FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 12955

Facility Name: GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW

Address: 310 MOSHER DRIVE (Number) PROPHETSTOWN (City) 61277-1002 (Zip Code)

County: WHITESIDE

Telephone Number: 825-537-5175 **Fax #** 825-537-2628

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1970

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Kim Kouri **Telephone Number:** 605-362-3178
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 01/01/2011 to 12/31/2011 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) JOSEPH HERDINA
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,524	11,929	2,826	23,279	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,524	11,929	2,826	23,279	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.11%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/20/1967

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided _____

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHE # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	205,152	15,244	7,500	227,896		227,896	(233)	227,663			1
2	Food Purchase		153,545		153,545		153,545	(6,422)	147,123			2
3	Housekeeping	60,184	19,130		79,314		79,314	(329)	78,985			3
4	Laundry	55,137	17,851		72,988		72,988	(316)	72,672			4
5	Heat and Other Utilities			71,313	71,313		71,313		71,313			5
6	Maintenance	108,589	5,592	49,016	163,197		163,197	(8,995)	154,202			6
7	Other (specify):*			1,694	1,694		1,694	(677)	1,017			7
8	**TOTAL General Services**	429,062	211,362	129,523	769,947		769,947	(16,972)	752,975			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,468,310	171,299	3,506	1,643,115		1,643,115	(82,017)	1,561,098			10
10a	Therapy	9,888	1,627	406,751	418,266		418,266	(133,329)	284,937			10a
11	Activities	97,082	3,274	11,669	112,025		112,025	(8,838)	103,187			11
12	Social Services	53,591	484	496	54,571		54,571	(9)	54,562			12
13	CNA Training											13
14	Program Transportation			5,120	5,120		5,120		5,120			14
15	Other (specify):*	25			25		25		25			15
16	**TOTAL Health Care and Programs**	1,628,896	176,684	434,742	2,240,322		2,240,322	(224,193)	2,016,129			16
	C. General Administration											
17	Administrative	84,656		180,005	264,661		264,661	33,460	298,121			17
18	Directors Fees											18
19	Professional Services			3,970	3,970		3,970		3,970			19
20	Dues, Fees, Subscriptions & Promotions			25,192	25,192		25,192	(19,246)	5,946			20
21	Clerical & General Office Expenses	87,121	30,842	44,884	162,847		162,847	(1,023)	161,824			21
22	Employee Benefits & Payroll Taxes			418,746	418,746		418,746	4,089	422,835			22
23	Inservice Training & Education			13,811	13,811		13,811	(71)	13,740			23
24	Travel and Seminar			4,376	4,376		4,376	(1,278)	3,098			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			20,225	20,225		20,225	28,590	48,815			26
27	Other (specify):*	5,988		1,991	7,979		7,979	(7,930)	49			27
28	**TOTAL General Administration**	177,765	30,842	713,200	921,807		921,807	36,591	958,398			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,235,723	418,888	1,277,465	3,932,076		3,932,076	(204,574)	3,727,502			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.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIE\#12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			143,520	143,520		143,520		143,520			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			177	177		177	(177)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,669	8,669		8,669		8,669			35
36	Other (specify):*											36
37	**TOTAL Ownership**			152,366	152,366		152,366	(177)	152,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		35	3,746	3,781		3,781	(3,781)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*			9,499	9,499		9,499	(9,499)				43
44	**TOTAL Special Cost Centers**		35	51,570	51,605		51,605	(13,280)	38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,235,723	418,923	1,481,401	4,136,047		4,136,047	(218,031)	3,918,016			45

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERV # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(6,422)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,781)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,572	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(271,990)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (284,621)		$	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	66,590		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 66,590		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (218,031)		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.			$		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

GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW

ID# 12955

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See attached schedule	$ (233)	1	1
2	See attached schedule	(133,329)	10a	2
3	See attached schedule		2	3
4	See attached schedule	(329)	3	4
5	See attached schedule	(316)	4	5
6	See attached schedule		5	6
7	See attached schedule	(8,995)	6	7
8	See attached schedule	(677)	7	8
9	See attached schedule		8	9
10	See attached schedule		9	10
11	See attached schedule	(82,017)	10	11
12	See attached schedule	(57)	11	12
13	See attached schedule	(9)	12	13
14	See attached schedule		13	14
15	See attached schedule		14	15
16	See attached schedule		15	16
17	See attached schedule		16	17
18	See attached schedule		17	18
19	See attached schedule		18	19
20	See attached schedule		19	20
21	See attached schedule	(19,246)	20	21
22	See attached schedule	(3,595)	21	22
23	See attached schedule	(451)	22	23
24	See attached schedule	(71)	23	24
25	See attached schedule	(1,278)	24	25
26	See attached schedule		25	26
27	See attached schedule		26	27
28	See attached schedule	(7,930)	27	28
29	See attached schedule		28	29
30	See attached schedule		29	30
31	See attached schedule		30	31
32	See attached schedule		31	32
33	See attached schedule	(177)	32	33
34	See attached schedule		33	34
35	See attached schedule		34	35
36	See attached schedule		35	36
37	See attached schedule		36	37
38	See attached schedule		37	38
39	See attached schedule		38	39
40	See attached schedule		39	40
41	See attached schedule	(3,781)	40	41
42	See attached schedule		41	42
43	See attached schedule		42	43
44	See attached schedule	(9,499)	43	44
45	See attached schedule		44	45
46	See attached schedule		45	46
47	See attached schedule		46	47
48	See attached schedule		47	48
49	**Total**	(271,990)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIE # 12955 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(233)	0	0	0	0	0	0	0	0	0	0	(233)	1
2	Food Purchase	(6,422)	0	0	0	0	0	0	0	0	0	0	(6,422)	2
3	Housekeeping	(329)	0	0	0	0	0	0	0	0	0	0	(329)	3
4	Laundry	(316)	0	0	0	0	0	0	0	0	0	0	(316)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(8,995)	0	0	0	0	0	0	0	0	0	0	(8,995)	6
7	Other (specify):*	(677)	0	0	0	0	0	0	0	0	0	0	(677)	7
8	**TOTAL General Services**	(16,972)	0	0	0	0	0	0	0	0	0	0	(16,972)	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	(82,017)	0	0	0	0	0	0	0	0	0	0	(82,017)	10
10a	Therapy	(133,329)	0	0	0	0	0	0	0	0	0	0	(133,329)	10a
11	Activities	(8,838)	0	0	0	0	0	0	0	0	0	0	(8,838)	11
12	Social Services	(9)	0	0	0	0	0	0	0	0	0	0	(9)	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**	(224,193)	0	0	0	0	0	0	0	0	0	0	(224,193)	16
	C. General Administration													
17	Administrative	0	33,460	0	0	0	0	0	0	0	0	0	33,460	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(19,246)	0	0	0	0	0	0	0	0	0	0	(19,246)	20
21	Clerical & General Office Expenses	(1,023)	0	0	0	0	0	0	0	0	0	0	(1,023)	21
22	Employee Benefits & Payroll Taxes	(451)	4,540	0	0	0	0	0	0	0	0	0	4,089	22
23	Inservice Training & Education	(71)	0	0	0	0	0	0	0	0	0	0	(71)	23
24	Travel and Seminar	(1,278)	0	0	0	0	0	0	0	0	0	0	(1,278)	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	28,590	0	0	0	0	0	0	0	0	0	28,590	26
27	Other (specify):*	(7,930)	0	0	0	0	0	0	0	0	0	0	(7,930)	27
28	**TOTAL General Administration**	(29,999)	66,590	0	0	0	0	0	0	0	0	0	36,591	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(271,164)	66,590	0	0	0	0	0	0	0	0	0	(204,574)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVII # 12955 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(177)	0	0	0	0	0	0	0	0	0	0	(177)	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**	(177)	0	0	0	0	0	0	0	0	0	0	(177)	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	(3,781)	0	0	0	0	0	0	0	0	0	0	(3,781)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,499)	0	0	0	0	0	0	0	0	0	0	(9,499)	43
44	**TOTAL Special Cost Centers**	(13,280)	0	0	0	0	0	0	0	0	0	0	(13,280)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(284,621)	66,590	0	0	0	0	0	0	0	0	0	(218,031)	45

