

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	85	Skilled (SNF)	85	31,025	1
2		Skilled Pediatric (SNF/PED)			2
3	118	Intermediate (ICF)	118	43,070	3
4		Intermediate/DD			4
5	28	Sheltered Care (SC)	28	10,220	5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	873	1,034	6,747	8,654	8
9	SNF/PED					9
10	ICF	20,592	31,865		52,457	10
11	ICF/DD					11
12	SC	2,585	2,344		4,929	12
13	DD 16 OR LESS					13
14	TOTALS	24,050	35,243	6,747	66,040	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.33%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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, Assisted Living Center days 7,043

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 35 and days of care provided 5,690

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: 9/30/18 Fiscal Year: 9/30/18

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	1,121,446	77,551	26,763	1,225,760		1,225,760		1,225,760		1
2	Food Purchase		952,013		952,013		952,013	(94,625)	857,388		2
3	Housekeeping	415,849	63,229		479,078		479,078	(2,500)	476,578		3
4	Laundry	160,894	17,884	(2,800)	175,978		175,978		175,978		4
5	Heat and Other Utilities			396,721	396,721		396,721		396,721		5
6	Maintenance	327,387	82,372	312,469	722,228		722,228		722,228		6
7	Other (specify):*										7
8	TOTAL General Services	2,025,576	1,193,049	733,153	3,951,778		3,951,778	(97,125)	3,854,653		8
	B. Health Care and Programs										
9	Medical Director			1,600	1,600		1,600		1,600		9
10	Nursing and Medical Records	5,884,927	353,911	25,906	6,264,744		6,264,744		6,264,744		10
10a	Therapy	90,926	4,003	535,675	630,604		630,604		630,604		10a
11	Activities	240,034	18,284	13,241	271,559		271,559		271,559		11
12	Social Services	197,502	(881)	712	197,333		197,333		197,333		12
13	CNA Training					11,212	11,212		11,212		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,413,389	375,317	577,134	7,365,840	11,212	7,377,052		7,377,052		16
	C. General Administration										
17	Administrative	241,394		20,051	261,445		261,445		261,445		17
18	Directors Fees										18
19	Professional Services			121,161	121,161		121,161		121,161		19
20	Dues, Fees, Subscriptions & Promotions			56,676	56,676		56,676	(4,762)	51,914		20
21	Clerical & General Office Expenses	626,648	67,881	355,229	1,049,758		1,049,758	(255,086)	794,672		21
22	Employee Benefits & Payroll Taxes			2,899,938	2,899,938	(11,212)	2,888,726	(12,855)	2,875,871		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,845	8,845		8,845	(1,389)	7,456		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			177,898	177,898		177,898		177,898		26
27	Other (specify):*										27
28	TOTAL General Administration	868,042	67,881	3,639,798	4,575,721	(11,212)	4,564,509	(274,092)	4,290,417		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,307,007	1,636,247	4,950,085	15,893,339		15,893,339	(371,217)	15,522,122		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.

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			1,172,531	1,172,531		1,172,531	(5,480)	1,167,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			176,440	176,440		176,440		176,440			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,348,971	1,348,971		1,348,971	(5,480)	1,343,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			297,721	297,721		297,721		297,721			39
40	Barber and Beauty Shops	72,693	4,678		77,371		77,371		77,371			40
41	Coffee and Gift Shops	22,880	39,264		62,144		62,144		62,144			41
42	Provider Participation Fee			450,279	450,279		450,279		450,279			42
43	Other (specify):*	260,946		992,502	1,253,448		1,253,448	(1,253,448)				43
44	TOTAL Special Cost Centers	356,519	43,942	1,740,502	2,140,963		2,140,963	(1,253,448)	887,515			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,663,526	1,680,189	8,039,558	19,383,273		19,383,273	(1,630,145)	17,753,128			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	
	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	(84,051)	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	(1,375)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(10,574)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,110)	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				24
25	Fund Raising, Advertising and Promotional	(2,295)	20		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	(1,529,740)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,630,145)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,630,145)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/1/17

Ending: 9/30/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISCELLANEOUS INCOME	\$ (12,250)	21	1
2	MANAGEMENT FEE INCOME	(200,000)	21	2
3	GUEST ROOM INCOME	(3,364)	30	3
4	SMOKING/PET CLEANING FEE	(2,500)	3	4
5	PUBLIC RELATIONS-SALARY	(42,836)	21	5
6	PUBLIC RELATIONS-EMP BENEFIT ALLOC	(12,855)	22	6
7	LOBBYING EXPENSE	(2,214)	20	7
8	DUES: CHAMBER OF COMMERCE	(253)	20	8
9	ENDOWMENT EXPENSES	(73,208)	43	9
10	REAL ESTATE TAXES	(51,000)	43	10
11	FOUNDATION EXPENSES	(25,858)	43	11
12	RESIDENT CABLE	(34,869)	43	12
13	COTTAGE EXPENSES	(775,959)	43	13
14	ASSISTED LIVING SALARIES	(179,099)	43	14
15	ASSISTED LIVING DEPRECIATON	(111,345)	43	15
16	SEMINARS-DEV DIRECTOR	(1,389)	24	16
17	DEPR - CIP	(741)	30	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	(1,529,740)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(94,625)	0	0	0	0	0	0	0	0	0	0	(94,625)	2
3	Housekeeping	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(97,125)	0	(97,125)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,762)	0	0	0	0	0	0	0	0	0	0	(4,762)	20
21	Clerical & General Office Expenses	(255,086)	0	0	0	0	0	0	0	0	0	0	(255,086)	21
22	Employee Benefits & Payroll Taxes	(12,855)	0	0	0	0	0	0	0	0	0	0	(12,855)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,389)	0	0	0	0	0	0	0	0	0	0	(1,389)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(274,092)	0	(274,092)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(371,217)	0	(371,217)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/17 Ending: 9/30/18

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(5,480)	0	0	0	0	0	0	0	0	0	0	(5,480) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(5,480)	0	(5,480) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(1,253,448)	0	0	0	0	0	0	0	0	0	0	(1,253,448) 43
44	TOTAL Special Cost Centers	(1,253,448)	0	(1,253,448) 44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,630,145)	0	(1,630,145) 45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	N/A	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.

