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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0007344

Facility Name: GOOD SAM SOC-MT CARROLL

Address: 1006 NORTH LOWDEN (Number) MOUNT CARROLL (City) 61053 (Zip Code)

County: CARROLL

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: KIM KOURI **Telephone Number:** 605-362-3178
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JOE HERDINA
(Title) VICE PRESIDENT OF FINANCE

Paid Preparer

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

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,281	9,430	1,937	19,648	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,281	9,430	1,937	19,648	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.76%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	190,390	8,498	6,032	204,920		204,920	(157)	204,763			1
2	Food Purchase		124,555		124,555		124,555	(7,839)	116,716			2
3	Housekeeping	60,415	16,854		77,269		77,269	(307)	76,962			3
4	Laundry	33,101	7,787		40,888		40,888	(148)	40,740			4
5	Heat and Other Utilities			88,815	88,815		88,815		88,815			5
6	Maintenance	43,214	7,913	59,002	110,129		110,129	(764)	109,365			6
7	Other (specify):*			1,886	1,886		1,886	(563)	1,323			7
8	TOTAL General Services	327,120	165,607	155,735	648,462		648,462	(9,778)	638,684			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,158,706	116,318	11,388	1,286,412		1,286,412	(44,619)	1,241,793			10
10a	Therapy		180	168,437	168,617		168,617	(23,767)	144,850			10a
11	Activities	60,035	2,757	1,959	64,751		64,751	(2,864)	61,887			11
12	Social Services	34,833	12	1,842	36,687		36,687		36,687			12
13	CNA Training											13
14	Program Transportation			5,571	5,571		5,571		5,571			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,253,574	119,267	191,597	1,564,438		1,564,438	(71,250)	1,493,188			16
	C. General Administration											
17	Administrative	63,458		172,577	236,035		236,035	90,976	327,011			17
18	Directors Fees											18
19	Professional Services			1,428	1,428		1,428		1,428			19
20	Dues, Fees, Subscriptions & Promotions			16,620	16,620		16,620	(11,697)	4,923			20
21	Clerical & General Office Expenses	139,757	53,215	33,476	226,448		226,448	(3,580)	222,868			21
22	Employee Benefits & Payroll Taxes			446,047	446,047		446,047	(2,944)	443,103			22
23	Inservice Training & Education			5,527	5,527		5,527	(1,051)	4,476			23
24	Travel and Seminar			6,124	6,124		6,124	(5,092)	1,032			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			33,791	33,791		33,791	(6,085)	27,706			26
27	Other (specify):*	12,127		51	12,178		12,178	(12,178)				27
28	TOTAL General Administration	215,342	53,215	715,641	984,198		984,198	48,349	1,032,547			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,796,036	338,089	1,062,973	3,197,098		3,197,098	(32,679)	3,164,419			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 SAM SOC-MT CARROLL #0007344 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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			175,241	175,241		175,241		175,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(251)	(251)		(251)	251				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,991	1,991		1,991	(120)	1,871			35
36	Other (specify):*											36
37	**TOTAL Ownership**			176,981	176,981		176,981	131	177,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,497	194,497		194,497		194,497			42
43	Other (specify):*			5,372	5,372		5,372	(6,803)	(1,431)			43
44	**TOTAL Special Cost Centers**			199,869	199,869		199,869	(6,803)	193,066			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,796,036	338,089	1,439,823	3,573,948		3,573,948	(39,351)	3,534,597			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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	(7,839)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,811)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,101	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(118,255)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (126,804)		$	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)	87,453		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 87,453		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (39,351)		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 SAM SOC-MT CARROLL

