

		FOR BHF USE					

LL1

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

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.

<p><b>I. IDPH License ID Number:</b> <u>0050575</u></p> <p><b>Facility Name:</b> <u>Good Samaritan-Pontiac</u></p> <p><b>Address:</b> <u>15335 US Hwy 66</u> <u>Pontiac</u> <u>61764</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Livingston</u></p> <p><b>Telephone Number:</b> <u>815-844-5121</u> <b>Fax #</b> <u>815-844-5690</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>3/1/10</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Rob Schlicht</u> <b>Telephone Number:</b> <u>414-431-9335</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;"><b>Officer or Administrator of Provider</b></td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;"><b>Paid Preparer</b></td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>Rob Schlicht</u> <u>Director</u> (Firm Name &amp; Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u> (Telephone) <u>414-431-9335</u> Fax # <u>414-431-9303</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Rob Schlicht</u> <u>Director</u> (Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u> (Telephone) <u>414-431-9335</u> Fax # <u>414-431-9303</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Rob Schlicht</u> <u>Director</u> (Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee WI 53226</u> (Telephone) <u>414-431-9335</u> Fax # <u>414-431-9303</u>							

Facility Name & ID Number Good Samaritan-Pontiac

# 0050575 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	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	44	Skilled (SNF)	44	16,104	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,548	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,652	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,895	1,895	8
9	SNF/PED					9
10	ICF	10,874	2,379		13,253	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,874	2,379	1,895	15,148	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 33.92%

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

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

n/a

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 3/1/2010

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 3/1/2010 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 28 and days of care provided 1,038

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	165,869	8,167	4,311	178,347		178,347		178,347		1
2	Food Purchase		98,861		98,861		98,861	(6,319)	92,542		2
3	Housekeeping	67,347	15,512		82,859		82,859		82,859		3
4	Laundry	54,344	574	4,921	59,839		59,839		59,839		4
5	Heat and Other Utilities			156,294	156,294		156,294		156,294		5
6	Maintenance	82,827	1,384	71,792	156,003		156,003		156,003		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	370,387	124,498	237,318	732,203		732,203	(6,319)	725,884		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	848,498	37,704	10,297	896,499		896,499		896,499		10
10a	Therapy			261,287	261,287		261,287		261,287		10a
11	Activities	32,339	334	1,929	34,602		34,602		34,602		11
12	Social Services	37,481	25	792	38,298		38,298		38,298		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	918,318	38,063	282,705	1,239,086		1,239,086		1,239,086		16
	<b>C. General Administration</b>										
17	Administrative	68,370			68,370		68,370		68,370		17
18	Directors Fees										18
19	Professional Services			131,626	131,626		131,626		131,626		19
20	Dues, Fees, Subscriptions & Promotions			41,431	41,431		41,431		41,431		20
21	Clerical & General Office Expenses	78,675	3,382	220,714	302,771		302,771		302,771		21
22	Employee Benefits & Payroll Taxes			217,793	217,793		217,793		217,793		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,561	2,561		2,561		2,561		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			(20,537)	(20,537)		(20,537)		(20,537)		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	147,045	3,382	593,588	744,015		744,015		744,015		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,435,750	165,943	1,113,611	2,715,304		2,715,304	(6,319)	2,708,985		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-Pontiac

#0050575

Report Period Beginning:

1/1/12

Ending:

12/31/12

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							98,952	98,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>							98,952	98,952			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			56,069	56,069		56,069		56,069			39
40	Barber and Beauty Shops			432	432		432		432			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,154	156,154		156,154		156,154			42
43	Other (specify):*			9,584	9,584		9,584	(9,584)				43
44	<b>TOTAL Special Cost Centers</b>			222,239	222,239		222,239	(9,584)	212,655			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,435,750	165,943	1,335,850	2,937,543		2,937,543	83,049	3,020,592			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-Pontiac

# 0050575

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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,319)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	98,952	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,034)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,550)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 83,049		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 83,049		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Good Samaritan-Pontiac

ID# 0050575

Report Period Beginning: 1/1/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Xray expense	\$ (4,145)	43	1
2	Lab expenses	(4,405)	43	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>		(8,550)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan-Pontiac# 0050575

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,319)	0	0	0	0	0	0	0	0	0	0	(6,319)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,319)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,319)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(6,319)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,319)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan-Pontiac# 0050575

