,017		14,743	55			
56	Roof	1996		9,016	20	451		6,537	56			
57	Roof - Anna Brown Wing	1996		70,800	20	3,540		49,265	57			
58	Building Services Equipment - Disposal	1996		38,438	various	2,128		30,853	58			
59	Lights/Front Land Improvements	1997		5,360	15	357		4,913	59			
60	Walls/Floor - Anna Brown Wing -Disposal	1997			20	1,567			60			
61	Freezer Floor -Disposal	1997			17	194			61			
62	Roof-Anna Brown Wing	1997		48,740	39	1,250		16,064	62			
63	Sprinkling System	1997		3,354	10			3,354	63			
64	Tamper Detectors	1997		2,818	10			2,818	64			
65	Compressor - Eber - Disposal	1997			15	102	(261)		65			
66	Compressor - East	1997		11,808	15	787		10,430	66			
67	Sprinkler System	1997		102,875	20	5,144		67,297	67			
68	Air Exchange -Pool Area State Audit adjustment 480	1997			15	429	(1,143)		68			
69	Roof- Kitchen/Dinning	1998		45,550	39	1,168		14,887	69			
70	TOTAL (lines 4 thru 69)		\$	8,990,045	\$	211,405		\$ 208,626	\$ (2,779)	\$	5,769,579	70

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,990,045	\$ 211,405		\$ 208,626	\$ (2,779)	\$ 5,769,579	1
2	<u>Elevator Doors - Dietary</u>	1998	1,095		10			1,095	2
3	<u>Remodeling -Anna Brow Wing Walls, Ceiling, Floors,Lights</u>	1999	199,131	4,978	39	4,978		55,798	3
4	<u>Remodeling -Anna Brow Wing - Duct Detectors</u>	1999	1,444		5			1,444	4
5	<u>Remodeling -Anna Brow Wing - Carpeting -Disposal</u>	1999			10				5
6	<u>Remodeling -Anna Brow Wing - Fire Damper</u>	1999	21,915	548	39	548		6,232	6
7	<u>Chapel Roof</u>	1999	21,515	538	39	538		6,387	7
8	<u>Fire Damper Alarm</u>	1999	5,490		5			5,490	8
9	<u>Eber Parking Lot Lights</u>	1999	5,495	366	15	366		4,213	9
10	<u>Stainless Steel D/W Exhaust</u>	1999	1,659		10			1,659	10
11	<u>Wiring Chapel Roof</u>	1999	332		10			332	11
12	<u>HVAC Chapel</u>	1999	23,760	1,584	15	1,584		18,216	12
13	<u>Code Alert System</u>	1999	61,985		5			61,985	13
14	<u>Elevator Upgrade A/B East</u>	1999	22,556		10			22,556	14
15	<u>Elevator Upgrade - Special Care</u>	1999	5,970		10			5,970	15
16	<u>Fire Protection A/B</u>	1999	4,500		10			4,500	16
17	<u>Condensor Unit</u>	1999	22,945	1,530	15	1,530		17,591	17
18	<u>Fire Protection Pool Area</u>	1999	776		10			776	18
19	<u>Damper Duct Work</u>	1999	5,602	373	15	373		4,295	19
20	<u>Lighting- Special Care</u>	1999	2,075	138	15	138		1,591	20
21	<u>Chapel Remodeling - Fire Damper</u>	2000	3,196	213	15	213		2,237	21
22	<u>Chapel Remodeling - Sign -Disposal</u>	2000			5				22
23	<u>Chapel Remodeling - Painting -Disposal</u>	2000	4,616	118	39	118		1,159	23
24	<u>Chapel Remodeling - Carpeting</u>	2000	3,073	205	15	205		2,151	24
25	<u>Chapel Remodeling - Unity & Pews</u>	2000	14,760	369	39	369		3,705	25
26	<u>Kitchen Remodeling - Sky Roof Flashing</u>	2000	3,086	206	15	206		2,160	26
27	<u>Kitchen Remodeling - Sidewalls</u>	2000	3,485	232	15	232		2,439	27
28	<u>Kitchen Remodeling - Galvanized Wall Divider</u>	2000	2,601	173	15	173		1,820	28
29	<u>East Nursing Remodeling - Walls, Ceilings, Floors</u>	2000	26,757	669	39	669		6,884	29
30	<u>Eber Wing Smoke Damper</u>	2000	16,485	1,099	15	1,099		11,540	30
31	<u>Special Care Lighting</u>	2000	14,290	953	15	953		10,003	31
32	<u>HVAC Rehab Eber Wing</u>	2000	305,419	20,361	15	20,361		213,793	32
33	<u>3 Ton Rooftop Unit A/C West Dining</u>	2000	2,776	185	15	185		1,943	33
34	TOTAL (lines 1 thru 33)		\$ 9,798,834	\$ 246,243		\$ 243,464	\$ (2,779)	\$ 6,249,543	34