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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 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	17	Admin/Accting	$ 180,005	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 213,465	$ 33,460	1
2	V	22	Workers Comp	56,822			101,741	44,919	2
3	V	22	Unemployment	2,429			2,521	92	3
4	V	26	Insurance	20,225			48,815	28,590	4
5	V	22	Group Health Insurance	150,746			110,275	(40,471)	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			$ 410,227			$ 476,817	$ * 66,590	14

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 SOCIETY - PROPHE # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVII # 12955 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										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 SOCIETY - PROPHET # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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												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. **$** _____ **Line #** _____

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW **#** 12955 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEV COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 12955

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1967	1967	$ 347,118	$		$	$	$ 347,118	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1967	1,223					1,223	9
10				1973	669	17		17		639	10
11				1974	483	12		12		452	11
12				1975	33,671	758		758		31,398	12
13				1977	4,676					4,676	13
14				1978	2,854					2,854	14
15				1979	10,205					10,205	15
16				1980	2,114	9		9		2,044	16
17				1981	60,747	1,404		1,404		47,040	17
18				1982	10,416					10,416	18
19				1983	16,071					16,071	19
20				1984	8,772					8,772	20
21				1985	17,007					17,007	21
22				1986	3,134					3,134	22
23				1987	78,081					78,081	23
24				1988	47,917	430		430		47,201	24
25				1989	90,335					90,335	25
26				1990	805,403					805,403	26
27				1991	8,759					8,708	27
28				1992	28,408	214		214		28,237	28
29				1993	6,447	107		107		6,269	29
30				1994	44,592	404		404		43,776	30
31				1995	32,831	285		285		31,928	31
32				1996	40,289	990		990		35,476	32
33				1997	58,092	2,292		2,292		41,913	33
34				1998	26,516	959		959		23,378	34
35				1999	18,382	172		172		17,111	35
36				2000	16,758	48		48		16,352	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 SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		2001	$ 42,137	$ 1,874		$ 1,874	$	$ 27,585	37
38		2002	149,332	9,861		9,861		100,120	38
39		2003	63,243	4,216		4,216		37,837	39
40		2004	68,785	6,518		6,518		50,922	40
41		2005	218,729	17,576		17,576		113,299	41
42		2006	206,296	13,806		13,806		77,218	42
43		2007	238,987	16,186		16,186		73,263	43
44	Dining,Conf Rm Shades	2008	2,009	201	120	201		787	44
45	Carpet-Floor Covering Replace	2008	32,057	6,411	60	6,411		24,043	45
46	Vinyl-Floor Covering Replace	2008	8,090	809	120	809		3,034	46
47	Door Openers-300 Wing NF	2008	9,193	460	240	460		1,685	47
48	AC Compressor	2008	2,153	215	120	215		772	48
49	RADIATOR/REPAIR GENERATOR	2009	2,239	224	120	224		560	49
50	100 Wing Handicap Door	2009	6,303	420	180	420		1,015	50
51	Building-Room Remodel	2009	12,399	496	300	496		1,075	51
52	Carpet-Room Remodel	2009	1,752	350	60	350		759	52
53	Drapes-Room Remodel	2009	85	17	60	17		37	53
54	Duct Work-Room Remodel	2009	192	10	240	10		21	54
55	Paint-Room Remodel	2009	92	18	60	18		40	55
56	Windows-Room Remodel	2009	4,633	309	180	309		669	56
57	Building-Wall Covering Project	2009	21,034	841	300	841		2,524	57
58	Handrail-Wall Covering Project	2009	4,112	274	180	274		822	58
59	Wallpaper-WallCovering Project	2009	674	135	60	135		404	59
60	SHEERWEAVE ROLLER SHADES (7)	2010	869	174	60	174		275	60
61	WALL PROTECTORS,CORNERS,DIVIDE	2010	719	72	120	72		96	61
62	Wallpaper-Resident Rooms	2010	3,629	726	60	726		1,089	62
63	WALL BOARD, CORNER GUARDS	2010	1,177	118	120	118		137	63
64	Roof Replacement	2010	53,823	2,691	240	2,691		3,364	64
65	Doors-Resident Baths	2010	2,601	173	180	173		303	65
66	AWNING-FRONT OF BLDG	2011	1,770	148	108	148		148	66
67	Boiler Replacement	2011	51,936	432	240	432		433	67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		$ 3,033,023	$ 93,862		$ 93,862	$	$ 2,301,553	70

