		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0050575

Facility Name: Good Samaritan - Pontiac

Address: 15335 US Highway 66 (Number) Pontiac (City) 61764 (Zip Code)

County: Livingston

Telephone Number: (815) 844-5121 **Fax #** (815) 844-5690

HFS ID Number:

Date of Initial License for Current Owners: 03/01/10

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 (c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 03/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	13,464	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	23,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	37,332	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	730	42	1,598	2,370	8
9	SNF/PED					9
10	ICF	8,625	1,004		9,629	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,355	1,046	1,598	11,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 32.14%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 03/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,232

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	139,736	8,064	3,937	151,737		151,737		151,737			1
2	Food Purchase		70,942		70,942		70,942	(3,797)	67,145			2
3	Housekeeping	57,483	9,751		67,234		67,234		67,234			3
4	Laundry	34,657	1,442		36,099		36,099		36,099			4
5	Heat and Other Utilities			96,900	96,900		96,900		96,900			5
6	Maintenance	63,497	417	144,209	208,123		208,123	(14,839)	193,284			6
7	Other (specify):*											7
8	TOTAL General Services	295,373	90,616	245,046	631,035		631,035	(18,636)	612,399			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	691,546	44,595	55,133	791,274		791,274		791,274			10
10a	Therapy			121,440	121,440		121,440		121,440			10a
11	Activities	32,515	532	1,609	34,656		34,656		34,656			11
12	Social Services	29,389	78	1,032	30,499		30,499		30,499			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	753,450	45,205	185,214	983,869		983,869		983,869			16
	C. General Administration											
17	Administrative	63,917			63,917		63,917		63,917			17
18	Directors Fees											18
19	Professional Services			(34,763)	(34,763)		(34,763)	56,452	21,689			19
20	Dues, Fees, Subscriptions & Promotions			11,891	11,891		11,891	(227)	11,664			20
21	Clerical & General Office Expenses	92,463	5,859	33,595	131,917		131,917	(526)	131,391			21
22	Employee Benefits & Payroll Taxes			144,102	144,102		144,102		144,102			22
23	Inservice Training & Education			3,093	3,093		3,093		3,093			23
24	Travel and Seminar			8,984	8,984		8,984	(5,795)	3,189			24
25	Other Admin. Staff Transportation			55,095	55,095		55,095		55,095			25
26	Insurance-Prop.Liab.Malpractice			32,650	32,650		32,650		32,650			26
27	Other (specify):*											27
28	TOTAL General Administration	156,380	5,859	254,647	416,886		416,886	49,904	466,790			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,205,203	141,680	684,907	2,031,790		2,031,790	31,268	2,063,058			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Good Samaritan - Pontiac #0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							99,556	99,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			837	837		837		837			35
36	Other (specify):*											36
37	**TOTAL Ownership**			837	837		837	99,556	100,393			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,997		43,997		43,997		43,997			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			16,653	16,653		16,653		16,653			42
43	Other (specify):* Non-Allowable Cos			52,483	52,483		52,483	(52,483)				43
44	**TOTAL Special Cost Centers**		43,997	69,136	113,133		113,133	(52,483)	60,650			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,205,203	185,677	754,880	2,145,760		2,145,760	78,341	2,224,101			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,797)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,714)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	99,556	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	56,470	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,321)	43		24
25	Fund Raising, Advertising and Promotional	(8,684)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(41,169)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ 78,341		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 78,341		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Good Samaritan - Pontiac

ID# 0050575

Report Period Beginning: 03/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X Ray Expense	$ (139)	43	1
2	Laboratory Expense	(3,651)	43	2
3	Medicare Expense	(9,258)	43	3
4	Flowers	(30)	43	4
5	Resident Pending Disb	735	43	5
6	Resident Relief Fund	(285)	43	6
7	Special Account	820	43	7
8	Special Project	1	43	8
9	Gift / Memorial Expense	(125)	43	9
10	Marketing	(7,832)	43	10
11	Offset Miscellaneous Income	(526)	21	11
12	Disallow Rotary Fees	(245)	20	12
13	Disallow Travel & Seminar	(5,795)	24	13
14	To capitalize repairs and Maintenance items	(14,839)	6	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(41,169)		49

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	See Attached Schedule 7A	Board Members	Administrative	0.00	N/A	1hr each	2% each	N/A	N/A	N/A	3
4											4
5	No members of the Board of Directors have ownership in a business that conducts business with the organization										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

N/A

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

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan - Pontiac COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050575

CONTACT PERSON REGARDING THIS REPORT Stephen Johnson

TELEPHONE (815) 844-5121 FAX #: (815) 844-5690

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 X NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,820 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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.) See Attached Schedule 11A.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

None

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1968	$ 199,500	1
2					2
3	TOTALS			$ 199,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Good Samaritan - Pontiac
Fiscal Period 3/1/10 thru 12/31/10
Schedule 11A

Note : Livingston County and Good Samaritan Group have entered into an economic development agreement in which the county owns the facility and fixed assets, while Good Samaritan does not pay rent for either.