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,798,834	\$ 246,243		\$ 243,464	\$ (2,779)	\$ 6,249,543	1
2	Telephone Unit - Disposal	2000			7				2
3	Elevator Up Grade East Wing	2000	12,776	852	15	852		8,943	3
4	Superior Boiler Burner Up Grade - Disposal	2000		37	15	37			4
5	Entrance Codelock Special Care	2000	1,848	490	15	123	(367)	1,294	5
6	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		4,900	6
7	Land Improvement New Sidewalk	2000	1,200	60	20	60		570	7
8	Renovation of East Nursing Wing	2001	369,213	9,230	39	9,230		84,996	8
9	Exterior Painting -Disposal	2001		478	15	478			9
10	Painting Kitchen	2001	2,550	170	15	170		1,615	10
11	Chapel Renovation	2000	2,001	50	39	50		494	11
12	Kitchen Electrical Work	2000	611	41	15	41		387	12
13	HVAC Rehab Eber Wing	2000	5,584	372	15	372		3,536	13
14	Sprinklers	2000	4,151	277	15	277		2,629	14
15	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		2,340	15
16	Electrical Work	2001	1,609	107	15	107		1,019	16
17	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		32,132	17
18	Air Compressor Anna Brown Wing - Disposal	2001		4,728	15	364	(4,364)		18
19	3D Detectors in Elevators	2001	4,916	344	10	344		3,252	19
20	Compensators	2001	2,724	191	10	191		1,802	20
21	33 Lever Passage Locks	2002	2,904	203	10	203		1,921	21
22	Exit Lights and Hold Opens	2002	966	68	10	68		639	22
23	16 Lever Passage Locks	2002	1,408	99	10	99		931	23
24	48 Lockouts	2002	985	69	10	69		652	24
25	Water Piping	2001	4,600	115	39	115		1,021	25
26	New Curb & Driveway	2002	16,118	564	20	564		5,723	26
27	Buffet in Dining Area	2003	2,977	198	15	198		1,524	27
28	Door - code alert and keypad	2003	2,489	249	10	249		1,908	28
29	Fire Collars	2003	3,619	362	10	362		2,757	29
30	Main Breaker	2003	3,291	219	15	219		1,554	30
31	Elevator Master Door Operator	2003	4,278	428	10	428		3,173	31
32	Training Room Drainage - Disposal	2003		14	39	14			32
33	Dietary - Floor Drain - Disposal	2003		4	39	4			33
34	TOTAL (lines 1 thru 33)		\$ 10,313,082	\$ 270,357		\$ 262,847	\$ (7,510)	\$ 6,421,255	34