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	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)	
	<b>D. Ownership</b>													
30	Depreciation	98,952	0	0	0	0	0	0	0	0	0	0	98,952	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>98,952</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>98,952</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(9,584)	0	0	0	0	0	0	0	0	0	0	(9,584)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(9,584)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,584)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	83,049	0	0	0	0	0	0	0	0	0	0	83,049	45

**VII. RELATED PARTIES**

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number

Good Samaritan-Pontiac

# 0050575

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 - PONTIAC		Good Samaritan - Flanagan					1
2	Audrey Harlan	BOD						2
3	Pauline Murray	BOD						3
4	Allen Toeper	BOD						4
5	Jeff Rients	BOD						5
6	Richard Hiatt	BOD						6
7								7
8								8
9								9
10	GOOD SAMARITAN GROUP							10
11								11
12	Richard Hiatt	BOD						12
13	William Coffin	BOD						13
14	Arlene Martin	BOD						14
15	Allen Toeper	BOD						15
16	Pauline Murray	BOD						16
17	Jeff Rients	BOD						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Good Samaritan-Pontiac # 0050575 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See page 6 supplemental	Board Members	Administrative	0.00	n/a			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-Pontiac

# 0050575

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

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

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

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

Facility Name & ID Number

Good Samaritan-Pontiac

# 0050575

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

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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2011 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 2012 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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	<u>n/a</u>			8
	2008				9
	2009				10
	2010				11
	2011				12
<b>Facility is not for profit entity and does not pay real estate taxes</b>					
<b>FOR BHF USE ONLY</b>					
	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-Pontiac COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050575

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 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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>Facility is not for profit entity and does not pay real estate taxes</u>	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**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 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-Pontiac

# 0050575 Report Period Beginning:

1/1/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,720 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

---



---



---



---



---

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1968</u>	<u>\$ 199,500</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 199,500</b>	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	122		1968	\$ 954,253	\$		\$ 19,085	\$ 19,085	\$ 881,060	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1968	57,846		20			57,846	9
10	Various		1969	4,376		20			4,376	10
11	Various		1973	2,959		20	59	59	2,340	11
12	Various		1977	15,710		20	282	282	11,487	12
13	Various		1978	61,749		20	435	435	55,227	13
14	Various		1979	63,068		20	1,151	1,151	44,653	14
15	Various		1980	11,757		20	57	57	10,783	15
16	Various		1981	16,455		20	156	156	13,651	16
17	Various		1982	14,538		20	28	28	13,994	17
18	Various		1983	25,807		20	233	233	21,142	18
19	Various		1984	41,685		20			41,685	19
20	Various		1985	10,183		20			10,183	20
21	Various		1986	14,031		20	85	85	12,067	21
22	Various		1987	28,935		20			28,935	22
23	Various		1988	6,621		20			6,621	23
24	Various		1989	116,257		20	2,169	2,169	59,947	24
25	Various		1990	20,708		20	732	732	21,440	25
26	Various		1991	31,573		20	766	766	16,992	26
27	Various		1992	391,614		20	8,966	8,966	175,930	27
28	Various		1993	563,498		20	10,153	10,153	225,051	28
29	Various		1994	27,223		20	726	726	12,774	29
30	Various		1995	173,018		20	3,377	3,377	62,251	30
31	Various		1996	19,810		20	414	414	7,417	31
32	Various		1997	17,298		20	751	751	11,951	32
33	Various		1998	13,384		20	642	642	9,128	33
34	Various		1999	453,866		20	9,611	9,611	129,709	34
35	Various		2000	31,996		20	1,601	1,601	19,981	35
36	Various		2001	74,897		20	3,745	3,745	42,548	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 &amp; ID Number Good Samaritan-Pontiac

