FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0050567

Facility Name: Good Samaritan-Flanagan

Address: 205 N Adams St (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2288 **Fax #** 815-796-2280

HFS ID Number:

Date of Initial License for Current Owners: 12/1/68

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 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Rob Schlicht **Telephone Number:** 414-431-9335
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 1/1/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Rob Schlicht, Director

(Firm Name & Address) Wipfli LLP, 10000 Innovation Drive, Suite 250, Milwaukee WI 53226

(Telephone) 414-431-9335 Fax # 414-431-9303

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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	60	Skilled (SNF)	60	21,960	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	60	TOTALS	60	21,960	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	9,145	9,048	1,737	19,930	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,145	9,048	1,737	19,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.76%

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)
Peace Meals

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

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

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 12/1/1968

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 60 and days of care provided 1,266

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,834	12,313	5,178	211,325		211,325		211,325			1
2	Food Purchase		155,753		155,753		155,753	(11,749)	144,004			2
3	Housekeeping	71,408	16,006	791	88,205		88,205		88,205			3
4	Laundry	46,168			46,168		46,168		46,168			4
5	Heat and Other Utilities			63,118	63,118		63,118		63,118			5
6	Maintenance	70,238	8,546	62,253	141,037		141,037	(8,339)	132,698			6
7	Other (specify):*											7
8	TOTAL General Services	381,648	192,618	131,340	705,606		705,606	(20,088)	685,518			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	984,631	45,347	11,153	1,041,131		1,041,131		1,041,131			10
10a	Therapy			251,963	251,963		251,963		251,963			10a
11	Activities	68,106	2,167	12,111	82,384		82,384		82,384			11
12	Social Services	18,863	25	613	19,501		19,501		19,501			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,071,600	47,539	281,840	1,400,979		1,400,979		1,400,979			16
	C. General Administration											
17	Administrative	49,433			49,433		49,433		49,433			17
18	Directors Fees											18
19	Professional Services			26,260	26,260		26,260		26,260			19
20	Dues, Fees, Subscriptions & Promotions			9,079	9,079		9,079		9,079			20
21	Clerical & General Office Expenses	164,104	6,988	51,494	222,586		222,586		222,586			21
22	Employee Benefits & Payroll Taxes			429,668	429,668		429,668		429,668			22
23	Inservice Training & Education											23
24	Travel and Seminar			873	873		873		873			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			120,188	120,188		120,188		120,188			26
27	Other (specify):*											27
28	TOTAL General Administration	213,537	6,988	637,562	858,087		858,087		858,087			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,666,785	247,145	1,050,742	2,964,672		2,964,672	(20,088)	2,944,584			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-Flanagan #0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			93,630	93,630		93,630	(27,333)	66,297			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,272	13,272		13,272	(11,505)	1,767			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			106,902	106,902		106,902	(38,838)	68,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,321		21,321		21,321		21,321			39
40	Barber and Beauty Shops		11,730		11,730		11,730		11,730			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,725	161,725		161,725		161,725			42
43	Other (specify):* **See grouping**	13,170		232,960	246,130		246,130	(246,130)				43
44	**TOTAL Special Cost Centers**	13,170	33,051	394,685	440,906		440,906	(246,130)	194,776			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,679,955	280,196	1,552,329	3,512,480		3,512,480	(305,056)	3,207,424			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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	(11,749)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,339)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,333)	30		9
10	Interest and Other Investment Income	(11,505)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				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	(246,130)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (305,056)		$	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))**	$ (305,056)		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-Flanagan

ID# 0050567

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartments	$ (19,759)	43	1
2	Duplexes	(137,400)	43	2
3	Ancillary lab expenses	(7,563)	43	3
4	Ancillary xray expenses	(1,103)	43	4
5	Newsletter expense	(353)	43	5
6	Flower expense	(754)	43	6
7	Resident Expense	(1,980)	43	7
8	Volunteer apprciation	(588)	43	8
9	Summerfest expense	(458)	43	9
10	Strategic consulting	(250)	43	10
11	Staff fund raisers	(308)	43	11
12	Public relations	(3,388)	43	12
13	Marketing	(2,007)	43	13
14	Med Cash Fee	(56,510)	43	14
15	Non allowable fund development salaries	(13,170)	43	15
16	Gift/Memorial Expense	(539)	43	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(246,130)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,749)	0	0	0	0	0	0	0	0	0	0	(11,749)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(8,339)	0	0	0	0	0	0	0	0	0	0	(8,339)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,088)	0	0	0	0	0	0	0	0	0	0	(20,088)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,088)	0	0	0	0	0	0	0	0	0	0	(20,088)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan-Flanagan **#** 0050567 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	(27,333)	0	0	0	0	0	0	0	0	0	0	(27,333)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,505)	0	0	0	0	0	0	0	0	0	0	(11,505)	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**	(38,838)	0	0	0	0	0	0	0	0	0	0	(38,838)	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):*	(246,130)	0	0	0	0	0	0	0	0	0	0	(246,130)	43
44	**TOTAL Special Cost Centers**	(246,130)	0	0	0	0	0	0	0	0	0	0	(246,130)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(305,056)	0	0	0	0	0	0	0	0	0	0	(305,056)	45