See Accountants' Compilation Report

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122			1968	$ 954,253	$		$ 19,085	$ 19,085	$ 842,890	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1968	57,846		20			57,846	9
10	Various			1969	4,376		20			4,376	10
11	Various			1973	2,959		20	59	59	2,222	11
12	Various			1977	15,710		20	282	282	10,923	12
13	Various			1978	61,749		20	435	435	54,357	13
14	Various			1979	63,068		20	1,151	1,151	42,351	14
15	Various			1980	11,757		20	57	57	10,669	15
16	Various			1981	16,455		20	156	156	13,339	16
17	Various			1982	14,538		20	28	28	13,938	17
18	Various			1983	25,807		20	233	233	20,676	18
19	Various			1984	41,685		20			41,685	19
20	Various			1985	10,183		20			10,183	20
21	Various			1986	14,031		20	85	85	11,897	21
22	Various			1987	28,935		20			28,935	22
23	Various			1988	6,621		20			6,621	23
24	Various			1989	116,257		20	2,169	2,169	55,609	24
25	Various			1990	20,708		20	954	954	19,976	25
26	Various			1991	31,573		20	766	766	15,460	26
27	Various			1992	391,614		20	8,966	8,966	157,998	27
28	Various			1993	563,498		20	10,153	10,153	204,745	28
29	Various			1994	27,223		20	726	726	11,322	29
30	Various			1995	173,018		20	3,377	3,377	55,497	30
31	Various			1996	19,810		20	414	414	6,589	31
32	Various			1997	17,298		20	751	751	10,449	32
33	Various			1998	13,384		20	642	642	7,844	33
34	Various			1999	453,866		20	9,611	9,611	110,487	34
35	Various			2000	31,996		20	1,601	1,601	16,779	35
36	Various			2001	74,897		20	3,745	3,745	35,058	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2002	$ 48,224	$	20	$ 2,411	$ 2,411	$ 20,813	37
38	Various	2003	5,662		20	450	450	3,256	38
39	Various	2004	17,148		20	1,716	1,716	11,226	39
40	Various	2005	1,829		20	91	91	487	40
41									41
42	Alarm and keypad for door	2006	1,565		20	78	78	371	42
43	Paving and concrete	2006	23,550		20	1,178	1,178	5,496	43
44	Double door system	2006	5,747		20	287	287	1,341	44
45	A/C parts	2006	4,659		20	233	233	990	45
46	Boiler and stack repairs	2006	5,950		20	298	298	1,290	46
47	Door alarm system	2006	40,131		20	2,007	2,007	8,361	47
48	Motion lights	2006	1,174		20	59	59	289	48
49	Repipe and rewire kitchen	2006	1,409		20	70	70	346	49
50	Fire doors	2006	6,281		20	314	314	1,466	50
51	Fire alarm control panel	2006	2,122		20	106	106	424	51
52	Smoke dampers	2007	5,504		20	275	275	986	52
53	Hot water tank repair	2007	1,350		20	68	68	259	53
54	Roof top ac unit	2007	4,596		20	383	383	1,277	54
55	Circuit breaker panel	2007	3,780		20	189	189	614	55
56	Well water pump	2007	2,013		20	101	101	311	56
57	Door alarm system - camera	2007	5,577		20	372	372	1,332	57
58	Door alarm system - voice page	2007	1,777		20	254	254	910	58
59	Coil for walk in cooler	2008	1,132		20	113	113	236	59
60	Thermostats	2008	3,350		20	335	335	698	60
61	Block heater	2008	1,127		20	113	113	329	61
62	Thermostatic mixing valve ins	2008	14,000		20	1,400	1,400	2,917	62
63	Kitchen waste line	2008	5,900		20	590	590	1,278	63
64	Hvac system	2009	6,500		20	325	325	650	64
65	Boiler work	2009	3,521		20	176	176	352	65
66	Boiler and plumbing repair	2010	9,435		20	236	236	236	66
67	Fire alarm	2010	5,404		20	135	135	135	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,505,532	$		$ 79,809	$ 79,809	$ 1,949,397	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 245,836	$	$ 18,995	$ 18,995	10	$ 195,919	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	398,724				10	398,724	73
74								74
75	TOTALS	$ 644,560	$	$ 18,995	$ 18,995		$ 594,643	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1993 Taurus	1993	$ 14,704	$	$	$	5	$ 14,704	76
77	Facility Use	Bus	1996	45,146		752	752	5	45,146	77
78										78
79										79
80	TOTALS			$ 59,850	$	$ 752	$ 752		$ 59,850	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)	$ 4,409,442	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,556	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 99,556	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,603,890	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	Chevy Caprise - 1990	$ 15,635	$	$	86
87	1993 GMS Sierra - 1994	15,947			87
88					88
89					89
90					90
91	TOTALS	$ 31,582	$	$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 837 Description: Equipment Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	779	$ 56,084	$	779	$ 56,084	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		269	19,396		269	19,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		638	45,960		638	45,960	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				32,361		32,361	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					11,636		11,636	12
13	Other (specify):									13
14	TOTAL			$	1,686	$ 121,440	$ 43,997	1,686	$ 165,437	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 254,581	$ 254,581	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	418,068	418,068	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,611	11,611	6
7	Other Prepaid Expenses	33,672	33,672	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	99,021	99,021	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 816,953	$ 816,953	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		199,500	13
14	Buildings, at Historical Cost		3,505,532	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	207	704,410	16
17	Accumulated Depreciation (book methods)		(2,603,890)	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)**	$ 207	$ 1,805,552	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 817,160	$ 2,622,505	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 91,089	$ 91,089	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,383	65,383	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	66,875	66,875	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 223,347	$ 223,347	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 223,347	$ 223,347	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 593,813	$ 2,399,158	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 817,160	$ 2,622,505	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Good Samaritan - Pontiac
Fiscal Period 3/1/10 thru 12/31/10
Schedule 17A