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V	N/A						17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Gary Blickhan	BOD						1
2	Andrew Cashman	BOD						2
3	Chris Daniels	BOD						3
4	Laura Ehrhart	BOD	N/A	N/A	N/A	N/A	N/A	4
5	Jerry Jackson	BOD						5
6	Paul Kemner	BOD						6
7	Rob Overholser	BOD						7
8	Alok Patel	BOD						8
9	Randy Riley	BOD						9
10	Larry Shepherd	BOD						10
11	Jeff Spear	BOD						11
12	Steve Wavering	BOD						12
13								13
14								14
15	Auxillary Representatives							15
16								16
17								17
18	Uncle Sam Representatives							18
19	Richard Bowman	BOD						19
20								20
21	Robert Young	BOD						21
22								22
23	Illinois Conference UCC Representatives							23
24	Sharon Higgins	BOD						24
25	Mike Oberdahlhoff	BOD						25
26								26
27								27
28	Michael Duffy, Administrator	BOD						28
29	Stephanie Erwin, Associate Administrator	BOD						29
30								30

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	N/A											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 Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

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	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

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	Name of Lender	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	SERIES 2013C BONDS		X	MORTGAGE	\$44,540.00	7/11/13	\$ 7,960,000	\$ 5,121,792	8/1/33	3.0500	\$ 164,032	1						
2				AMORT OF LOAN COST				(48,314)			12,408	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$44,540.00		\$ 7,960,000	\$ 5,073,478			\$ 176,440	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 7,960,000	\$ 5,073,478			\$ 176,440	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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 2017 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 2018 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:	2013	<u>N/A</u>	8
	2014		9
	2015		10
	2016		11
	2017		12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

CONTACT PERSON REGARDING THIS REPORT _____

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 2017 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 2017.

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

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

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 2015 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 2015.

	(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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,970 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

C. Does the Operating Entity? [X] (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? [X] (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 180 Units for 199,478 square feet

Assisted Living Facilities with 26 beds for 15,900 square feet Resident Days 7043

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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:

A. Land.

Table with 6 columns: Line Item, Use, Square Feet, Year Acquired, Cost, and another column. Rows include Facility (1,219,680 sq ft, 1956-2010, \$114,502), Facility (330,147), and TOTALS (1,219,680, \$444,649).