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES

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

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

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				$	n/a		$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	GOOD SAMARITAN FLANAGAN BOARD		Good Samaritan - Pontiac	Pontiac IL				1
2	Richard Hiatt	BOD						2
3	Allen Toepper	BOD						3
4	Pastor Gabriel Baumgardner	BOD						4
5	Jeff Rients	BOD						5
6	Marilyn Shields	BOD						6
7	Pauline Murray	BOD						7
8	Alrene Martin	BOD						8
9	Gene Simmons	BOD						9
10	Dennis Jones	BOD						10
11	Pastor Michael Scully	BOD						11
12								12
13								13
14								14
15								15
16								16
17	Good Samaritan Group Board	BOD	Good Samaritan - Pontiac	Pontiac IL				17
18	Richard Hiatt	BOD						18
19	William Coffin	BOD						19
20	Alrene Martin	BOD						20
21	Allen Toepper	BOD						21
22	Pauline Murray	BOD						22
23	Jeff Rients	BOD						23
24	Audrey Harlan	BOD						24
25	Joe Imhoff	BOD						25
26								26
27								27
28	No member of either board provides services to the facility nor owns or has interest in a business that provides services to the facility							28
29								29
30								30

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	See page 6 supplemental	Board of Directors	Administrative	0.00	n/a	1	2.00	n/a	n/a	n/a	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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Flanagan State Bank		x	Mortgage	Int & Princip	4/18/08	$ 361,000	$ 279,385		6.0000	$ 13,272	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 361,000	$ 279,385			$ 13,272	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13									Interest income		(11,505)	13
14	TOTAL Non-Facility Related						$	$			$ (11,505)	14
15	TOTALS (line 9+line14)						$ 361,000	$ 279,385			$ 1,767	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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 54,984	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.)		$ 54,184	2
3. Under or (over) accrual (line 2 minus line 1).		$ (800)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,984	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.)**		$ (54,184)	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:			
	2007	52,557	8
	2008	53,671	9
	2009	54,017	10
	2010	56,663	11
	2011	54,984	12

Real estate taxes applies to duplexes and is eliminated on schedule V, line 43, column 7

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan-Flanagan COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050567

CONTACT PERSON REGARDING THIS REPORT Rob Schlicht

TELEPHONE 414-431-9335 FAX #: 414-431-9303

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-22-278-009	Duplexes	$ 54,184.48	$
2.			$	$
3.	Real estate taxes applies to duplexes and is eliminated on schedule V, line 43, column 7		$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,184.48	$

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? x 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,700 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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).

Independent living facilities - duplexes and congregate living apartments

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	14 acres	1966	$ 22,917	1
2					2
3	TOTALS	#VALUE!		$ 22,917	3

