		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: 7344

Facility Name: GOOD SAMARITAN SOCIETY-MOUNT CARROLL

Address: 1006 N LOWDEN RD (Number) MOUNT CARROLL (City) 61053-0008 (Zip Code)

County: CARROLL

Telephone Number: 815-244-7150 **Fax #** 815-244-3127

HFS ID Number:

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

Type of Ownership:

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

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)	JOE HERDINA
	(Title)	Vice President of Finance
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-MOUNT CARROLL # 7344 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,551	7,463	2,454	21,468	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,551	7,463	2,454	21,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.69%

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

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

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 [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 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 [X] 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-MOUNT C # 7344 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	196,536	8,295	6,737	211,568		211,568	(171)	211,397			1
2	Food Purchase		136,692		136,692		136,692	(13,375)	123,317			2
3	Housekeeping	68,119	16,636		84,755		84,755	(363)	84,392			3
4	Laundry	38,914	8,470		47,384		47,384	(186)	47,198			4
5	Heat and Other Utilities			82,970	82,970		82,970		82,970			5
6	Maintenance	65,462	9,371	53,602	128,435		128,435	(1,912)	126,523			6
7	Other (specify):*			1,797	1,797		1,797	(527)	1,270			7
8	TOTAL General Services	369,031	179,464	145,106	693,601		693,601	(16,534)	677,067			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,240,245	145,353	2,823	1,388,421		1,388,421	(76,349)	1,312,072			10
10a	Therapy		174	223,014	223,188		223,188	(46,484)	176,704			10a
11	Activities	71,403	2,459	11,095	84,957		84,957	(8,834)	76,123			11
12	Social Services	38,287	26	1,824	40,137		40,137	(1)	40,136			12
13	CNA Training											13
14	Program Transportation			4,774	4,774		4,774		4,774			14
15	Other (specify):*	1,273			1,273		1,273		1,273			15
16	TOTAL Health Care and Programs	1,351,208	148,012	245,930	1,745,150		1,745,150	(131,668)	1,613,482			16
	C. General Administration											
17	Administrative	60,586		144,233	204,819		204,819	51,409	256,228			17
18	Directors Fees											18
19	Professional Services			4,211	4,211		4,211		4,211			19
20	Dues, Fees, Subscriptions & Promotions			17,223	17,223		17,223	(12,698)	4,525			20
21	Clerical & General Office Expenses	134,343	26,777	66,374	227,494		227,494	830	228,324			21
22	Employee Benefits & Payroll Taxes			437,626	437,626		437,626	(18,196)	419,430			22
23	Inservice Training & Education			7,567	7,567		7,567	(115)	7,452			23
24	Travel and Seminar			3,298	3,298		3,298	(1,064)	2,234			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,537	17,537		17,537	12,641	30,178			26
27	Other (specify):*	11,629		177	11,806		11,806		11,806			27
28	TOTAL General Administration	206,558	26,777	698,246	931,581		931,581	32,807	964,388			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,926,797	354,253	1,089,282	3,370,332		3,370,332	(115,395)	3,254,937			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-MOUNT CARROLL #7344 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			172,118	172,118		172,118		172,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			323	323		323	(323)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,332	5,332		5,332	(14)	5,318			35
36	Other (specify):*											36
37	TOTAL Ownership			177,773	177,773		177,773	(337)	177,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		10		10		10		10			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,420	39,420		39,420		39,420			42
43	Other (specify):*			7,140	7,140		7,140	(7,140)				43
44	TOTAL Special Cost Centers		10	46,560	46,570		46,570	(7,140)	39,430			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,926,797	354,263	1,313,615	3,594,675		3,594,675	(122,872)	3,471,803			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-MOUNT CARROLL # 7344 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,375)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,780)	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	2,421	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	(161,720)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,454)		$	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))**	$ (181,454)		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