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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				1962	\$ 683,823	\$	40	\$	\$	\$ 683,823	4
5				1973	1,683,761		40			1,683,761	5
6				1984	1,953,541	48,839	40	48,839		1,689,004	6
7				2010	1,695,151	73,166	Various	73,166		615,816	7
8											8
		Improvement Type**									
9		Building Service Equipment		1983	10,058		20			10,058	9
10		Land Improvements		1984	37,294		15			37,294	10
11		Building Service Equipment		1984	299,341		Various			299,341	11
12		Building Improvements		1985	250,935	6,273	40	6,273		208,696	12
13		Building Service Equipment		1985	23,430		Various			23,430	13
14		Building Improvements		1986	119,616	2,990	40	2,990		96,687	14
15		Building Service Equipment		1986	137,391		Various			137,391	15
16		Building Service Equipment		1987	10,451		20			10,451	16
17		Building Service Equipment - Disposal 2017		1988			15				17
18		Building Improvements		1989	130,612	4,354	30	4,354		130,610	18
19		Building Improvements State Audit Adjustments 10881+30372		1991	511,992	18,441	30	17,066	(1,375)	466,419	19
20		Building Services Equipment		1991	22,309		Various			22,309	20
21		Kitchen/Dining Room		1993	310,412	7,760	40	7,760		196,593	21
22		Building Services Equipment		1993	5,941	218	25	218		5,941	22
23		Parking Lot		1994	87,827		15			87,827	23
24		Sidewalk		1994	7,875		15			7,875	24
25		Dining Room		1994	6,305		Various			6,305	25
26		Building Services Equipment		1994	61,368		Various			61,368	26
27		Building Services Equipment		1995	12,183		15			12,183	27
28		Gutters		1996	10,817		20			10,817	28
29		Roof		1996	9,016		20			9,016	29
30		Roof - Anna Brown Wing		1996	70,800		20			70,800	30
31		Building Services Equipment		1996	38,438		various			38,438	31
32											32
33		Sprinkling System		1997	3,354		10			3,354	33
34		Tamper Detectors - Dispose of in 2016		1997							34
35		Sprinkler System		1997	102,875		20			102,875	35
36		Roof- Kitchen/Dining		1998	40,400	1,036	39	1,036		21,486	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Elevator Doors - Dietary</u>	1998	\$ 1,095	\$	10	\$	\$	\$ 1,095	37
38	<u>Remodeling -Anna Brow Wing Walls, Ceiling, Floors,Lights</u>	1999	199,131	4,978	39	4,978		95,624	38
39	<u>Remodeling -Anna Brow Wing - Fire Damper</u>	1999	21,915	538	39	538		10,691	39
40	<u>Chapel Roof</u>	1999	21,515	548	39	548		10,615	40
41	<u>Fire Damper Alarm - Dispose of 2016</u>	1999							41
42	<u>Eber Parking Lot Lights</u>	1999	5,495		15			5,495	42
43	<u>Stainless Steel D/W Exhaust</u>	1999	1,659		10			1,659	43
44	<u>Wiring Chapel Roof</u>	1999	332		10			332	44
45	<u>Code Alert System - Disposal 2017</u>	1999			5				45
46	<u>Elevator Upgrade A/B East</u>	1999	22,556		10			22,556	46
47	<u>Elevator Upgrade - Special Care</u>	1999	5,970		10			5,970	47
48	<u>Fire Protection A/B</u>	1999	4,500		10			4,500	48
49	<u>Condensor Unit - Disposal 2017</u>	1999			15				49
50	<u>Fire Protection Pool Area</u>	1999	776		10			776	50
51	<u>Damper Duct Work - Disposal 2017</u>	1999			15				51
52	<u>Chapel Remodeling - Unity & Pews</u>	2000	14,760	369	39	369		6,657	52
53	<u>Kitchen Remodeling - Sidewalls</u>	2000	3,485		15			3,485	53
54	<u>Kitchen Remodeling - Galvanized Wall Divider</u>	2000	2,601		15			2,601	54
55	<u>East Nursing Remodeling - Walls, Ceilings, Floors</u>	2000	26,757	669	39	669		12,236	55
56	<u>Eber Wing Smoke Damper Dispose of 2016</u>	2000							56
57	<u>HVAC Rehab Eber Wing - Dispose of in 2016</u>	2000							57
58	<u>3 Ton Rooftop Unit A/C West Dining - Disposal 2017</u>	2000			15				58
59	<u>Elevator Up Grade East Wing</u>	2000	12,776		15			12,776	59
60	<u>Entrance Code Lock Special Care</u>	2000							60
61	<u>Life Safety Code Sprinkler Drains</u>	2000	7,000		15			7,000	61
62	<u>Land Improvement New Sidewalk</u>	2000	1,200	60	20	60		1,050	62
63	<u>Renovation of East Nursing Wing</u>	2001	369,213	9,230	39	9,230		158,838	63
64	<u>Painting Kitchen Dispose of in 2016</u>	2001							64
65	<u>Kitchen Electrical Work</u>	2000	611		15			611	65
66	<u>HVAC Rehab Eber Wing - Dispose of in 2016</u>	2000			15				66
67	<u>Sprinklers</u>	2000	4,151		15			4,151	67
68	<u>Wet Chemical Fire Suppressor Work</u>	2000	3,695		15			3,695	68
69	<u>Electrical Work</u>	2001	1,609		15			1,609	69
70	TOTAL (lines 4 thru 69)		\$ 9,070,118	\$ 179,469		\$ 178,094	\$ (1,375)	\$ 7,123,990	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,070,118	\$ 179,469		\$ 178,094	\$ (1,375)	\$ 7,123,990	1
2	Smoke/ Fire Damper East, South and Eber - Dispose in 2016	2001			15				2
3	3D Detectors in Elevators	2001	4,916		10			4,916	3
4	Compensators	2001	2,724		10			2,724	4
5	33 Lever Passage Locks	2002	2,904		10			2,904	5
6	Exit Lights and Hold Opens	2002	966		10			966	6
7	16 Lever Passage Locks	2002	1,408		10			1,408	7
8	Water Piping	2001	4,600	115	39	115		1,941	8
9	Buffet in Dining Area	2003	2,977	64	15	64		2,977	9
10	Door - code alert and keypad	2003	2,489		10			2,489	10
11	Fire Collars	2003	3,619		10			3,619	11
12	Main Breaker	2003	3,291	202	15	202		3,291	12
13	Elevator Master Door Operator	2003	4,278		10			4,278	13
14	Annunciators	2004	51,494		10			51,494	14
15	Sewer Lines	2003	5,801	387	15	387		5,769	15
16	Smoke Damper - Eber	2003	698	47	15	47		691	16
17	Beauty Shop Wiring	2003	2,272	151	15	151		2,234	17
18	Dietary Doors	2004	3,801	253	15	253		3,716	18
19	Roof	2004	4,028	269	15	269		3,895	19
20	Remote Annunciator Dispose of 2016	2004							20
21	Cooler Expansion	2004	6,120	408	15	408		5,848	21
22	Parking Lot	2004	6,800	453	15	453		6,459	22
23	Ambulance Garage Doors	2004	1,070		10			1,070	23
24	Kitchen Remodel	2004	6,425		10			6,425	24
25	Plumbing wok in Eber/South	2004	5,147	343	15	343		4,746	25
26	Water Softener System	2004	15,642		10			15,642	26
27	Kitchen Electrical Work	2004	247	12	20	12		172	27
28	Kitchen Remodel	2004	1,248	62	20	62		868	28
29	Sprinkler System	2004	980	49	20	49		678	29
30	Sprinkler System	2005	2,373	119	20	119		1,622	30
31	Perry Suite Renovations	2005	2,470	165	15	165		2,237	31
32	Water Heater	2006	723		10			723	32
33	Telephone System	2006	50,625	3,375	15	3,375		42,468	33
34	TOTAL (lines 1 thru 33)		\$ 9,272,254	\$ 185,943		\$ 184,568	\$ (1,375)	\$ 7,312,260	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,272,254	\$ 185,943		\$ 184,568	\$ (1,375)	\$ 7,312,260	1
2	Sprinkler System Pipes	2006	1,645	88	various	88		1,645	2
3	Overhead Door	2005	1,400		10			1,400	3
4	Concrete Work	2005	9,936	662	15	662		8,500	4
5	Fire Walls	2006	14,948	747	20	747		9,217	5
6	Fire Alarm System	2006	23,500	1,567	15	1,567		19,845	6
7	Life Safety Code Renovations	2006	1,905		10			1,905	7
8	Renovations to Building Front Entrance	2006	38,611	1,931	20	1,931		23,811	8