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		$ 3,033,023	$ 93,862		$ 93,862	$	$ 2,301,553	1
2	Drain Tile	2008	3,543	177	240	177		679	2
3	Preen,Mulch Around Building	2008	4,218		24			4,218	3
4	Shrubs & Sugar Maple Tree	2008	2,774	139	240	139		485	4
5	Sidewalk	2008	2,820	188	180	188		595	5
6	New Signage	2008	6,940	694	120	694		2,198	6
7	MULCH,PREEN,LABOR/LANDSCAPING	2009	5,806	581	120	581		1,548	7
8	CRIMSON KING MAPLE TREE	2009	800	80	120	80		193	8
9	TREES,PLANTS,MULCH	2009	2,800	280	120	280		630	9
10	New Curb/Blacktop-Parking Lot	2009	9,275	464	240	464		1,005	10
11	FLAGPOLE BASE	2010	1,215	122	120	122		203	11
12	FLOWERS,BOXWOOD,SPRUCE,MULCH	2010	4,956	496	120	496		785	12
13	PLANTS,SHRUBS,TREES	2010	4,846	485	120	485		808	13
14	PLANTS,SHRUBS,TREES	2010	4,858	486	120	486		810	14
15	MULCH, PREEN	2010	1,946	195	120	195		324	15
16	MAPLE,JUNIPER,SPRUCE TREES	2010	4,704	470	120	470		745	16
17	RESEAL & RESTRIPE 2 PARKING LO	2010	4,215	2,108	24	2,108		2,810	17
18	FLAG POLE CONCRETE & STRIPING	2010	1,100	73	180	73		98	18
19	SHRUBS & LAWN	2011	6,679	891	60	891		891	19
20	Prior Year Depreciation on Asset #234023			10		10			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	TOTAL (lines 1 thru 33)		$ 3,106,518	$ 101,799		$ 101,799	$	$ 2,320,577	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIV # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 351,193	$ 36,161	$ 36,161	$		$ 212,012	71
72	Current Year Purchases	47,350	2,805	2,805			2,805	72
73	Fully Depreciated Assets	533,682	2,173	2,173			533,682	73
74								74
75	TOTALS	$ 932,225	$ 41,139	$ 41,139	$		$ 748,499	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	Resident Use	Van and License	1992	$ 35,985	$	$	$		$ 35,985	76
77	Resident Use	2002 Olds Mini Van	2004	16,850					16,850	77
78	Resident Use	1995 Chrysler Van	2008	3,000	583	583		3	3,000	78
79										79
80	TOTALS			$ 55,835	$ 583	$ 583	$		$ 55,835	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)	$ 4,109,578	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,521	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,521	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,124,911	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building & Land Improvements	$ 2,349,851	$ 113,270	$ 459,453	86
87	FFE	92,949	5,956	30,917	87
88					88
89					89
90					90
91	TOTALS	$ 2,442,800	$ 119,226	$ 490,370	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIE # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,669 Description: Computer Lease, Companion Pump, Dishwasher
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

   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.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a, Col 3	hrs	$	8,286	$ 124,290	$	8,286	$ 124,290	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		4,627	69,410		4,627	69,410	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 3	hrs		14,203	213,051		14,203	213,051	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	27,116	$ 406,751	$	27,116	$ 406,751	14

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIE\# 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 26,657	$	1
2	Cash-Patient Deposits	2,947		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (23,671))	665,400		3
4	Supply Inventory (priced at)	16,093		4
5	Short-Term Investments	1,446,016		5
6	Prepaid Insurance	6,754		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,163,867	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	5,020,223		14
15	Leasehold Improvements, at Historical Cost	436,148		15
16	Equipment, at Historical Cost	1,081,009		16
17	Accumulated Depreciation (book methods)	(3,615,281)		17
18	Deferred Charges	30,247		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):	31,983		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,999,329	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,163,196	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,854	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,947		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,393		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	Security Deposits	10,841		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 360,035	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,579,959		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,579,959	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,939,994	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,223,202	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,163,196	$	48