STATE OF ILLINOIS

GOOD SAMARITAN SOCIETY-MOUNT CARROLL

ID# 7344

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See attached schedule	$ (171)	1	1
2	See attached schedule	(46,484)	10a	2
3	See attached schedule		2	3
4	See attached schedule	(363)	3	4
5	See attached schedule	(186)	4	5
6	See attached schedule		5	6
7	See attached schedule	(1,912)	6	7
8	See attached schedule	(527)	7	8
9	See attached schedule		8	9
10	See attached schedule		9	10
11	See attached schedule	(76,349)	10	11
12	See attached schedule	(54)	11	12
13	See attached schedule	(1)	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		21	18
19	See attached schedule		18	19
20	See attached schedule		19	20
21	See attached schedule	(12,698)	20	21
22	See attached schedule	(1,591)	21	22
23	See attached schedule	(922)	22	23
24	See attached schedule	(115)	23	24
25	See attached schedule	(1,064)	24	25
26	See attached schedule		25	26
27	See attached schedule	(11,806)	26	27
28	See attached schedule		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	(323)	32	33
34	See attached schedule		33	34
35	See attached schedule		34	35
36	See attached schedule	(14)	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		40	41
42	See attached schedule		41	42
43	See attached schedule		42	43
44	See attached schedule	(7,140)	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**	(161,720)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROLL # 7344 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	(171)	0	0	0	0	0	0	0	0	0	0	(171)	1
2	Food Purchase	(13,375)	0	0	0	0	0	0	0	0	0	0	(13,375)	2
3	Housekeeping	(363)	0	0	0	0	0	0	0	0	0	0	(363)	3
4	Laundry	(186)	0	0	0	0	0	0	0	0	0	0	(186)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,912)	0	0	0	0	0	0	0	0	0	0	(1,912)	6
7	Other (specify):*	(527)	0	0	0	0	0	0	0	0	0	0	(527)	7
8	**TOTAL General Services**	(16,534)	0	0	0	0	0	0	0	0	0	0	(16,534)	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	(76,349)	0	0	0	0	0	0	0	0	0	0	(76,349)	10
10a	Therapy	(46,484)	0	0	0	0	0	0	0	0	0	0	(46,484)	10a
11	Activities	(8,834)	0	0	0	0	0	0	0	0	0	0	(8,834)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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**	(131,668)	0	0	0	0	0	0	0	0	0	0	(131,668)	16
	C. General Administration													
17	Administrative	0	51,409	0	0	0	0	0	0	0	0	0	51,409	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	(12,698)	0	0	0	0	0	0	0	0	0	0	(12,698)	20
21	Clerical & General Office Expenses	830	0	0	0	0	0	0	0	0	0	0	830	21
22	Employee Benefits & Payroll Taxes	(922)	(17,274)	0	0	0	0	0	0	0	0	0	(18,196)	22
23	Inservice Training & Education	(115)	0	0	0	0	0	0	0	0	0	0	(115)	23
24	Travel and Seminar	(1,064)	0	0	0	0	0	0	0	0	0	0	(1,064)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(11,806)	24,447	0	0	0	0	0	0	0	0	0	12,641	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,775)	58,582	0	0	0	0	0	0	0	0	0	32,807	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,977)	58,582	0	0	0	0	0	0	0	0	0	(115,395)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
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	(323)	0	0	0	0	0	0	0	0	0	0	(323)	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	(14)	0	0	0	0	0	0	0	0	0	0	(14)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(337)	0	0	0	0	0	0	0	0	0	0	(337)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(7,140)	0	0	0	0	0	0	0	0	0	0	(7,140)	43
44	**TOTAL Special Cost Centers**	(7,140)	0	0	0	0	0	0	0	0	0	0	(7,140)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(181,454)	58,582	0	0	0	0	0	0	0	0	0	(122,872)	45

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROLL # 7344 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin/Accting	$ 144,233	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 195,642	$ 51,409	1
2	V	22	Workers Comp	48,435			86,130	37,695	2
3	V	22	Unemployment	9,133			9,502	369	3
4	V	26	Insurance	17,537			41,984	24,447	4
5	V	22	Group Health Insurance	206,122			150,784	(55,338)	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			$ 425,460			$ 484,042	$ * 58,582	14

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT (# 7344 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								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-MOUNT CARROLL # 7344 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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-MOUNT C# 7344 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	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-MOUNT CARROLL # 7344 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

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

Item	Amount	Line
1. Real Estate Tax accrual used on 2010 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:	Amount	Line
2006		8
2007		9
2008		10
2009		11
2010		12

FOR BHF USE ONLY

Line	Description	Amount	Line
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-MOUNT CARROLL COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 7344

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)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,795 B. General Construction Type: Exterior ______ Frame ______ Number of Stories ______