# 0050575

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2002	\$ 48,224	\$	20	\$ 2,411	\$ 2,411	\$ 25,635	37
38	Various	2003	5,662		20	450	450	4,156	38
39	Various	2004	17,148		20	1,716	1,716	14,658	39
40	Various	2005	1,829		20	91	91	669	40
41		2006							41
42	Alarm and keypad for door	2006	1,565		20	78	78	527	42
43	Paving and concrete	2006	23,550		20	1,178	1,178	7,852	43
44	Double door system	2006	5,747		20	287	287	1,915	44
45	A/C Parts	2006	4,659		20	233	233	1,456	45
46	Boiler and stack repairs	2006	5,950		20	298	298	1,886	46
47	Door alarm system	2006	40,131		20	2,007	2,007	12,375	47
48	Motion Lights	2006	1,174		20	59	59	407	48
49	Repipe and rewire kitchen	2006	1,409		20	70	70	486	49
50	Fire Doors	2006	6,281		20	314	314	2,094	50
51	Fire alarm control panel	2006	2,122		20	106	106	636	51
52	Smoke dampers	2007	5,504		20	275	275	1,536	52
53	Hot water tank repairs	2007	1,350		20	68	68	395	53
54	Roof top A/C unit	2007	4,596		20	383	383	2,043	54
55	Circuit breaker panel	2007	3,780		20	189	189	992	55
56	Well water pump	2007	2,013		20	101	101	513	56
57	Door alarm system - camera	2007	5,577		20	372	372	2,076	57
58	Door alarm system - voice page	2007	1,777		20	254	254	1,418	58
59	Coil for walk in cooler	2008	1,132		20	113	113	462	59
60	Thermostats	2008	3,350		20	335	335	1,368	60
61	Block Heater	2008	1,127		20	113	113	555	61
62	Thermostatic mixing valve	2008	14,000		20	1,400	1,400	5,717	62
63	Kitchen waste line	2008	5,900		20	590	590	2,458	63
64	HVAC System	2009	6,500		20	325	325	1,300	64
65	Boiler Work	2009	3,521		20	176	176	704	65
66	Boiler and plumbing repair	2010	9,435		20	472	472	1,180	66
67	Fire alarm	2010	5,404		20	270	270	675	67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,505,532	\$		\$ 79,957	\$ 79,957	\$ 2,109,313	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 245,836	\$	\$ 18,995	\$ 18,995		\$ 233,909	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	398,724					398,724	73
74								74
75	TOTALS	\$ 644,560	\$	\$ 18,995	\$ 18,995		\$ 632,633	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1993 Taurus	1993	\$ 14,704	\$	\$	\$		\$ 14,704	76
77	Facility Use	Bus	1996	45,146					45,146	77
78										78
79										79
80	TOTALS			\$ 59,850	\$	\$	\$		\$ 59,850	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,409,442	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,952	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 98,952	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,801,796	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	New Building project	\$ 183,771	92
93			93
94			94
95		\$ 183,771	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-Pontiac

# 0050575

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				<u>n/a</u>			4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 496 Description: maintenance equipment \$496

(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	<b>TOTAL</b>		\$	\$	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-Pontiac # 0050575 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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	79,517	\$ 120,280	\$	79,517	\$ 120,280	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		16,989	23,763		16,989	23,763	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		77,164	117,245		77,164	117,245	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				42,668		42,668	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	L39, C2					13,401		13,401	12
13	Other (specify):									13
14	TOTAL			\$	173,670	\$ 261,288	\$ 56,069	173,670	\$ 317,357	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-Pontiac# 0050575Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 40,105	\$ 40,106	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	916,920	916,920	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	47,491	47,491	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,004,516	\$ 1,004,517	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		199,500	13
14	Buildings, at Historical Cost		3,505,332	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,836	707,246	16
17	Accumulated Depreciation (book methods)		(2,702,843)	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): <u>Construction in progress</u>	43,678	43,678	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 46,514	\$ 1,752,913	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,051,030	\$ 2,757,430	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,046,540	\$ 1,046,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,365	129,365	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>See grouping schedule</u>	47,354	47,354	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,223,259	\$ 1,223,259	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,223,259	\$ 1,223,259	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (172,229)	\$ 1,534,171	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,051,030	\$ 2,757,430	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>486,053</b>	<b>1</b>
<b>2</b>	Restatements (describe):	<b>13,625</b>	<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>499,678</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(671,907)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(671,907)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(172,229)</b>	<b>24</b> *

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

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

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

		1	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,961,041	1
2	Discounts and Allowances for all Levels	(224,477)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,736,564</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	403,433	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 403,433</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	8	13
14	Non-Patient Meals	6,319	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	20,653	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,257	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 38,237</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	8,579	24
25	Interest and Other Investment Income***	1,276	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 9,855</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>res purchase, vending income, miscellaneou inc.</b>	77,547	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 77,547</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,265,636</b>	<b>30</b>