ID# 0007344

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SEE ATTACHED SCHEDULE	$ (157)	1	1
2	SEE ATTACHED SCHEDULE	(23,767)	10A	2
3	SEE ATTACHED SCHEDULE	(307)	3	3
4	SEE ATTACHED SCHEDULE	(148)	4	4
5	SEE ATTACHED SCHEDULE		5	5
6	SEE ATTACHED SCHEDULE	(764)	6	6
7	SEE ATTACHED SCHEDULE	(563)	7	7
8	SEE ATTACHED SCHEDULE		8	8
9	SEE ATTACHED SCHEDULE		9	9
10	SEE ATTACHED SCHEDULE	(44,619)	10	10
11	SEE ATTACHED SCHEDULE	(53)	11	11
12	SEE ATTACHED SCHEDULE		12	12
13	SEE ATTACHED SCHEDULE		13	13
14	SEE ATTACHED SCHEDULE		14	14
15	SEE ATTACHED SCHEDULE		15	15
16	SEE ATTACHED SCHEDULE		16	16
17	SEE ATTACHED SCHEDULE	(4,500)	17	17
18	SEE ATTACHED SCHEDULE		18	18
19	SEE ATTACHED SCHEDULE		19	19
20	SEE ATTACHED SCHEDULE	(11,697)	20	20
21	SEE ATTACHED SCHEDULE	(5,681)	21	21
22	SEE ATTACHED SCHEDULE	(1,006)	22	22
23	SEE ATTACHED SCHEDULE	(1,051)	23	23
24	SEE ATTACHED SCHEDULE	(5,092)	24	24
25	SEE ATTACHED SCHEDULE		25	25
26	SEE ATTACHED SCHEDULE		26	26
27	SEE ATTACHED SCHEDULE	(12,178)	27	27
28	SEE ATTACHED SCHEDULE		28	28
29	SEE ATTACHED SCHEDULE		29	29
30	SEE ATTACHED SCHEDULE		30	30
31	SEE ATTACHED SCHEDULE		31	31
32	SEE ATTACHED SCHEDULE	251	32	32

33	SEE ATTACHED SCHEDULE		**33**	**33**
34	SEE ATTACHED SCHEDULE		**34**	**34**
35	SEE ATTACHED SCHEDULE	**(120)**	**35**	**35**
36	SEE ATTACHED SCHEDULE		**36**	**36**
37	SEE ATTACHED SCHEDULE		**37**	**37**
38	SEE ATTACHED SCHEDULE		**38**	**38**
39	SEE ATTACHED SCHEDULE		**39**	**39**
40	SEE ATTACHED SCHEDULE		**40**	**40**
41	SEE ATTACHED SCHEDULE		**41**	**41**
42	SEE ATTACHED SCHEDULE		**42**	**42**
43	SEE ATTACHED SCHEDULE	**(6,803)**	**43**	**43**
44	SEE ATTACHED SCHEDULE		**44**	**44**
45	SEE ATTACHED SCHEDULE		**45**	**45**
46	SEE ATTACHED SCHEDULE		**46**	**46**
47	SEE ATTACHED SCHEDULE		**47**	**47**
48	SEE ATTACHED SCHEDULE		**48**	**48**
49	**Total**	(118,255)		**49**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(157)	0	0	0	0	0	0	0	0	0	0	(157)	1
2	Food Purchase	(7,839)	0	0	0	0	0	0	0	0	0	0	(7,839)	2
3	Housekeeping	(307)	0	0	0	0	0	0	0	0	0	0	(307)	3
4	Laundry	(148)	0	0	0	0	0	0	0	0	0	0	(148)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(764)	0	0	0	0	0	0	0	0	0	0	(764)	6
7	Other (specify):*	(563)	0	0	0	0	0	0	0	0	0	0	(563)	7
8	**TOTAL General Services**	(9,778)	0	0	0	0	0	0	0	0	0	0	(9,778)	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	(44,619)	0	0	0	0	0	0	0	0	0	0	(44,619)	10
10a	Therapy	(23,767)	0	0	0	0	0	0	0	0	0	0	(23,767)	10a
11	Activities	(2,864)	0	0	0	0	0	0	0	0	0	0	(2,864)	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**	(71,250)	0	0	0	0	0	0	0	0	0	0	(71,250)	16
	C. General Administration													
17	Administrative	(4,500)	95,476	0	0	0	0	0	0	0	0	0	90,976	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	(11,697)	0	0	0	0	0	0	0	0	0	0	(11,697)	20
21	Clerical & General Office Expenses	(3,580)	0	0	0	0	0	0	0	0	0	0	(3,580)	21
22	Employee Benefits & Payroll Taxes	(1,006)	(1,938)	0	0	0	0	0	0	0	0	0	(2,944)	22
23	Inservice Training & Education	(1,051)	0	0	0	0	0	0	0	0	0	0	(1,051)	23
24	Travel and Seminar	(5,092)	0	0	0	0	0	0	0	0	0	0	(5,092)	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	(6,085)	0	0	0	0	0	0	0	0	0	(6,085)	26
27	Other (specify):*	(12,178)	0	0	0	0	0	0	0	0	0	0	(12,178)	27
28	**TOTAL General Administration**	(39,104)	87,453	0	0	0	0	0	0	0	0	0	48,349	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,132)	87,453	0	0	0	0	0	0	0	0	0	(32,679)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	251	0	0	0	0	0	0	0	0	0	0	251	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	(120)	0	0	0	0	0	0	0	0	0	0	(120)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	131	0	0	0	0	0	0	0	0	0	0	131	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):*	(6,803)	0	0	0	0	0	0	0	0	0	0	(6,803)	43
44	**TOTAL Special Cost Centers**	(6,803)	0	0	0	0	0	0	0	0	0	0	(6,803)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(126,804)	87,453	0	0	0	0	0	0	0	0	0	(39,351)	45