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	60		1968	1968	$ 754,053	$	40	$	$	$ 754,053	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	49,983		20	584	584	27,953	9
10	Various			1981	4,961		20			4,961	10
11	Various			1982	7,246		20			7,246	11
12	Various			1991	58,000		20			58,000	12
13	Various			1992	49,137		20			49,137	13
14	Various			1995	257,361		20	6,454	6,454	111,543	14
15	Various			1996	30,610		20	765	765	13,009	15
16	Various			1997	29,894		20	766	766	11,782	16
17	Various			2000	34,290		20	1,040	1,040	13,271	17
18	Various			2001	150,943		20			150,943	18
19	Kitchen and office addition			2000	739,459		10			669,456	19
20	Painting			2000	2,680		10			2,390	20
21	None			2000	1,629		10			1,629	21
22	New Floors			2000	872		10	30	30	872	22
23	Air conditioner compressor			2000	6,651		10	333	333	6,651	23
24	Cabling			2003	1,541		10	154	154	1,450	24
25	Windows			2003	6,350		10	635	635	5,768	25
26	Brass plaques			2003	884		15	59	59	590	26
27	Dishwasher rack			2003	160		7			160	27
28	Kitchen addition			2003	60,663		7			60,663	28
29	Kitchen addition			2003	6,019		7			6,019	29
30	Kitchen addition			2003	113,993		7			113,993	30
31	Kitchen addition			2003	2,086		7			2,086	31
32	Mini blinds			2003	616		10	69	69	616	32
33	Mini blinds			2003	2,236		10	221	221	2,236	33
34	Telephone system			2003	(4,707)		10	(469)	(469)	(4,707)	34
35	Kitchen addition			2003	60,514		7			60,514	35
36	Kitchen addition			2003	9,492		7			9,492	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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Kitchen Addition	2003	$ 5,377	$	7	$	$	$ 5,377	37
38	Mc Cable	2003	589		10	59	59	555	38
39	Kitchen Addition	2003	2,562		7			2,562	39
40	Wire	2003	2,045		10	205	205	1,895	40
41	Backflow preventer	2003	398		10	40	40	386	41
42	HVAC	2003	865		10	87	87	833	42
43	Kitchen & Office addition	2003	480		20	24	24	218	43
44	Phone Switch	2003	150		10	15	15	121	44
45	Paint rooms	2004	1,120		10	112	112	882	45
46	Am carad for boiler	2004	816		10	81	81	642	46
47	Door alarm service	2004	597		5			597	47
48	Repair south chiller/fans	2004	440		5			440	48
49	Blacktop home	2005	1,176		20	59	59	439	49
50	Painting	2005	2,200		10	220	220	1,723	50
51	Nurses station	2005	5,000		20	250	250	1,792	51
52									52
53	Nurses station updgrade	2006	1,279		20	32	32	224	53
54	General project parts - nurses station	2006	1,127		20	28	28	196	54
55	Fire safety systems additions	2006	2,977		20	74	74	518	55
56	Phone lines	2006	344		10	17	17	119	56
57	Annunciation panel	2006	5,554		10	278	278	1,946	57
58	Entryway flooring, wallcovering, and countertop replace	2007	6,024		10	409	409	2,454	58
59	Water heater install and plumbing	2007	10,500		10	788	788	4,728	59
60	Doorlock system	2007	13,986		10	466	466	2,796	60
61	Water heater replacement	2007	18,612		10	1,396	1,396	8,376	61
62	Landscaping - painting and patch wrok	2008	3,332		10	333	333	1,665	62
63	Heat pump	2009	6,478		10	648	648	2,268	63
64	Fire alarm upgrade	2009	15,977		10	1,065	1,065	3,727	64
65	New roof - nursing home	2010	93,753		15	2,344	2,344	5,469	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,641,374	$		$ 19,671	$ 19,671	$ 2,194,724	70

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

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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		$ 2,641,374	$		$ 19,671	$ 19,671	$ 2,194,724	1
2	Sprinkler System	2011	22,847		15	1,523	1,523	1,904	2
3	HVAC Compressor	2011	10,722		12	894	894	1,490	3
4	Installation new indoor & outdoor lighting, new wiring, outlets	2011	7,463		10	746	746	1,119	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,682,406	$		$ 22,834	$ 22,834	$ 2,199,237	34

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

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 405,912	$	$ 37,694	$ 37,694	5-15	$ 361,663	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	664,595					664,595	73
74								74
75	TOTALS	$ 1,070,507	$	$ 37,694	$ 37,694		$ 1,026,258	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 Care	Ford E450	1998	$ 48,859	$	$	$		$ 48,859	76
77	Resident Care	Brake Repairs Ford E450	2006	1,792					1,792	77
78	Resident Care	Dodge Sprinter Van	2007	47,092		5,769	5,769	7	30,860	78
79										79
80	TOTALS			$ 97,743	$	$ 5,769	$ 5,769		$ 81,511	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)	$ 3,873,573	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,297	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,297	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,307,006	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.

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ N/A Description: N/A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	10a(3)	hrs	$		$ 116,530	$		$ 116,530	1
2	Licensed Speech and Language Development Therapist	10a(3)	hrs			20,675			20,675	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a(3)	hrs			114,757			114,757	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				18,539		18,539	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): oxygen	39(2)					2,579		2,579	13
14	TOTAL			$		$ 251,962	$ 21,118		$ 273,080	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.