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	732,203	31
32	Health Care	1,239,086	32
33	General Administration	744,015	33
<b>B. Capital Expense</b>			
34	Ownership		34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	66,085	35
36	Provider Participation Fee	156,154	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,937,543</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(671,907)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (671,907)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	<b>49</b>

\* 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-Pontiac

# 0050575

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,912	1,960	\$ 66,898	\$ 34.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,976	6,502	127,707	19.64	3
4	Licensed Practical Nurses	9,081	9,748	198,544	20.37	4
5	CNAs & Orderlies	29,324	31,082	455,348	14.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,426	3,764	47,738	12.68	10
11	Social Service Workers	1,694	2,080	22,082	10.62	11
12	Dietician					12
13	Food Service Supervisor	1,693	2,080	34,892	16.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,613	12,312	130,977	10.64	15
16	Dishwashers					16
17	Maintenance Workers	4,038	4,728	82,827	17.52	17
18	Housekeepers	6,881	7,475	67,347	9.01	18
19	Laundry	2,891	3,186	54,345	17.06	19
20	Administrator	2,000	2,080	68,370	32.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,059	4,460	78,675	17.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,588	91,457	\$ 1,435,750 *	\$ 15.70	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	76	\$ 3,934	3-3	35
36	Medical Director	48	8,400	9-3	36
37	Medical Records Consultant	25	1,780	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	318	1,872	10-3	39
40	Physical Therapy Consultant	77,164	117,245	10a-3	40
41	Occupational Therapy Consultant	79,517	120,151	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16,898	23,761	10a-3	43
44	Activity Consultant	26	792	11-3	44
45	Social Service Consultant	26	792	12-3	45
46	Other(specify)				46
47	Pharmacy Consultant	164	1,165	10-3	47
48					48
49	TOTAL (lines 35 - 48)	174,262	\$ 279,892		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Stehen Johnson</u>	<u>Adminsitrator</u>	<u>0</u>	<u>\$ 60,000</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 26,493</u>	<u>IDPH License Fee</u>	<u>\$ 2,860</u>	
				<u>Unemployment Compensation Insurance</u>	<u>27,294</u>	<u>Advertising: Employee Recruitment</u>	<u>1,198</u>	
				<u>FICA Taxes</u>	<u>106,150</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>54,577</u>	<u>(Indicate # of checks performed _____)</u>	<u>687</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>(74)</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and subscriptions</u>	<u>36,760</u>	
				<u>Employee Physicals</u>	<u>2,951</u>			
				<u>Miscellaneous Benefits</u>	<u>328</u>			
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 60,000</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
<b>(List each licensed administrator separately.)</b>				<b>\$ 217,793</b>		<b>\$ 41,431</b>		
<b>B. Administrative - Other</b>							<b>Less: Public Relations Expense</b> ( )	
<b>Description</b>			<b>Amount</b>				<b>Non-allowable advertising</b> ( )	
			\$				<b>Yellow page advertising</b> ( )	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>					
<b>(Attach a copy of any management service agreement)</b>								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Ungaretti &amp; Harris</u>	<u>Legal Fees</u>		<u>\$ 48,245</u>			\$	<u>Out-of-State Travel</u>	\$
<u>Hartweg, Turner</u>	<u>Legal Fees</u>		<u>18,220</u>					
<u>Foley and Associates</u>	<u>CON consulting</u>		<u>15,000</u>					
<u>Accumed</u>	<u>Software support</u>		<u>1,305</u>				<u>In-State Travel</u>	
<u>Getz</u>	<u>Fire hood cleaning</u>		<u>1,746</u>					
<u>McGladrey and Pullen</u>	<u>Audit</u>		<u>41,780</u>				<u>See attached schedule</u>	<u>2,561</u>
<u>payroll</u>	<u>payroll processing</u>		<u>5,330</u>					
							<u>Seminar Expense</u>	
							<u>Entertainment Expense</u>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 131,626</b>	<b>TOTAL</b>		<b>\$</b>	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<b>\$ 2,561</b>	

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Good Samaritan-Pontiac# 0050575Report Period Beginning: 1/1/12Ending: 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. \$ 13,742 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 154,154  
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,319
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? 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.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (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.