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

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

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

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

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

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			1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROLL # 7344 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			1970	1970	$ 418,766	$		$	$	$ 418,766	4
5			1991	1991	912,123	11,477		11,477		909,588	5
6			2010	2010	192,900	7,716		7,716		14,146	6
7											7
8											8
	Improvement Type**										
9				1970	3,703					3,703	9
10				1971	382	5		5		382	10
11				1975	1,986					1,986	11
12				1976	3,352					3,352	12
13				1977	185					185	13
14				1979	6,037					6,037	14
15				1980	1,559					1,559	15
16				1981	33,937					33,627	16
17				1982	29,188					29,188	17
18				1983	8,193					8,193	18
19				1985	1,224					1,224	19
20				1985	14,500					14,500	20
21				1986	14,463					14,463	21
22				1987	15,273					15,273	22
23				1988	17,879					17,879	23
24				1989	6,652					6,652	24
25				1990	24,930					24,930	25
26				1991	98,158					98,158	26
27				1992	10,950	518		518		10,950	27
28				1993	4,994					4,994	28
29				1994	68,612	558		558		67,281	29
30				1995	36,887					36,887	30
31				1996	177,229	3,822		3,822		159,407	31
32				1997	24,046	877		877		19,563	32
33				1998	16,770	856		856		13,030	33
34				1999	37,004	888		888		30,943	34
35				2000	88,586	1,057		1,057		69,882	35
36				2002	52,368	4,071		4,071		38,078	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-MOUNT CARROLL # 7344 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		2003	$ 58,269	$ 3,049		$ 3,049	$	$ 25,720	37
38		2004	15,218	606		606		10,280	38
39		2005	109,024	3,644		3,644		48,744	39
40		2006	385,284	18,411		18,411		104,426	40
41		2007	33,074	6,768		6,768		20,385	41
42	HARDWARE FOR DOORS	2008	2,083	139	180	139		532	42
43	BLINDS	2008	3,895	779	60	779		2,921	43
44	Chiller	2008	43,782	2,919	180	2,919		10,459	44
45	Rooftop AC unit Replacement	2008	7,943	530	180	530		1,942	45
46	ADJUSTABLE DOOR CLOSER	2008	2,066	207	120	207		706	46
47	Doors	2008	3,720	248	180	248		909	47
48	DOOR AND FRAME	2008	4,990	333	180	333		1,109	48
49	ADA GOOSENECK FAUCET	2008	647	32	240	32		100	49
50	8X34 KICKPLATES FOR DOORS	2008	630	84	90	84		294	50
51	ROOFTOP A/C -FRONT OFFICE AREA	2009	15,724	1,048	180	1,048		2,708	51
52	CHICAGO TWO HANDLE FAUCET (4)	2009	514	26	240	26		62	52
53	BACKFLOW PREVENTOR	2009	4,000	200	240	200		433	53
54	Asbestos Flooring Removal	2009	20,700	2,070	120	2,070		5,003	54
55	LAMINATE WOOD DOOR/AMBER CHRRY	2009	729	49	180	49		97	55
56	LAM WOOD DOORS (2) & HARDWARE	2009	4,200	280	180	280		630	56
57	REPAIR GENERATOR -ASSET#187349	2009	3,103	310	120	310		621	57
58	OUTSIDE DOOR AND HARDWARE	2010	4,652	310	180	310		569	58
59	DIGITAL VIDEO SYSTEM	2010	26,540	2,654	120	2,654		5,087	59
60	REPAIR ROOF - ICE DAMAGE	2010	3,300	330	120	330		578	60
61	20' SUNSETTER RETRACTBL AWNING	2010	3,474	386	108	386		676	61
62	Air Cond-BathNurseStation Rmdl	2010	3,176	318	120	318		582	62
63	Building-BathNurseStation Rmdl				300				63
64	Carpet-BathNurseStation Rmdl	2010	6,514	1,303	60	1,303		2,389	64
65	Doors-BathNurseStation Rmdl	2010	980	65	180	65		120	65
66	Electric-BathNurseStation Rmdl	2010	24,946	1,663	180	1,663		3,049	66
67	HVAC-BathNurseStation Rmdl	2010	6,365	424	180	424		778	67
68	Paint-BathNurseStation Rmdl	2010	19,405	3,881	60	3,881		7,115	68
69	Plumbing-BathNurseStation Rmdl	2010	4,233	212	240	212		388	69
70	TOTAL (lines 4 thru 69)		$ 3,146,016	$ 85,122		$ 85,122	$	$ 2,334,216	70