9	Telephone System Wiring	2006	35,781		10			35,781	9
10	Pool Area Renovations	2006	98,370	4,919	20	4,919		61,072	10
11	Concrete Work	2006	3,850	257	15	257		3,188	11
12	Lighting in the Hallway	2006	7,872	394	20	394		4,822	12
13	Laundry Renovations- Air System	2006	9,841	492	20	492		6,028	13
14	Smoke/Fire Dampers Special Care Area	2006	14,683	734	20	734		8,993	14
15	Eber Elevator Remodel	2006	12,769	851	15	851		10,143	15
16	Sprinkler System Heads	2006	20,456	1,364	15	1,364		16,024	16
17	South Wing Fiber Server	2007	2,526	168	15	168		1,978	17
18	Smoke/Fire Detectors	2007	10,431		10			10,431	18
19	Repairs to Boiler Motor	2007	954		10			953	19
20	Smoke/Fire Dampers	2007	1,125		10			1,125	20
21	CO Detectors	2007	1,483	25	10	25		1,410	21
22	Call Lights - Dining Hall	2007	823	6	10	6		759	22
23	Hot Water Tank	2007	2,588	43	10	43		2,458	23
24	Repairs to Hot Water Shower Area	2007	1,113		10			1,113	24
25	Compressor - Walk in	2007	2,922		10			2,921	25
26	Repairs to Wiring in Chapel Area	2007	14,516	968	15	968		10,645	26
27	HVAC Controllers	2007	11,952	797	15	797		8,765	27
28	Physical Therapy Ductwork Repairs	2006	2,254	150	15	150		1,790	28
29	Alarm Stations Repairs	2006	27,685	1,846	15	1,846		21,687	29
30	Dining Hall Electric	2007	890	59	15	59		696	30
31	Chapel Roof Repair	2007	3,528	235	15	235		2,763	31
32	Dining Hall Paint	2007	7,401		10			7,401	32
33	Dinning Hall Roof Repairs	2007	573	38	15	38		439	33
34	TOTAL (lines 1 thru 33)		\$ 9,660,585	\$ 204,284		\$ 202,909	\$ (1,375)	\$ 7,601,968	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,660,585	\$ 204,284		\$ 202,909	\$ (1,375)	\$ 7,601,968	1
2	Storm Sewer Line	2007	3,459	231	15	231		2,615	2
3	Dietary Doors	2007	1,485		10			1,485	3
4	Alarm System at Stations	2007	4,450	74	10	74		4,450	4
5	Roof South Eber Diposal 2017	2007	9,587	639	15	639		6,924	5
6	Fiber Project Improvements	2008	10,646	710	15	710		7,453	6
7	Door Closers	2008	10,180	1,018	10	1,018		10,180	7
8	Elevator Renovation	2008	122,827	8,188	15	8,188		84,613	8
9	Wanderer Alert System	2008	1,968	99	10	99		1,968	9
10	CO System Detectors	2008	1,395	81	10	81		1,395	10
11	Improvements Fire Protection	2009	35,300	2,353	15	2,353		22,748	11
12	New Doors Alarm	2008	8,704	435	20	435		4,243	12
13	Improvements to Elevator	2008	27,518	1,835	15	1,835		18,194	13
14	Improvement to Alarms	2009	14,985	749	20	749		7,180	14
15	Eber Water Project	2009	3,795	190	20	190		1,803	15
16	Improvements Fire Protection	2009	1,640	82	20	82		745	16
17	Hot Water Heater	2009	5,577	558	10	558		5,299	17
18	Improvements to Heater in Pool	2009	14,325	1,433	10	1,433		13,490	18
19	Run Fiber - Anna Brown to switch in Maint. For Phone Sys.	2009	1,040		5			1,040	19
20	IDCS 500 Release - Wiring & Cabinet for Phone System	2009	7,099		5			7,099	20
21	Addition to Walking Freezer	2009	88,733	5,916	20	5,916		49,790	21
22	Roof Repair to the East Circle and Chapel	2009	61,810	3,091	20	3,091		27,300	22
23	East Circle Laundry- Labor, Plumbing Materials,	2009	11,420	571	20	571		4,996	23
24	Install Upgrade to Code Alert System - Wiring and Labor	2009	85,645	8,564	10	8,564		72,083	24
25	Wiring for the Facility Phone System	2010	10,951	1,095	10	1,095		9,125	25
26	Replace the Transfer Switch - Wiring and Labor	2009	12,414	621	20	621		5,122	26
27	Install Water Value in Meter Pit/ Fire Hydrant	2009	13,300	1,330	10	1,330		11,675	27
28	Concrete Work for Ambulance Garage,Sidewalks, & Drives	2010	24,818	1,241	20	1,241		10,548	28
29	Alzheimer's Unit -Landscaping	2010	51,508	3,434	15	3,434		28,902	29
30	Alzheimer's Unit -Parking Lot	2010	154,072	10,271	15	10,271		86,451	30
31	New Alzheimer Building	2010	4,789,401	119,735	40	119,735		1,007,770	31
32	New Alzheimer Building -Unit Mechanical	2010	838,272	41,914	20	41,914		352,774	32
33	New Alzheimer Building -Unit Roofing	2010	223,472	8,939	25	8,939		75,236	33
34	TOTAL (lines 1 thru 33)		\$ 16,312,381	\$ 429,681		\$ 428,306	\$ (1,375)	\$ 9,546,664	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,312,381	\$ 429,681		\$ 428,306	\$ (1,375)	\$ 9,546,664	1
2	New Alzheimer -Mega Plant	2010	1,405,351	46,845	30	46,845		394,279	2
3	New Alzheimer -Unit Generator	2010	383,839	19,192	20	19,192		161,532	3
4	New Alzheimer - Unit Elevator	2010	117,455	7,830	15	7,830		65,905	4
5	New Alzheimer -Counter Tops and Cabinets	2010	354,518	17,726	20	17,726		149,193	5
6	New Alzheimer -Floor Coverings & Carpet	2010	209,459	13,964	15	13,964		117,530	6
7	Office Building	2010	167,615	4,190	40	4,190		34,570	7
8	Handicapped Doors for South Hall	2010	5,872	294	20	294		2,423	8
9	Air Curtain -Dietary	2010	1,455	146	10	146		1,189	9
10	Code Alert -Eber South	2010	105,708	10,571	10	10,571		85,448	10
11	Patios & sidewalk -Foose	2010	11,290	565	20	565		4,517	11
12	Windows-Dinning Room	2010	2,672	134	20	134		1,058	12
13	Elevator Kitchen - Door Operator	2010	3,335	334	10	334		2,669	13
14	Installing Ballast (Dimming)	2010	4,350	435	10	435		3,444	14
15	Transfer Switch - Eber	2010	8,600	860	10	860		6,808	15
16	Sprinkler Heads - West Nursing	2010	2,688	269	10	269		2,084	16
17	Code Alert - Eber/ South	2011	10,751	1,075	10	1,075		7,705	17
18	Plumbing Rehab. East Circle	2011	33,362	3,336	10	3,336		25,021	18
19	Walk-in-Freezer	2011	3,245	325	10	325		2,408	19
20	Foose & AB Unit Room Controllers	2011	75,000	3,750	20	3,750		26,250	20
21	Wash Station for the eye	2011	18,800	1,880	10	1,880		13,630	21
22	Land Improvement New Bldg-Crubs, Sidewalks, Sewers etc	2011	392,571	26,171	15	26,171		183,199	22
23	Renovations to Special Care Unit	2012	1,152,325	28,808	40	28,808		175,249	23
24	Special Care Mechanical	2012	609,108	30,455	20	30,455		185,270	24
25	Administration Office and AL	2011	1,673,695	41,842	40	41,842		292,896	25
26	Roof for Administration Bldg & AL	2011	50,491	1,262	40	1,262		8,835	26
27	Mechanical for Administration and AL	2011	383,112	19,156	20	19,156		134,090	27
28	New Roof Ambulance Bay	2012	54,200	2,710	20	2,710		16,486	28
29	New Roof West Nursing	2011	52,290	2,615	20	2,615		17,867	29
30	Electrical Work Remodel for signs & wiring for Medicare unit	2012	13,070	523	25	523		3,268	30
31	Doors- Remodel electric doors closers in nursing facility	2012	10,437	417	25	417		2,504	31
32	Controls for Individual Rooms	2012	62,000	6,200	10	6,200		41,850	32
33	Dry Pipe System Remodeling	2011	12,582	1,258	10	1,258		8,493	33
34	TOTAL (lines 1 thru 33)		\$ 23,703,627	\$ 724,819		\$ 723,444	\$ (1,375)	\$ 11,724,334	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 23,703,627	\$ 724,819		\$ 723,444	\$ (1,375)	\$ 11,724,334	1
2	Addressable Pull Stations	2012	2,366	237	10	237		1,598	2
3	Laundry Control System	2011	2,890	289	10	289		1,951	3
4	Water Heater Barber Shop	2011	8,971	897	10	897		6,130	4