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,313,082	\$ 270,357		\$ 262,847	\$ (7,510)	\$ 6,421,255	1
2	Handicap Accessible Entrance and Sidewalk	2003	3,200	160	20	160		1,120	2
3	Annunciators	2004	51,494	5,149	10	5,149		33,471	3
4	Sewer Lines	2003	5,801	387	15	387		2,675	4
5	Smoke Damper - Eber	2003	698	47	15	47		318	5
6	Beauty Shop Wiring	2003	2,272	151	15	151		1,023	6
7	Dietary Doors	2004	3,801	253	15	253		1,689	7
8	Roof	2004	4,028	269	15	269		1,746	8
9	Remote Annunciator	2004	4,650	465	10	465		2,945	9
10	Cooler Expansion	2004	6,120	408	15	408		2,584	10
11	Parking Lot	2004	6,800	453	15	453		2,833	11
12	Ambulance Garage Doors	2004	1,070	107	10	107		660	12
13	Kitchen Remodel	2004	6,425	643	10	643		3,855	13
14	Plumbing wok in Eber/South	2004	5,147	343	15	343		2,001	14
15	Water Softener System	2004	15,642	1,564	10	1,564		8,994	15
16	Storage Tank Replacement	2004	2,454	245	10	245		1,411	16
17	Air Handler in East Circle	2005	1,297	130	10	130		702	17
18	Parking Lot Off-Street	2005	68,884	4,592	15	4,592		24,492	18
19	Kitchen Electrical Work	2004	247	12	20	12		74	19
20	Kitchen Remodel	2004	1,248	62	20	62		369	20
21	Sprinkler System	2004	980	49	20	49		286	21
22	Sprinkler System	2005	2,373	119	20	119		672	22
23	Tunnel Closure	2005		94	15	94			23
24	Perry Suite Renovations	2005	2,470	165	15	165		915	24
25	Water Heater	2006	13,003	1,300	10	1,300		5,827	25
26	Telephone System	2006	65,476	4,613	various	4,613		20,956	26
27	Sprinkler System Pipes	2006	1,645	142	various	142		593	27
28	Overhead Door	2005	1,400	140	10	140		688	28
29	Concrete Work	2005	9,936	662	15	662		3,202	29
30	Fire Walls	2006	14,948	747	20	747		3,239	30
31	Fire Alarm System	2006	23,500	1,567	15	1,567		7,311	31
32	Life Safety Code Renovations	2006	1,905	191	10	191		873	32
33	Renovations to Building Front Entrance	2006	38,611	1,931	20	1,931		8,656	33
34	TOTAL (lines 1 thru 33)		\$ 10,680,607	\$ 297,517		\$ 290,007	\$ (7,510)	\$ 6,567,435	34

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,680,607	\$ 297,517		\$ 290,007	\$ (7,510)	\$ 6,567,435	1
2	Telephone System Wiring	2006	35,781	3,578	10	3,578		14,630	2
3	Pool Area Renovations	2006	98,370	4,919	20	4,919		21,723	3
4	Concrete Work	2006	3,850	257	15	257		1,134	4
5	Lighting in the Hallway	2006	7,872	394	20	394		1,673	5
6	Laundry Renovations- Air System	2006	9,841	492	20	492		2,091	6
7	Smoke/Fire Dampers Special Care Area	2006	14,683	734	20	734		3,120	7
8	Eber Elevator Remodel	2006	12,769	851	15	851		3,334	8
9	Sprinkler System Heads	2006	20,456	1,364	15	1,364		5,114	9
10	South Wing Fiber Server	2007	2,526	168	15	168		632	10
11	Smoke/Fire Detectors	2007	10,431	1,043	10	1,043		3,825	11
12	Repairs to Boiler Motor	2007	954	95	10	95		350	12
13	Smoke/Fire Dampers	2007	1,125	113	10	113		413	13
14	CO Detectors	2007	1,483	148	10	148		470	14
15	Call Lights - Dining Hall	2007	823	82	10	82		254	15
16	Hot Water Tank	2007	2,588	259	10	259		820	16
17	Repairs to Hot Water Shower Area	2007	1,113	111	10	111		334	17
18	Compressor - Walk in	2007	2,922	292	10	292		876	18
19	Repairs to Wiring in Chapel Area	2007	14,516	968	15	968		2,903	19
20	HVAC Controllers	2007	11,952	797	15	797		2,390	20
21	Physical Therapy Ductwork Repairs	2006	2,254	150	15	150		589	21
22	Alarm Stations Repairs	2006	27,685	1,846	15	1,846		6,921	22
23	Dining Hall Electric	2007	890	59	15	59		222	23
24	Chapel Roof Repair	2007	3,528	235	15	235		882	24
25	Special Care Area Door	2007	3,038	304	10	304		1,114	25
26	Dining Hall Paint	2007	7,401	740	10	740		2,652	26
27	Special Care Area Bathroom Repairs	2007	4,106	274	15	274		958	27
28	Pool Area Renovations	2007	5,108	341	15	341		1,192	28
29	Dinning Hall Roof Repairs	2007	573	38	15	38		134	29
30	Front Hall Area Roof Repair	2007		155	15	155			30
31	Storm Sewer Line	2007	3,459	231	15	231		769	31
32	Dietary Doors	2007	1,485	148	10	148		445	32
33	Alarm System at Stations	2007	4,450	445	10	445		1,261	33
34	TOTAL (lines 1 thru 33)		\$ 10,998,639	\$ 319,148		\$ 311,638	\$ (7,510)	\$ 6,650,660	34