***(See instructions.)**

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,048,074	1
2	Restatements (describe):		2
3	Apartments	17,033	3
4	Dnr Ret Prop/Oper Gift Cash	3,180	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,068,287	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	442,402	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)**	$ 442,402	17
	B. Transfers (Itemize):		
18	Reserve Fund Assessment NC	(122,982)	18
19	Technology User Assessment NC	(20,946)	19
20	Senior Living	(141,613)	20
21	Dnr Rest Oper Gift	(1,946)	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (287,487)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,223,202	24 *

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RI' # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 3,562,473	1
2	Discounts and Allowances for all Levels	(597,542)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,964,931	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	61,648	5
6	Therapy	1,216,440	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,278,088	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	3,435	13
14	Non-Patient Meals	6,422	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	215,748	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,178	19
20	Radiology and X-Ray	3,847	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 236,630	23
	D. Non-Operating Revenue		
24	Contributions	16,957	24
25	Interest and Other Investment Income***	18,523	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35,480	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	53,001	28
28a	Misc Income/PY Settlements/Bad debt/Gains	10,319	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 63,320	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,578,449	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	769,571	31
32	Health Care	2,240,698	32
33	General Administration	921,807	33
	B. Capital Expense		
34	Ownership	152,365	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37	Other	13,281	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,136,047	40
41	**Income before Income Taxes (line 30 minus line 40)****	442,402	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 442,402	43

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

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

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

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

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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	2,089	1,913	$ 67,442	$ 35.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,971	13,678	355,316	25.98	3
4	Licensed Practical Nurses	12,118	10,872	261,861	24.09	4
5	CNAs & Orderlies	63,529	58,128	719,204	12.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	402	369	9,888	26.80	8
9	Activity Director	2,099	1,756	36,868	21.00	9
10	Activity Assistants	5,339	4,682	60,530	12.93	10
11	Social Service Workers	2,635	2,416	52,917	21.90	11
12	Dietician					12
13	Food Service Supervisor	1,749	1,508	33,373	22.13	13
14	Head Cook	5,318	5,024	67,719	13.48	14
15	Cook Helpers/Assistants	10,101	9,174	102,481	11.17	15
16	Dishwashers					16
17	Maintenance Workers	7,494	6,636	109,901	16.56	17
18	Housekeepers	5,953	5,401	60,095	11.13	18
19	Laundry	5,488	4,470	56,245	12.58	19
20	Administrator	1,952	1,787	84,528	47.30	20
21	Assistant Administrator					21
22	Other Administrative	7,455	6,676	123,453	18.49	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	1,769	32,377	18.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,776	136,259	$ 2,234,198 *	$ 16.40	34

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

** See instructions.

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	132	$ 7,132	Ln 1, col 3	35
36	Medical Director		7,200	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,506	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	691	Ln 11 Col 3	44
45	Social Service Consultant	5	496	Ln 12 col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	140	$ 19,025		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 SOCIETY - PROPHETS RIV # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ford Craven	Administrator	0	$ 84,656
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,656

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 180,005
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 180,005

C. Professional Services

Vendor/Payee	Type	Amount
Medicare cost report preparation		$ 950
Medicaid cost report preparation		1,000
Contract Serv - Admin		2,020
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 3,970

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,822
Unemployment Compensation Insurance	2,429
FICA Taxes	166,577
Employee Health Insurance	150,746
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	40,449
Taxable Gifts	350
Other	1,374
NCO adjustments	4,540
Resource Development expenses	(452)
TOTAL (agree to Schedule V, line 22, col.8)	$ 422,835

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,332
Health Care Worker Background Check (Indicate # of checks performed)	
Dues	5,532
Inter Reim	2,379
Newsletter	3,137
Publications	1,799
Shrd Employees	(220)
Public Relations	3,233
Less: Public Relations Expense	( )
Non-allowable advertising	(18,753)
Yellow page advertising	(493)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,946

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 991
In-State Travel	3,385
Seminar Expense	
Travel - Resource & Marketing	(287)
Out of State Travel	(991)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,098

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERV # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GOOD SAMARITAN SOCIETY - PROPHETS RIVERVIEW # 12955 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8.45 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,705** 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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,422**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **19%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **LARSON ALLEN LLP**

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

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