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROLL # 7344 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		$ 3,146,016	$ 85,122		$ 85,122	$	$ 2,334,216	1
2	NURSING CALL LIGHT SYSTEM	2010	8,851	885	120	885		1,328	2
3	REPEATER	2010	541	108	60	108		162	3
4	PANIC BAR FOR EXIT DOOR	2010	690	69	120	69		109	4
5	COPPER PIPE-CHLLR/BOILR TO RMS	2010	30,000	1,200	300	1,200		1,700	5
6	WEIL MCLAIN 230 BOILER	2010	9,172	459	240	459		535	6
7	GARAGE DOOR AND OPERATOR	2010	1,804	180	120	180		226	7
8	7.5 TON ROOFTOP UNIT 100 WING	2011	8,760	657	120	657		657	8
9	300 WING DOOR AND CLOSER	2011	2,531	63	120	63		63	9
10	Logo Sign	2008	9,000	900	120	900		3,375	10
11	ConcreteParkingLot/Curb/Gutter	2008	77,206	5,153	180	5,153		17,515	11
12	40' COMMERCIAL FLAGPOLE	2009	1,975	98	240	98		288	12
13	Concrete Parking Lot	2009	77,080	3,854	240	3,854		9,314	13
14	PREP&POUR SIDEWALK 800SQ FT	2010	2,975	198	180	198		331	14
15	ConcreteSidewalk-West Side Bld	2010	19,895	1,326	180	1,326		2,211	15
16	SIDEWALK REMOVAL AND REPOUR	2011	3,822	191	180	191		191	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	TOTAL (lines 1 thru 33)		$ 3,400,318	$ 100,464		$ 100,464	$	$ 2,372,220	34

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROI # 7344 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	$ 664,534	$ 64,067	$ 64,067	$		$ 383,947	71
72	Current Year Purchases	16,882	1,424	1,424			1,424	72
73	Fully Depreciated Assets	521,427	2,596	2,596			521,427	73
74								74
75	TOTALS	$ 1,202,843	$ 68,087	$ 68,087	$		$ 906,798	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	Bus	2002	$ 42,763	$	$	$		$ 42,763	76
77	Resident Use	2002 Odsmobile Silhouette	2005	15,173					15,173	77
78	Resident Use	2005 Chevy Pickup truck	2009	14,273	3,568	3,568		4	7,136	78
79										79
80	TOTALS			$ 72,209	$ 3,568	$ 3,568	$		$ 65,072	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)	$ 4,681,090	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 172,119	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,119	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)	$ 3,344,090	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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: $ 5,332 Description: GSS Computers, Admin Technicare Nursing
(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-MOUNT CARROLL # 7344 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.

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	Ln 10a, Col 3	hrs	$	6,756	$ 101,337	$	6,756	$ 101,337	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		682	10,233		682	10,233	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 3	hrs		7,430	111,445		7,430	111,445	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			$	14,868	$ 223,015	$	14,868	$ 223,015	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-MOUNT CARROLL # 7344 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	$ 52,509	$	1
2	Cash-Patient Deposits	1,842		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (37,790))	638,383		3
4	Supply Inventory (priced at)	8,264		4
5	Short-Term Investments	1,295,885		5
6	Prepaid Insurance	5,829		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)**	$ 2,002,712	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	3,031,686		14
15	Leasehold Improvements, at Historical Cost	368,630		15
16	Equipment, at Historical Cost	1,276,375		16
17	Accumulated Depreciation (book methods)	(3,344,089)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	130,874		21
22	Other Long-Term Assets (spe CIP	64,652		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,533,848	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,536,560	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 145,506	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,842		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	154,864		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 302,212	$	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	Annuities	20,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 20,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 322,212	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,214,348	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,536,560	$	48

*(See instructions.)

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROLL # 7344 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**	$ 3,069,482	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,069,482	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	275,678	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)**	$ 275,678	17
	B. Transfers (Itemize):		
18	**Reserve Fund Assessment NC**	(108,570)	18
19	**Technology User Assessment NC**	(17,268)	19
20	**Donor Rst Prop/Oper Gift-Cash**	(4,974)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (130,812)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,214,348	24 *

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARRC # 7344 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	$ 3,815,995	1
2	Discounts and Allowances for all Levels	(1,175,359)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,640,636	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	731,326	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 731,326	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	13,375	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	14	16
17	Sale of Drugs	184,689	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,014	19
20	Radiology and X-Ray	2,930	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 215,022	23
	D. Non-Operating Revenue		
24	Contributions	141,242	24
25	Interest and Other Investment Income***	29,254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 170,496	26
	E. Other Revenue (specify):*****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Nursing & Medical Supplies	77,632	28
28a	Misc Income/PY Settlements/Bad debt/Gains	35,241	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 112,873	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,870,353	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	692,765	31
32	Health Care	1,745,986	32
33	General Administration	931,581	33
	B. Capital Expense		
34	Ownership	177,773	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,420	36
	D. Other Expenses (specify):		
37	Other	7,150	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,594,675	40
41	**Income before Income Taxes (line 30 minus line 40)****	275,678	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 275,678	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.