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	ADMIN/ACCOUNTING	$ 172,577	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	$ 268,053	$ 95,476	1
2	V	22	WORKERS COMP	68,462	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	79,978	11,516	2
3	V	22	UNEMPLOYMENT	16,813	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	18,060	1,247	3
4	V	26	INSURANCE	33,791	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	27,706	(6,085)	4
5	V	22	GROUP HEALTH INSURANCE	197,631	THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOC	100.00%	182,930	(14,701)	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			$ 489,274			$ 576,727	$ * 87,453	14

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Neil Gulsveg	BOD CHAIR						2
3	Christopher Johnson	BOD VICE CHAIR						3
4	John Holt	BOD						4
5	David Horazdovsky	CEO						5
6	Elwin Brown	BOD						6
7	Liane Connelly	BOD						7
8	Gwen Halaas	BOD						8
9	Michael Deuth	BOD						9
10	Theodore Gindal	BOD						10
11	Kari Berit Ramlo Gustafson	BOD						11
12	Teresa Hildebrandt	BOD						12
13	Michelle Juffer	BOD						13
14	Guy Matson	BOD						14
15	John Racek	BOD						15
16	Philip Samuelson	BOD						16
17	Sharon St. Mary	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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL **#** 0007344 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2008	8
	2009	9
	2010	10
	2011	11
	2012	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAM SOC-MT CARROLL COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0007344

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LAND		1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1970	$ 388,819	$		$	$	$ 388,819	4
5				1991	805,551					803,855	5
6				2010							6
7											7
8											8
	Improvement Type**										
9				1970	3,702					3,702	9
10				1971	262					262	10
11				1975	1,986					1,986	11
12				1976	2,090					2,090	12
13				1977	185					185	13
14				1979	6,037					6,037	14
15				1980	1,559					1,559	15
16				1981	33,937					33,627	16
17				1982	29,188					29,188	17
18				1983	8,193					8,193	18
19				1984	1,224					1,224	19
20				1985							20
21				1986	4,163					4,163	21
22				1987	15,273					15,273	22
23				1988	6,707					6,707	23
24				1989	5,010					5,010	24
25				1990	6,322					6,322	25
26				1991	98,155					97,409	26
27				1992	10,350					10,350	27
28				1993	4,260					4,260	28
29				1994	66,654	528		528		66,453	29
30				1995	36,466					36,466	30
31				1996	78,462	3,822		3,822		68,284	31
32				1997	24,046	749		749		21,177	32
33				1998	16,770	576		576		14,462	33
34				1999	37,004	888		888		32,719	34
35				2000	88,586	1,057		1,057		71,997	35
36				2002	51,858	2,201		2,201		43,415	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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2003	$ 58,269	$ 2,933		$ 2,933	$	$ 31,702	37
38		2004	13,568	564		564		9,924	38
39		2005	109,024	3,644		3,644		56,032	39
40		2006	385,285	18,411		18,411		141,248	40
41		2007	29,076	1,525		1,525		21,582	41
42		2008	155,962	10,739		10,739		61,924	42
43		2009	128,025	7,936		7,936		35,027	43
44	OUTSIDE DOOR AND HARDWARE	2010	4,652	310		310		1,189	44
45	DIGITAL VIDEO SYSTEM	2010	26,540	2,654		2,654		10,395	45
46	REPAIR ROOF - ICE DAMAGE	2010	3,300	330		330		1,238	46
47	20' SUNSETTER RETRACTBL AWNING	2010	3,474	386		386		1,448	47
48	Air Cond-BathNurseStation Rmdl	2010	3,176	318		318		1,218	48
49	Building-BathNurseStation Rmdl	2010	192,900	7,716		7,716		29,578	49
50	Carpet-BathNurseStation Rmdl	2010	6,514	1,303		1,303		4,994	50
51	Doors-BathNurseStation Rmdl	2010	980	65		65		250	51
52	Electric-BathNurseStation Rmdl	2010	24,946	1,663		1,663		6,375	52
53	HVAC-BathNurseStation Rmdl	2010	6,365	424		424		1,627	53
54	Paint-BathNurseStation Rmdl	2010	19,405	3,881		3,881		14,877	54
55	Plumbing-BathNurseStation Rmdl	2010	4,233	212		212		811	55
56	NURSING CALL LIGHT SYSTEM	2010	8,851	885		885		3,098	56
57	REPEATER	2010	541	108		108		378	57
58	PANIC BAR FOR EXIT DOOR	2010	690	69		69		247	58
59	COPPER PIPE-CHLLR/BOILR TO RMS	2010	30,000	1,200		1,200		4,100	59
60	WEIL MCLAIN 230 BOILER	2010	9,172	459		459		1,452	60
61	GARAGE DOOR AND OPERATOR	2010	1,804	180		180		586	61
62	7.5 TON ROOFTOP UNIT 100 WING	2011	8,760	876		876		2,409	62
63	300 WING DOOR AND CLOSER	2011	2,531	253		253		569	63
64	OUTSIDE METAL DOOR W WINDOW	2012	1,770	89		89		162	64
65	GENERATOR REPAIRS/SERVICE	2012	2,629	263		263		438	65
66	ASBESTOS-FLOORING ABATEMENT	2012	90,701	9,070		9,070		12,849	66
67	VINYL FLOORING	2012	92,467	9,247		9,247		13,099	67
68	MCLAIN BOILER W 2WATER HEATERS	2012	34,754	1,738		1,738		2,896	68
69	CASCADE PREMIER SPA	2012	19,440	1,941		1,941		2,457	69
70	TOTAL (lines 4 thru 69)		$ 3,312,623	$ 101,212		$ 101,212	$	$ 2,261,375	70