5	Data Connections Administration Building	2011	5,262	526	10	526		3,639	5
6	Water Heater Dietary Department	2011	9,510	951	10	951		6,657	6
7	Floor coverings Special Care Unit	2011	123,277	12,328	10	12,328		74,994	7
8	Floor coverings Administration	2011	55,207	5,521	10	5,521		38,646	8
9	HVAC Roof Unit	2011	7,845	785	10	785		5,100	9
10	Flooring Ann Brown	2011	10,249	1,025	10	1,025		7,089	10
11	Chapel Renovations - Phase III	2013	135,247	5,410	25	5,410		29,304	11
12	Rounda Renovation Phase III	2013	19,306	772	25	772		4,182	12
13	Can Lights - Medicare Unit	2012	2,750	110	25	110		660	13
14	Exit Lighting Panel- Medicare Unit	2012	2,779	111	25	111		667	14
15	Painting - Ecircle Eber South Ct	2013	35,753	1,430	25	1,430		7,746	15
16	Neighborhoods - Phase III	2013	691,456	27,658	25	27,658		149,815	16
17	Sunnydale Transition	2013	2,895	72	40	72		403	17
18	Convert Foose Singles	2013	9,698	485	20	485		2,546	18
19	Eastbrook Lane	2013	13,087	654	20	654		3,435	19
20	Sunny Dale Tile Project	2013	16,955	848	20	848		4,239	20
21	Courtyard Railing	2012	4,292	172	25	172		1,002	21
22	Fire Alarm - Social Room	2012	3,237	129	25	129		765	22
23	Paging System - Nursing	2013	10,826	722	15	722		4,151	23
24	Code Alert - E Circle, Social Room	2013	2,792	186	15	186		1,024	24
25	Voice, Dara, Video - Nursing	2013	11,551	770	15	770		4,235	25
26	Bradley HL80 Mixing Valves	2013	5,376	358	15	358		2,030	26
27	Power Assis Dooes - Medicare	2013	5,000	333	15	333		1,833	27
28	SS Sink & Eyewash - Special Care	2013	2,943	196	15	196		1,079	28
29	Flooring Covering -Phase III	2013	122,252	8,150	15	8,150		44,146	29
30	Window Treatment - Phase III	2013	6,416	428	15	428		2,317	30
31	Code Alert - E Circle, Social Room	2013	1,536	154	10	154		820	31
32	Eber Roof Unit	2013	8,244	824	10	824		4,327	32
33	Rheem Hot Water Tank - Dietary	2013	3,754	375	10	375		1,970	33
34	TOTAL (lines 1 thru 33)		\$ 25,047,348	\$ 797,725		\$ 796,350	\$ (1,375)	\$ 12,142,834	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 25,047,348	\$ 797,725		\$ 796,350	\$ (1,375)	\$ 12,142,834	1
2	E Circle Water & Sewer Lines	2013	1,473	147	10	147		748	2
3	RTU - Social Services	2013	5,570	557	10	557		2,831	3
4	Water Heater AO Smith - Dietary & Laundry Area)	2014	11,452	1,145	10	1,145		5,248	4
5	Installation and equipment for Wander Management System	2014	14,800	1,480	10	1,480		6,783	5
6	Eber/Southnurseing wings HVAC Replacement	2014	58,997	3,933	15	3,933		15,732	6
7	Condenser Unit for Laundry Area	2014	1,850	185	10	185		802	7
8	Nursing Area Compressor Unit	2014	8,497	850	10	850		3,470	8
9	Dietary Area Sprinkler System Upgrade	2014	1,895	190	10	190		775	9
10	Sunny Dale - Install Wallcovering and Painting	2013	20,595	1,030	20	1,030		5,063	10
11	Sunny Dale Painting the Exterior and West Kitchen Vestibule	2013	5,856	293	20	293		1,416	11
12	Sunny Dale Projest Counter Tops, Cabinet Cover and Cabinets	2014	11,472	574	20	574		2,678	12
13	Sunny Dale Improvements - Install Handrails	2014	5,200	260	20	260		1,213	13
14	Nursing Station Improv. Wallcovering and Painting	2014	18,850	943	20	943		4,164	14
15	Eber & South - Room Refurbishing Wallcovering/Painting	2014	29,920	1,496	20	1,496		6,483	15
16	Eber & South - Room Refurbishing Wallcovering/Painting	2014	11,968	598	20	598		2,493	16
17	Eber & South - Room Refurbishing Wallcovering/Painting	2014	5,984	299	20	299		1,196	17
18	New Sewer Line installed in the Dietary Labor/Materials	2013	4,677	234	20	234		1,111	18
19	East Circle Light Fixtures Wiring and Installation	2014	2,855	143	20	143		619	19
20	Accounting firm reclassification items 9/30/2013								20
21	Floor Tile in Kitchen	1999	2,455		10			2,455	21
22	Ductwork 213OH	2004	1,760		10			1,760	22
23	Flooring - Beauty Shop	2003	2,512		10			2,512	23
24	Junction Box Linal	2004	10,383		10			10,383	24
25	Carpet - Perry Suite	2005	1,916		10			1,916	25
26	Flooring - Medical Records	2005	1,337		10			1,337	26
27	Carpet - Exercise Room	2006	890		10			890	27
28	Base Cabinets - Dietary	2006	1,117		10			1,117	28
29	ABS Single Basin Sink - East Nursing	2007	1,141	9	10	9		1,054	29
30	Flooring - Rooms	2010	4,563	456	10	456		3,878	30
31	Dinning Floor - Eber * South Court	2010	14,397	1,440	10	1,440		12,118	31
32	Dinning Floor - Sunny Dale	2010	3,638	364	10	364		3,062	32
33	Floor - East Laundry	2010	1,003	100	10	100		844	33
34	TOTAL (lines 1 thru 33)		\$ 25,316,371	\$ 814,451		\$ 813,076	\$ (1,375)	\$ 12,248,985	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 25,316,371	\$ 814,451		\$ 813,076	\$ (1,375)	\$ 12,248,985	1
2	Dinning Floor - Main Dinning	2010	9,586	959	10	959		8,069	2
3	Eber Gardens Carpet	2011	27,615	2,762	10	2,762		19,332	3
4	Carpeting	2011	3,436	344	10	344		2,635	4
5	Floor Covering Room 451	2012	1,794	179	10	179		1,075	5
6	21 Showers Doors Anna Brown Section	2012	3,826	383	10	383		2,392	6
7	Floor Covering Room 447	2012	2,563	256	10	256		1,708	7
8	Floor Covering Room 126./132	2011	787	79	10	79		538	8
9	Eber & South	2015	95,744	4,787	20	4,787		16,356	9
10	Anna Brown - Roof	2015	50,480	2,524	20	2,524		8,413	10
11	Door Project - Automatic	2015	38,598	1,930	20	1,930		6,755	11
12	Door Alarm Fire Foose Section	2015	1,253	125	10	125		459	12
13	2 Jeld-Wen Casement Windows	2015	2,271	227	10	227		776	13
14	New Doors East Circle	2015	4,795	480	10	480		1,519	14
15	Eber and South Halls Lighting	2015	19,845	992	20	992		3,059	15
16	New Doors Chapel	2015	2,811	281	10	281		843	16
17	New Doors - Kitchen/Dinning	2015	2,721	272	10	272		816	17
18	Additional Recepticals Kitchen	2015	7,876	394	20	394		1,182	18
19	Cooling Tower Refurbish	2014	2,983	149	20	149		584	19
20	Hot Water Storage Tank - Dietary	2014	2,933	293	10	293		1,123	20
21	Fusible Links in Dampers	2014	8,800	587	15	587		2,201	21
22	Rebuild Mixing Valves	2015	2,167	217	10	217		813	22
23	Replace Inverter	2015	4,445	445	10	445		1,631	23
24	Anna Brown HVAC Upgrade	2015	5,692	569	10	569		2,087	24
25	Steel Pipe Epsilon Plant	2015	1,950	195	10	195		715	25
26	Wiring / Sprinkler Correction Plan	2015	17,979	1,798	10	1,798		6,143	26
27	Landscaping - Eber/South	2015	11,577	772	15	772		2,123	27
28	Parking Lot Jercho Road	2015	244,373	16,292	15	16,292		36,657	28
29	Room 601 - Painting and Refurbishing	2015	5,984	299	20	299		897	29
30	East Circle/ Chaple - wiring of receptacles to generator	2015	5,602	280	20	280		817	30
31	Eber Parking Lot Drain - Concrete work	2015	2,000	133	15	133		388	31
32	Rooms 516,517,521 Painting and Refurbishing	2015	17,952	898	20	898		2,619	32
33	Room 514 - Painting and Refurbishing	2015	5,984	299	20	299		822	33
34	TOTAL (lines 1 thru 33)		\$ 25,932,793	\$ 854,651		\$ 853,276	\$ (1,375)	\$ 12,384,532	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:

10/1/17

Ending:

9/30/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 25,932,793	\$ 854,651		\$ 853,276	\$ (1,375)	\$ 12,384,532	1
2	Room 515 - Painting and Refurbishing	2016	5,984	299	20	299		822	2
3	Room 609 - Painting and Refurbishing	2016	5,984	299	20	299		797	3
4	Room 501 - Painting and Refurbishing	2016	5,984	299	20	299		773	4
5	Staff Restroom - Eber South Patch and replace sinks	2015	2,268	227	10	227		643	5
6	HVAC Eber South	2016	927,249	46,362	20	46,362		96,588	6
7	Emergency Power Project	2015	195,687	9,784	20	9,784		26,906	7
8	Call Light System	2015	7,631	763	10	763		2,162	8
9	Emergency Call System Anna Brown	2016	50,856	5,086	10	5,086		13,139	9
10	Gas Line - Eber South	2016	15,000	750	20	750		1,875	10
11	Commercial Water Heater	2016	9,831	983	10	983		2,130	11
12	IDPH Code Electric Upgrades	2017	23,535	1,177	20	1,177		1,863	12
13	Pool Roof	2017	24,200	2,420	10	2,420		3,832	13
14	Eber Roof	2017	112,800	11,280	10	11,280		15,040	14
15	Dining Room Remodel-removal/rebuild wall & windows	2017	63,235	4,216	15	4,216		5,270	15
16	Refurb.Southern Court Rms-paint, trim/molding, redo ceilings	2017	35,904	2,394	15	2,394		2,992	16
17	Foose Center Wall Protection/Nurse Sun	2017	13,997	2,799	5	2,799		4,899	17
18	Water Heater-Maint Dept	2017	4,934	493	10	493		657	18
19	Breakroom HVAC	2017	8,421	842	10	842		982	19
20	Call Light System	2017	14,572	1,457	10	1,457		2,186	20
21	Replace Chiller & Pump	2017	100,488	6,699	15	6,699		10,920	21
22	HVAC-Eber/South, Anna Brown & Compressor	2017	50,569	5,057	10	5,057		7,436	22
23	Electric Water Heaters & Expansion Tank	2017	28,428	2,843	10	2,843		2,843	23
24	Employee Lounge-painting,drywalling	2017	7,212	1,442	5	1,442		1,442	24
25	Electric for Water Heaters	2017	4,475	447	10	447		447	25
26	Anna Brown 425 - replaced BX Box Heating & Air	2017	4,885	271	15	271		271	26
27	Mixing valve & Circulation Pump-Anna Brown East & McReynol	2017	3,927	295	10	295		295	27
28	Eber & South Shower Rooms-removal/rebuild wall, tile floor, plun	2018	186,812	9,630	15	9,630		9,630	28
29	Eber 523 & 526 -updates-lighting, wall repair, railings,bathroom u	2018	11,968	1,795	5	1,795		1,795	29
30	Employee Lounge-cabinets/countertops, sink, plumbing	2018	4,065	170	15	170		170	30
31	Dietary Doors replacement	2018	9,122	456	15	456		456	31
32	See Attachment PG 12J		131,788	4,999		4,999		4,999	32
33	Guest Room Income Offset					(3,364)	(3,364)		33
34	TOTAL (lines 1 thru 33)		\$ 28,004,604	\$ 980,685		\$ 975,946	\$ (4,739)	\$ 12,608,792	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 2,040,062	\$ 146,710	\$ 146,710	\$	3-20 yrs	\$ 989,686	71
72	Current Year Purchases	79,320	4,114	4,114		5-20 yrs	4,114	72
73	Fully Depreciated Assets	971,025				3-20 yrs	971,025	73
74								74
75	TOTALS	\$ 3,090,407	\$ 150,824	\$ 150,824	\$		\$ 1,964,825	75