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARROLL # 7344 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,090	1,826	$ 57,280	$ 31.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,837	15,136	398,254	26.31	3
4	Licensed Practical Nurses	4,458	4,194	94,151	22.45	4
5	CNAs & Orderlies	60,327	55,419	655,353	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,911	1,698	26,597	15.66	9
10	Activity Assistants	5,270	4,747	45,914	9.67	10
11	Social Service Workers	2,060	1,837	37,996	20.68	11
12	Dietician					12
13	Food Service Supervisor	2,048	1,723	31,174	18.09	13
14	Head Cook	5,652	5,020	56,846	11.32	14
15	Cook Helpers/Assistants	11,962	10,860	109,679	10.10	15
16	Dishwashers					16
17	Maintenance Workers	4,954	4,415	66,109	14.97	17
18	Housekeepers	6,861	5,954	70,653	11.87	18
19	Laundry	4,366	3,991	39,168	9.81	19
20	Administrator	1,802	1,693	58,155	34.35	20
21	Assistant Administrator					21
22	Other Administrative	8,932	8,319	165,983	19.95	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	1,877	1,659	30,107	18.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,407	128,491	$ 1,943,419 *	$ 15.12	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	24	2,400	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,426	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	24	1,857	Ln 11, Col 3	44
45	Social Service Consultant	24	1,824	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	$ 8,507		49

C. CONTRACT NURSES

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

Facility Name & ID Number GOOD SAMARITAN SOCIETY-MOUNT CARRO # 7344 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
David Simon	Administrator	0	$	60,586
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	60,586

B. Administrative - Other

Description		Amount
Admin/Accounting	$	144,233
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	144,233

C. Professional Services

Vendor/Payee	Type		Amount
Professional Services		$	367
Medicare Cost report preparation			850
Medicaid Cost report preparation			1,000
Contract Services - admin			1,994
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$	4,211

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	48,435
Unemployment Compensation Insurance		9,133
FICA Taxes		142,979
Employee Health Insurance		206,122
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Pension		37,691
Taxable Gifts		100
Other		522
NCO Adjustments		(17,276)
Resource Development expenses		(922)
Shared Employee Benefits		(7,354)
TOTAL (agree to Schedule V, line 22, col.8)	$	419,430

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

Description	Line #		Amount
		$	
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	
Advertising: Employee Recruitment		6,949
Health Care Worker Background Check (Indicate # of checks performed)		
Dues		4,150
Inter reim		2,160
Newsletter		2,678
Publications		1,004
Public Relations		282
Less: Public Relations Expense	(	)
Non-allowable advertising		(12,408)
Yellow page advertising		(290)
TOTAL (agree to Sch. V, line 20, col. 8)	$	4,525

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	1,029
In-State Travel		2,269
Seminar Expense		
Travel - Resource & Marketing		(35)
Out of State Travel		(1,029)
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	2,234

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	Heating	01/02	1,738	10	174	174	174	174	174	172			
3	Heating	04/02	1,288	10	129	129	129	129	129	127			
4	Heating	01/01	219	10	22	22	22	21					
5	Plumbing	02/01	910	10	91	91	91	91					
6	Wallpaper	07/01	230	5	49								
7	Paint	08/01	390	5	49								
8	Air Condition	09/01	511	10	51	51	51	51	51				
9	Air Condition	10/01	1,841	10	184	184	184	184	184				
10	Air Condition	02/01	901	10	90	90	90	90	90				
11	Plumbing	04/01	87	10	9	9	9	9	9				
12	Plumbing	01/01	5,879	10	58	58	58	58	58				
13	Heating	05/01	152	10	15	15	15	15	15				
14	Plumbing	08/01	1,402	10	140	140	140	140	140				
15	Plumbing	01/03	1,787	10	179	179	179	179	179	179	179		
16													
17													
18													
19													
20	TOTALS		$ 17,335		$ 1,240	$ 1,142	$ 1,142	$ 1,141	$ 1,029	$ 478	$ 179	$	$

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? ______
If YES, give association name and amount. **Life Service 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? **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,988** 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. $ **39,420**
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. $ **13,375**

(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? **4%**
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? **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. $ ______

(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 out of Schedule V? **N/A**

(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.