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 506,400	$ 506,400	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,330,160	1,330,160	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	75,520	75,520	5
6	Prepaid Insurance	63,844	63,844	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)**	$ 1,975,924	$ 1,975,924	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	486,270	486,270	12
13	Land		22,917	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		5,751,448	15
16	Equipment, at Historical Cost		1,068,249	16
17	Accumulated Depreciation (book methods)		(4,041,704)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 486,270	$ 3,287,180	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,462,194	$ 5,263,104	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 752,425	$ 752,425	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,628	181,628	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,984	54,984	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	see grouping schedule	171,115	171,115	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,160,152	$ 1,160,152	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	280,725	280,725	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred support	974,939	974,939	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,255,664	$ 1,255,664	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,415,816	$ 2,415,816	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 46,378	$ 2,847,288	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,462,194	$ 5,263,104	48

*(See instructions.)

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (725,065)	1
2	Restatements (describe):	(252,420)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (977,485)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,023,863	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,023,863	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 46,378	24 *

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

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,239,345	1
2	Discounts and Allowances for all Levels	(75,550)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,163,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	376,690	6
7	Oxygen	13,048	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 389,738	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	12,182	13
14	Non-Patient Meals	11,749	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,811	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,110	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,588	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 97,440	23
	D. Non-Operating Revenue		
24	Contributions	106,431	24
25	Interest and Other Investment Income***	11,505	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 117,936	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See grouping schedule	767,434	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 767,434	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,536,343	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	705,606	31
32	Health Care	1,400,979	32
33	General Administration	858,087	33
	B. Capital Expense		
34	Ownership	106,902	34
	C. Ancillary Expense		
35	Special Cost Centers	279,181	35
36	Provider Participation Fee	161,725	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,512,480	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,023,863	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,023,863	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,956	2,530	$ 71,716	$ 28.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,770	6,551	155,401	23.72	3
4	Licensed Practical Nurses	8,683	9,546	235,726	24.69	4
5	CNAs & Orderlies	41,438	45,778	521,788	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,787	2,020	27,083	13.41	9
10	Activity Assistants	4,281	4,990	41,023	8.22	10
11	Social Service Workers	1,553	1,711	18,863	11.02	11
12	Dietician					12
13	Food Service Supervisor	1,740	1,937	28,097	14.51	13
14	Head Cook	4,713	4,998	49,668	9.94	14
15	Cook Helpers/Assistants	10,076	11,011	116,069	10.54	15
16	Dishwashers					16
17	Maintenance Workers	3,587	3,924	70,238	17.90	17
18	Housekeepers	6,350	7,241	71,408	9.86	18
19	Laundry	4,225	4,714	46,168	9.79	19
20	Administrator	1,858	2,032	49,433	24.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,335	6,154	164,104	26.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	430	480	13,170	27.44	33
34	TOTAL (lines 1 - 33)	103,782	115,617	$ 1,679,955 *	$ 14.53	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	78	$ 3,306	1(3)	35
36	Medical Director	44	6,000	9(3)	36
37	Medical Records Consultant	33	2,334	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	2x weekly	5,876	10(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	5	453	11(3)	44
45	Social Service Consultant	5	297	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	165	$ 18,266		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-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jordan Post	Administrator	0	$ 49,433
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,433

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Hartweg, Turner	Legal fees - collections	$ 2,997
McGladrey and Pullen	Consulting	500
McGladrey and Pullen	Audit	41,976
Payroll	Payroll processing	7,686
Journal entries		(26,899)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ (18,320)
Unemployment Compensation Insurance	24,276
FICA Taxes	131,700
Employee Health Insurance	284,832
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
employee physicals	1,279
Employee vaccines	1,401
Employee moralen and motivation	2,334
uniforms	(5,453)
employee pension plan	150
Benefit administration fee	7,469
TOTAL (agree to Schedule V, line 22, col.8)	$ 429,668

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	$ 1,990
Advertising: Employee Recruitment	1,103
Health Care Worker Background Check	
(Indicate # of checks performed 56)	679
Patient Background Checks 83	830
dues and subscriptinos	4,477
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,079

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	873
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 873

**See instructions.

Facility Name & ID Number Good Samaritan-Flanagan # 0050567 Report Period Beginning: 1/1/12 Ending: 12/31/12

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-Flanagan **#** 0050567 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,049** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **161,725**
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? **n/a**

(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. $ **n/a** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,749**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients?
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? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **no**

(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.