D. Vehicle Costs. (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	Facility	Ford Starcraft Bus 2015 (2)	2015	\$ 128,098	\$ 12,810	\$ 12,810	\$	10 yrs.	\$ 43,767	76
77	Facility	Dodge Grand Carvan 2014	2015	39,255	7,851	7,851		5 yrs.	27,479	77
78	Maintenance	Ford E-150 2008	2015	11,056	2,211	2,211		5 yrs.	8,845	78
79	See Attach Sch 13A	Various	Various	283,173	17,409	17,409		5-10 yrs	161,442	79
80	TOTALS			\$ 461,582	\$ 40,281	\$ 40,281	\$		\$ 241,533	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)	\$ 32,001,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,171,790	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,167,051	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,739)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,815,150	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		\$	\$	\$	86
87	Cottage Land				87
88	Cottage Fixed Assets				88
89	Rental Property				89
90	Assisted Living				90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architect Work	\$ 16,670	92
93			93
94			94
95		\$ 16,670	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.

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/1/17

Ending: 9/30/18

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								5
6								6
7	TOTAL				\$			7

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ _____ Description: _____

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 7,521	\$	\$ 7,521
2	Books and Supplies		2,788		2,788
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		903		903
9	TOTALS	\$	\$ 11,212	\$	\$ 11,212
10	SUM OF line 9, col. 1 and 2 (e)	\$	11,212		

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	8
2. From other facilities (f)	1
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10a C. 3	hrs	\$	4,244	\$ 156,587	\$	4,244	\$ 156,587	1
2	Licensed Speech and Language Development Therapist	L. 10a C. 3	hrs		336	17,983		336	17,983	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C. 3	hrs		8,004	361,105	4,003	8,004	365,108	4
5	Physician Care		visits							5
6	Dental Care	L.10aC2,3	visits			2,400	554		2,954	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C 3	# of prescripts				262,544		262,544	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab & X-ray</u>	L. 39 C 3					35,177		35,177	12
13	Other (specify):									13
14	TOTAL			\$	12,584	\$ 538,075	\$ 302,278	12,584	\$ 840,353	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

0009258

Report Period Beginning: 10/1/17

Ending:

9/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/18

(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	\$ 498,409	\$	1
2	Cash-Patient Deposits	97,587		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>635,805</u>)	1,251,953		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	221,060		6
7	Other Prepaid Expenses	12,353		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DUE FROM OTHERS</u>	12,050		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,093,412	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,663,248		12
13	Land	3,833,292		13
14	Buildings, at Historical Cost	41,859,882		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,114,673		16
17	Accumulated Depreciation (book methods)	(22,699,661)		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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 35,771,434	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 37,864,846	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,250,057	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,514		28
29	Short-Term Notes Payable	282,158		29
30	Accrued Salaries Payable	615,900		30
31	Accrued Taxes Payable (excluding real estate taxes)	107,278		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,623		32
33	Accrued Interest Payable	8,903		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>OTHER LIAB</u>	355,121		36
37	<u>PREPAID RESIDENT RENT</u>	2,333,487		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,997,041	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,791,320		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)	\$ 4,791,320	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,788,361	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,076,485	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 37,864,846	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 30,248,622	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 30,248,620	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,054,822)	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) NET ASSETS-RESTRICTED-RELEASED	(117,313)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,172,135)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 28,076,485	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,742,428	1
2	Discounts and Allowances for all Levels	(3,215,695)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,526,733	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,271,435	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,271,435	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	45,177	12
13	Barber and Beauty Care	58,463	13
14	Non-Patient Meals	84,051	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	484,445	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,802	19
20	Radiology and X-Ray	18,614	20
21	Other Medical Services	320,985	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,049,537	23
D. Non-Operating Revenue			
24	Contributions	212,866	24
25	Interest and Other Investment Income***	783,433	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 996,299	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	318,922	28
28a	COTTAGE & RENTAL PROPERTY INCOME	3,165,525	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,484,447	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,328,451	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,951,778	31
32	Health Care	7,365,840	32
33	General Administration	4,575,721	33
B. Capital Expense			
34	Ownership	1,348,971	34
C. Ancillary Expense			
35	Special Cost Centers	1,690,684	35
36	Provider Participation Fee	450,279	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,383,273	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,054,822)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,054,822)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,044,168	44
45	Private Pay - Net Inpatient Revenue	7,160,626	45
46	Medicare - Net Inpatient Revenue	894,946	46
47	Other-(specify) MCR B & LIKE B ADJ/BAD DEBTS	(573,007)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,526,733	49

* 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.