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,998,639	\$ 319,148		\$ 311,638	\$ (7,510)	\$ 6,650,660	1
2	Roof South Eber	2007	9,587	639	15	639		1,811	2
3	B&G Series 1510- 2 Pump	2008	7,597	760	10	760		1,519	3
4	Fiber Project Improvements	2008	10,646	710	15	710		1,774	4
5	Door Closers	2008	10,180	1,018	10	1,018		2,036	5
6	Pine Doors	2008	1,714	171	10	171		400	6
7	Elevator Renovation	2008	122,827	8,188	15	8,188		19,106	7
8	Wanderer Alert System	2008	1,968	197	10	197		492	8
9	CO System Detectors	2008	1,395	140	10	140		337	9
10	Improvements Fire Protection	2009	35,300	2,353	15	2,353		3,922	10
11	New Doors Alarm	2008	8,704	435	20	435		761	11
12	Improvements to Elevator	2008	27,518	1,835	15	1,835		3,516	12
13	Improvement to Alarms	2009	14,985	749	20	749		1,186	13
14	Eber Water Project	2009	3,795	190	20	190		284	14
15	Improvements Fire Protection	2009	1,640	82	20	82		89	15
16	Hot Water Heater	2009	5,577	558	10	558		836	16
17	Improvements to Heater in Pool	2009	14,325	1,433	10	1,433		2,029	17
18	Run Fiber - Anna Brown to switch in Maint. For Phone Sys.	2009	1,040	208	5	208		243	18
19	IDCS 500 Release - Wiring & Cabinet for Phone System	2009	7,099	1,420	5	1,420		1,538	19
20	Addition to Walking Freezer	2009	88,733	2,465	20	2,465		2,465	20
21	Roof Repair to the East Circle and Chapel	2009	61,810	2,575	20	2,575		2,575	21
22	East Circle Laundry- Labor, Plumbing Materials,	2009	11,421	428	20	428		428	22
23	Electrical Work , and Tile Work								23
24	Install Upgrade to Code Alert System - Wiring and Labor	2009	85,645	3,569	20	3,569		3,569	24
25	Wiring for the Facility Phone System	2009	10,951	365	20	365		365	25
26	Replace the Transfer Switch - Wiring and Labor	2009	12,414	155	20	155		155	26
27	Install Water Value in Meter Pit/ Fire Hydrant	2009	13,300	1,035	20	1,035		1,035	27
28	Concrete Work for Ambulance Garage,Sidewalks, & Drives	2010	24,818	620	20	620		620	28
29	Alzheimer's Unit -Landscaping	2010	51,508	1,431	15	1,431		1,431	29
30	Alzheimer's Unit -Parking Lot	2010	154,072	4,280	15	4,280		4,280	30
31	New Alzheimer Building	2010	4,789,401	49,889	40	49,889		49,889	31
32	New Alzheimer Building -Unit Mechanical	2010	838,272	17,464	20	17,464		17,464	32
33	New Alzheimer Building -Unit Roofing	2010	223,472	3,724	25	3,724		3,724	33
34	TOTAL (lines 1 thru 33)		\$ 17,650,353	\$ 428,234		\$ 420,724	\$ (7,510)	\$ 6,780,539	34

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009 Ending: 9/30/2010**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	
1		\$ 17,650,353	\$ 428,234		\$ 420,724	\$ (7,510)	\$ 6,780,539	1
2	2010	1,405,351	19,519	30	19,519		19,519	2
3	2010	383,839	7,997	20	7,997		7,997	3
4	2010	117,455	3,263	15	3,263		3,263	4
5	2010	354,518	7,386	20	7,386		7,386	5
6	2010	209,459	5,818	15	5,818		5,818	6
7	2010	167,615	1,048	40	1,048		1,048	7
8	2010	5,872	73	20	73		73	8
9	2010	1,455	24	10	24		24	9
10	2010	105,708	881	10	881		881	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32					(3,678)	(3,678)		32
33					(1,054)	(1,054)		33
34		\$ 20,401,625	\$ 474,243		\$ 462,001	\$ (12,242)	\$ 6,826,548	34

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2009

Ending:

9/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,196,786	\$ 133,222	\$ 123,840	\$ (9,382)	3-20 yrs	\$ 710,874	71
72	Current Year Purchases	219,527	10,728	10,728		5-15 yrs	10,728	72
73	Fully Depreciated Assets	964,631				3-20 yrs	964,631	73
74								74
75	TOTALS	\$ 2,380,944	\$ 143,950	\$ 134,568	\$ (9,382)		\$ 1,686,233	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	Various	Various	\$ 74,241	\$	\$	\$	3-5 yrs	\$ 74,241	76
77	Maintenance	Various	Various	40,426				5 yrs	40,426	77
78	Maintenance	Various	Various	1,219				3 yrs	1,219	78
79	See Attach Sch 13A	Various	Various	219,869	15,320	15,320		5-10 yrs	173,724	79
80	TOTALS			\$ 335,755	\$ 15,320	\$ 15,320	\$		\$ 289,610	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 23,311,877	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 633,513	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 611,889	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,624)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,802,391	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage Land	\$ 207,379	\$	\$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,220,740	181,856	5,124,456	88
89	Rental Property Fixed Assets	367,490	13,252	113,087	89
90	Radio Station	15,038	88	14,475	90
91	TOTALS	\$ 8,886,377	\$ 195,196	\$ 5,252,018	91

G. Construction-in-Progress

	Description	Cost	
92	Building Construction	\$ 1,724,921	92
93			93
94			94
95		\$ 1,724,921	95

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

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

XI. OWNERSHIP COSTS (continued)

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

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

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Toro 2001	2001	\$ 825	\$ 0	\$ 0	\$ 0	5 yrs	\$ 710	42
43	Maintenance	Chevy S-10 98	2002	7,508	0	0	0	5 yrs	6,457	43
44	Facility	Toro mower	2003	7,139	0	0	0	5 yrs	7,139	44
44a	Facility	Ford/Goshen Bus (2)	2004	98,532	0	0	0	5 yrs	98,532	44a
44b	Facility	Lift for Van	2005	1,500	175	175	0	5 yrs	1,500	44b
44c	Facility	Toro mower	2005	9,792	1,142	1,142	0	5 yrs	9,792	44c
44d	Facility	2005 Chrysler Town	2005	21,931	4,386	4,386	0	5 yrs	21,931	44d
44e	Facility	1999 Chevy Van	2005	5,648	1,130	1,130	0	5 yrs	5,459	44e
44f	Facility	Kubota L3430	2006	18,895	1,890	1,890	0	10 yrs	7,243	44f
44g	Facility	Ford F350	2007	30,224	3,022	3,022	0	10 yrs	9,823	44g
44h	Facility	Toro Mower	2009	7,000	1,400	1,400	0	5 yrs	1,750	44h
44i	Facility	Toro mower	2009	9,000	1,800	1,800	0	5 yrs	2,700	44i
44j	Facility	Truck Plow 84 Rear	2008	675	135	135	0	5 yrs	248	44j
44k	Facility	Golf Cart	2008	1,200	240	240	0	5 yrs	440	44k
44l	Facility									44l
45							0			45
46	TOTALS			\$ 219,869	\$ 15,320	\$ 15,320	\$ 0		\$ 173,724	46

E. Summary of Care-Related Assets

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

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/01/2009

Ending: 9/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

**

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A
N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ N/A

13. _____ /2012 \$ N/A

14. _____ /2013 \$ N/A

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>104</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></p>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 9,974	\$	\$ 9,974
2	Books and Supplies		177		177
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		540		540
9	TOTALS	\$	\$ 10,691	\$	\$ 10,691
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,691		

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	<u>9</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

- (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	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10a C 3	hrs	\$	3,404	\$ 204,217	\$	3,404	\$ 204,217	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		329	19,765		329	19,765	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 3	hrs		6,411	384,658	3,053	6,411	387,711	4
5	Physician Care		visits							5
6	Dental Care	L. 10 C 2,3	visits		12	2,400		12	2,400	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C 2	# of prescripts				197,654		197,654	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	L. 10a C 3			5	493		5	493	12
13	Other (specify):									13
14	TOTAL			\$	10,161	\$ 611,533	\$ 200,707	10,161	\$ 812,240	14

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

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

Ending:

9/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,953,487	\$ 1,953,487	1
2	Cash-Patient Deposits	24,572	24,572	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,344,249	2,344,249	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,709,253	5,709,253	5
6	Prepaid Insurance	48,319	48,319	6
7	Other Prepaid Expenses	995	995	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Application Fee Repurchase</u>	34,227	34,227	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,115,102	\$ 10,115,102	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	26,880,425	26,880,425	12
13	Land	193,553	193,553	13
14	Buildings, at Historical Cost	20,525,854	20,401,625	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,716,699	2,716,699	16
17	Accumulated Depreciation (book methods)	(8,911,736)	(8,802,391)	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 (spec See Sch17A)	1,907,697	1,907,697	22
23	Other(specify): <u>Cottage & Rental Property</u>	3,447,359	3,447,359	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,759,851	\$ 46,744,967	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 56,874,953	\$ 56,860,069	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 724,026	\$ 724,026	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,572	24,572	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	649,084	649,084	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,279		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Sch 17C</u>	158,034	158,034	36
37	<u>Prepaid Resident Rent</u>	795,523	795,523	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,362,518	\$ 2,351,239	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,871,792	11,871,792	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,871,792	\$ 11,871,792	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,234,310	\$ 14,223,031	46
47	TOTAL EQUITY (page 18, line 24)	\$ 42,640,643	\$ 42,637,038	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 56,874,953	\$ 56,860,069	48

*(See instructions.)

Good Samaritan Home
0009258
9/30/2010

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
B. Long Term Assets

<u>Other Long Term Assets (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Loan Amortization Cost	182,776	182,776
Construction in Progress	1,724,921	1,724,921
Total Line 22 - Other Long Term Assets (specify):	<u>1,907,697</u>	<u>1,907,697</u>

Good Samaritan Home

0009258

9/30/2010

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
ST Disability Payable - Employee	3,422	3,422
United Way Deduction		
Misc. Employee Deduction	55	55
Employee Assist Fund Withheld	5,010	5,010
Pension Plan Payable-Employee	4,235	4,235
Capital Campaign Pledge	(88)	(88)
Capital Campaign Pledge - Residents		
Benevolent Fund Payable	7,897	7,897
Flower Fund Payable		
Application Fee Payable	26,655	26,655
Medicare Liability		
Medicaid Liability		
Employee Health/Life Liability	110,848	110,848
Total Line 36 - Other Current Liabilities(specify):	158,034	158,034

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 40,705,283	1
2	Restatements (describe):	1	2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 40,705,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,935,359	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)	\$ 1,935,359	17
	B. Transfers (Itemize):		
18			18
19	Rounding		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)	\$ 42,640,643	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/01/2009

Ending:

9/30/2010**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,948,075	1
2	Discounts and Allowances for all Levels	(2,012,042)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,936,033	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,120,088	6
7	Oxygen	11,839	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,131,927	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	38,382	12
13	Barber and Beauty Care	68,683	13
14	Non-Patient Meals	52,024	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	380,383	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,336	19
20	Radiology and X-Ray	14,889	20
21	Other Medical Services	119,135	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 693,832	23
D. Non-Operating Revenue			
24	Contributions	66,600	24
25	Interest and Other Investment Income***	3,666,789	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,733,389	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule 19E</u>	44,601	28
28a	<u>Cottage and Rental Property Income</u>	1,561,843	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,606,444	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,101,625	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,637,075	31
32	Health Care	6,096,948	32
33	General Administration	2,919,614	33
B. Capital Expense			
34	Ownership	1,153,771	34
C. Ancillary Expense			
35	Special Cost Centers	1,257,953	35
36	Provider Participation Fee	100,905	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,166,266	40
41	Income before Income Taxes (line 30 minus line 40)**	1,935,359	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,935,359	43

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

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

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

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

Good Samaritan Home
0009258
9/30/2010

Schedule 19E

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	1,054
Discount Earned Income	9,033
Adjustments	0
Guest Room Income	3,678
Van Transportation	28,711
Cottage Services Income	2,125
Application Fee Income	
Total Line 28 - Other Revenue (specify):	<u><u>44,601</u></u>

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2009

Ending:

9/30/2010

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	1,980	2,104	\$ 79,183	\$ 37.63	1
2	Assistant Director of Nursing	1,848	2,080	55,298	26.59	2
3	Registered Nurses	19,025	20,520	400,757	19.53	3
4	Licensed Practical Nurses	73,724	80,077	1,370,444	17.11	4
5	CNAs & Orderlies	207,462	224,810	2,558,369	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,296	14,744	173,714	11.78	8
9	Activity Director	1,834	2,081	35,643	17.13	9
10	Activity Assistants	13,869	15,056	149,359	9.92	10
11	Social Service Workers	12,958	13,992	147,766	10.56	11
12	Dietician					12
13	Food Service Supervisor	7,682	8,624	155,698	18.05	13
14	Head Cook	9,507	10,396	122,108	11.75	14
15	Cook Helpers/Assistants	63,020	60,076	678,242	11.29	15
16	Dishwashers	8,274	8,973	86,961	9.69	16
17	Maintenance Workers	22,527	24,542	293,059	11.94	17
18	Housekeepers	25,434	28,260	285,453	10.10	18
19	Laundry	13,434	15,020	160,190	10.67	19
20	Administrator	1,828	2,080	122,567	58.93	20
21	Assistant Administrator	1,876	2,080	100,880	48.50	21
22	Other Administrative	6,214	6,960	186,715	26.83	22
23	Office Manager					23
24	Clerical	18,294	20,136	296,227	14.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,949	2,184	34,736	15.90	31
32	Other Health C: SCH 20A	13,612	15,152	174,338	11.51	32
33	Other(specify) SCH 20A	12,871	13,921	166,164	11.94	33
34	TOTAL (lines 1 - 33)	552,518	593,868	\$ 7,833,871 *	\$ 13.19	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	611	\$ 24,219	L. 1 C3	35
36	Medical Director	Monthly	3,600	L. 9 C3	36
37	Medical Records Consultant	Quarterly	1,840	L. 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,868	L. 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	864	L. 11 C3	44
45	Social Service Consultant	10	809	L. 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	632	\$ 41,200		49

C. CONTRACT NURSES

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

Good Samaritan Home

0009258

9/30/2010

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Nursing Secretary	9,313	10,454	106,514	10.19
Medical Supply Clerk	2,317	2,560	28,525	11.14
Staff Coord.	1,982	2,138	39,299	18.38
Total Line 32 - Other	13,612	15,152	\$ 174,338	\$ 11.51

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Maintenance Cottages	5,632	6,136	\$ 73,265	11.94
Beauty Shop	4,906	5,311	70,269	13.23
General Store	2,333	2,474	22,630	9.15
Total Line 33 - Other	12,871	13,921	\$ 166,164	\$ 11.94

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	Amount	
Michael Duffy	Administrator	0	122,567	Workers' Compensation Insurance	137,422	IDPH License Fee	3,980		
Judy Graham	Asst Admin.	0	100,880	Unemployment Compensation Insurance	17,030	Advertising: Employee Recruitment	17,357		
				FICA Taxes	562,613	Health Care Worker Background Check	2,499		
				Employee Health Insurance	708,134	(Indicate # of checks performed 178)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	15,824		
				Employee Tuition	14,121	Council for Health and Human Services	8,395		
				Pension Plan	240,924	Various Dues, Licenses, and Permits	2,625		
				Employee Medical	14,228				
				Life Insurance	7,476				
				Employee Recognition	29,570				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 223,447	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 50,680	
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		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	17,007	
C. Professional Services							See attached Schedule		
Vendor/Payee	Type		Amount						
Schmiedeskamp, Robertson	Legal		15,891						
Dennis G. Koch	Accounting		23,750						
ACH	Payroll		638						
Architechnics, Inc	Architect Cost		1,370						
Klingner & Assocites, PC	Architect Cost		21,523						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 63,172	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		\$ 17,007

* Attach copy of IMRF notifications

**See instructions.

Good Samaritan Home
Provider #: 0009258
10/01/2009 to 9/30/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	63,172
Disallow Development Costs that relate to the Cottages.	(21,523)
Out of Period Legal Expenses	(3,425)
Total (agree to Schedule V, line 19, column 8)	<u>38,224</u>

Part I	Net profit or loss	Net self-employment tax	Net earnings or loss
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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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
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20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Good Samaritan Home# 0009258Report Period Beginning: 10/01/2009Ending: 9/30/2010**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$15,824 CHHS\$8,395
- (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? 8.25 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,611 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 100,905
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 52,024
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yers
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? N/a**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Dennis G. Koch
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.