Ln 9		Operating	After Consolidation
	FICA Tax Employer	78,469	78,469
	Unemployment Tax Liability	20,552	20,552
	Total Ln 9	99,021	99,021

Line 36		Operating	After Consolidation
	Accrued Fed Withholding	5,150	5,150
	Accrued FICA Payroll Taxes	5,351	5,351
	Accrued Medical Payroll Taxes	1,433	1,433
	Accrued State Withholding	1,430	1,430
	Accrued Sick	12,291	12,291
	Accrued Vacation	33,818	33,818
	Cafeteria 125 Plan	5,470	5,470
	Accrued Health Insurance	1,266	1,266
	Accrued Dental Insurance	666	666
	Total Ln 36	66,875	66,875

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 833,333	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 833,333	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,520)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (239,520)	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)**	$ 593,813	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,616,687	1
2	Discounts and Allowances for all Levels	(1,177,418)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,439,269	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	345,201	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 345,201	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,797	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,168	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,632	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,406	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 122,003	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		(233)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (233)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,906,240	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	631,035	31
32	Health Care	983,869	32
33	General Administration	416,886	33
	B. Capital Expense		
34	Ownership	837	34
	C. Ancillary Expense		
35	Special Cost Centers	96,480	35
36	Provider Participation Fee	16,653	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,145,760	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,520)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,520)	43

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

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

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

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

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,296	3,536	$ 85,682	$ 24.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,471	3,949	92,814	23.50	3
4	Licensed Practical Nurses	8,228	8,706	172,650	19.83	4
5	CNAs & Orderlies	31,171	33,340	340,400	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,968	3,285	32,515	9.90	10
11	Social Service Workers	1,726	1,846	29,389	15.92	11
12	Dietician					12
13	Food Service Supervisor	1,741	1,886	37,007	19.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,369	11,849	102,729	8.67	15
16	Dishwashers					16
17	Maintenance Workers	4,025	4,384	63,497	14.48	17
18	Housekeepers	5,656	6,135	57,483	9.37	18
19	Laundry	1,583	1,730	34,657	20.03	19
20	Administrator	1,627	1,747	63,917	36.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,103	6,715	92,463	13.77	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	82,964	89,108	$ 1,205,203 *	$ 13.53	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	63	$ 3,446	L1, C3	35
36	Medical Director	32	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	853	L10, 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	120	959	L11, C3	44
45	Social Service Consultant	120	1,016	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	$ 12,274		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	325	$ 18,619	L10, C3	50
51	Licensed Practical Nurses	192	10,784	L10, C3	51
52	Certified Nurse Assistants/Aides	1,312	24,877	L10, C3	52
53	TOTAL (lines 50 - 52)	1,829	$ 54,280		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephen Johnson	Administrator	0	$ 63,917
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,917

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Glenda Tannahill	Financial	$ 7,470
Sears Computer Service	Computers	295
Quest	Payroll	819
Ungaretti & Harris	Legal	13,000
Hartweg, Turner & Wo	Legal	3,485
Pontiac Daily Leader	Newspaper	18
YE Adjustment	Legal	(59,850)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ (34,763)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,675
Unemployment Compensation Insurance	3,033
FICA Taxes	7,957
Employee Health Insurance	51,999
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,065
Misc Employee Benefits	2,373
TOTAL (agree to Schedule V, line 22, col.8)	$ 144,102

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,864
Advertising: Employee Recruitment	2,095
Health Care Worker Background Check (Indicate # of checks performed 103)	1,234
Patient Background Checks 22	260
Life Services Network	2,506
ADP Payroll	2,362
Rotary Club of Pontiac	245
Miscellaneous Dues & Fees	1,343
Less : Rotary Club of Pontiac	(245)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,664

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,189
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,189

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Good Samaritan - Pontiac
Fiscal Period 3/1/10 thru 12/31/10
Schedule 21A

Schedule XIX. Support Schedules

C. Professional Services

Amount from Page 21 Sec C	(34,763)
Add : Additional Legal Invoices	11,631
Less : Legal Reclass to Dues	(18)
Less : Out of Period Legal	(15,011)
Less : Year End Adjustment Legal	59,850
Line 19 Column 8	21,689

See Accountants' Compilation Report

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan - Pontiac # 0050575 Report Period Beginning: 03/01/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $2,506**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,831** Line **Ln 10, C2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **16,653**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,797**

(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? **0**
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.