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/1/17

Ending:

9/30/18

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	1,932	2,338	\$ 89,550	\$ 38.30	1
2	Assistant Director of Nursing	1,956	2,160	66,506	30.79	2
3	Registered Nurses	44,027	48,593	1,361,396	28.02	3
4	Licensed Practical Nurses	49,190	53,462	1,193,779	22.33	4
5	CNAs & Orderlies	204,978	220,921	2,923,077	13.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,641	6,229	80,012	12.85	8
9	Activity Director	1,904	2,167	51,715	23.86	9
10	Activity Assistants	15,084	16,802	188,319	11.21	10
11	Social Service Workers	14,402	16,313	197,502	12.11	11
12	Dietician					12
13	Food Service Supervisor	5,579	6,577	148,340	22.55	13
14	Head Cook	5,792	6,466	87,204	13.49	14
15	Cook Helpers/Assistants	65,054	70,479	778,082	11.04	15
16	Dishwashers	9,334	9,903	107,820	10.89	16
17	Maintenance Workers	18,900	20,978	327,387	15.61	17
18	Housekeepers	32,596	36,111	415,849	11.52	18
19	Laundry	13,605	14,709	160,894	10.94	19
20	Administrator	1,832	2,140	154,855	72.36	20
21	Assistant Administrator	1,856	2,080	86,539	41.61	21
22	Other Administrative	7,578	8,307	148,161	17.84	22
23	Office Manager					23
24	Clerical	24,915	27,812	478,487	17.20	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	2,118	2,528	44,859	17.74	31
32	Other Health Care(specify)	14,860	16,612	216,674	13.04	32
33	Other(specify)	21,408	23,572	356,519	15.12	33
34	TOTAL (lines 1 - 33)	564,541	617,259	\$ 9,663,526 *	\$ 15.66	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	508	\$ 26,763	L. 1 C3	35
36	Medical Director	8	1,600	L. 9 C3	36
37	Medical Records Consultant	34	2,527	L. 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,265	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	7	607	L. 11 C3	44
45	Social Service Consultant	9	712	L. 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	566	\$ 44,474		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 & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/1/17

Ending: 9/30/18

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	
Michael Duffy	Administrator		\$ 154,855	Workers' Compensation Insurance	\$ 178,145	IDPH License Fee	\$	
Stephanie Erwin	CFO/Assoc Adm		86,539	Unemployment Compensation Insurance	1,991	Advertising: Employee Recruitment	14,561	
				FICA Taxes	695,518	Health Care Worker Background Check	4,276	
				Employee Health Insurance	1,408,385	(Indicate # of checks performed <u>106</u>)		
				Employee Meals		Patient Background Checks	300	
				Illinois Municipal Retirement Fund (IMRF)*		Council for Health and Human Services	10,365	
				Employee Tuition	3,071	Various Dues, Licenses, and Permits	7,110	
				Pension Plan	284,019	Leading Age Illinois	15,816	
				Employee Medical	288,824	Less Lobbying Expense	(2,214)	
				Life Insurance	4,228			
				Employee Recognition	24,545	Less: Public Relations Expense	()	
				Public Relations Benefits	(12,855)	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 241,394	TOTAL (agree to Schedule V, line 22, col.8)		\$ 51,914		
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
			\$			\$	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	8,845
C. Professional Services							Dev Director	(1,389)
Vendor/Payee	Type		Amount					
Schmiedeskamp, Robertson	Legal		\$ 33,865				Entertainment Expense	()
Littler	Legal		988				(agree to Sch. V, line 24, col. 8)	
First Bankers Trust	Legal		3,471				TOTAL	\$ 7,456
Dennis Koch	Accounting		600					
RSM	Accounting		1,875					
BKD	Accounting		79,371					
First Bankers Trust	Payroll acct fees		768					
Various			223					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 121,161	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

Facility Name & ID Number Good Samaritan Home# 0009258

Report Period Beginning:

10/1/17Ending: 9/30/18**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. LeadingAge \$15,816; CHHS \$10,365
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81,108 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 450,279
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. \$ 84,051
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BKD, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation	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	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Snow Salt Spreader	2015	1,600	320	320	0	5 yrs	880	42
43	Facility	Toro 8260XE Snow Blower	2014	1,189	119	119	0	10 yrs	456	43
44	Facility	Landpride RB1584 Blade	2014	575	57	57	0	10 yrs	220	44
44a	Facility	Landpride RTR0550 Tiller	2015	1,950	195	195	0	10 yrs	683	44a
44c	Facility	Toro Titan MX5400	2015	6,150	615	615	0	10 yrs	2,153	44c
44d	Facility	Toro Titan MX5400	2015	6,150	615	615	0	10 yrs	2,153	44d
44e	Facility	2005 Chrysler Town	2005	21,931			0	5 yrs	21,931	44g
44f	Facility	Kubota L3430	2006	18,895			0	10 yrs	18,895	44f
44g	Facility	Ford F350	2007	30,224			0	10 yrs	30,224	44g
44h	Facility	Golf Cart	2008	1,200			0	5 yrs	1,200	44h
44i	Facility	Tractor with Cab JD 4320	2010	33,977	3,398	3,398	0	10 yrs	26,898	44i
44j	Facility	2010 GMC Sierra	2010	32,410	0	0	0	5 yrs	32,410	44j
44k	Facility	Various Mower/Snow EQ	Various	6,637	505	505	0	10 yrs	6,007	44k
44l	Facility	2003 Ford F150	2013	3,500	233	233	0	5 yrs	3,500	44l
44m	Maintenance	Kubota KQ163	2014	1,850	185	185	0	10 yrs	832	44m
44n	Maintenance	Kubota Tractor-Snow Removal	2017	10,000	2,000	2,000	0	5 yrs	3,833	44n
44o	Facility	2018 Ford Starcraft Bus	2018	65,140	6,514	6,514	0	5 yrs	6,514	44o
44p	Facility	2018 Dodge Caravan	2018	39,795	2,653	2,653	0	5 yrs	2,653	44p
44q							0			44q
44r							0			44r
44s							0			44s
45							0			45
46	TOTALS			\$ 283,173	\$ 17,409	\$ 17,409	\$ 0		\$ 161,442	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.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	1
2	2018	29,915	125	20	125		125	2
3	2018	3,865	290	10	290		290	3
4	2018	19,600	1,388	10	1,388		1,388	4
5	2018	4,081	119	20	119		119	5
6	2018	10,945	343	15	343		343	6
7	2018	5,210	58	15	58		58	7
8	2018	17,755	888	15	888		888	8
9	2018	37,467	1,665	15	1,665		1,665	9
10	2018	2,950	123	10	123		123	10
11							0	11
12							0	12
13							0	13
14							0	14
15							0	15
16							0	16
17							0	17
18							0	18
19							0	19
20							0	20
21							0	21
22							0	22
23							0	23
24							0	24
25							0	25
26							0	26
27							0	27
28							0	28
29							0	29
30							0	30
31							0	31
32							0	32
33								33
34	TOTAL (lines 1 thru 33)	\$ 131,788	\$ 4,999		\$ 4,999	\$ 0	\$ 4,999	34

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