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,312,623	$ 101,212		$ 101,212	$	$ 2,261,375	1
2	TRANE FAN COIL COOL & HEATER	2012	2,962	296		296		296	2
3	DIRECT TV SYSTEM	2012	20,220	2,022		2,022		2,359	3
4	SHORETEL PHONE SYSTEM	2013	36,398	3,336		3,336		3,336	4
5	FIRE DOORS IN KIT/DIN ROOM WIN	2013	3,517	322		322		322	5
6	GENERATOR REPAIRS	2013	2,629	394		394		394	6
7	REPLACE ROOFTOP UNITS	2013	91,850	5,358		5,358		5,358	7
8	PREP&POUR SIDEWALK 800SQ FT	2010	2,975	198		198		727	8
9	ConcreteSidewalk-West Side Bld	2010	19,895	1,326		1,326		4,863	9
10	SIDEWALK REMOVAL AND REPOUR	2011	3,822	255		255		701	10
11	CHAIN LINK FENCE AT GENERATOR	2013	584	19		19		19	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)		$ 3,497,475	$ 114,740		$ 114,740	$	$ 2,279,752	34

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 524,892	$ 49,824	$ 49,824	$		$ 313,333	71
72	Current Year Purchases	24,675	1,765	1,765			1,765	72
73	Fully Depreciated Assets	528,737	4,844	4,844			528,737	73
74								74
75	TOTALS	$ 1,078,304	$ 56,433	$ 56,433	$		$ 843,835	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	NURSING HOME	BUS		$ 42,763	$	$	$		$ 42,763	76
77	NURSING HOME	2002 OLDSMOBILE SILHOUE		15,173					15,173	77
78	NURSING HOME	2005 CHEVY PICKUP		14,272	3,568	3,568			14,272	78
79										79
80	TOTALS			$ 72,209	$ 3,568	$ 3,568	$		$ 72,209	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)	$ 4,653,708	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 174,741	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 174,741	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,195,796	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		$	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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 1,991 Description: Nursing/Operations/Maint. Leasing equipment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	LINE 10A, COL 3	hrs	$	4,745	$ 71,180	$ 0	4,745	$ 71,180	1
2	Licensed Speech and Language Development Therapist	LINE 10A, COL 3	hrs		623	9,342	0	623	9,342	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	LINE 10A, COL 3	hrs		5,861	87,915	0	5,861	87,915	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	11,229	$ 168,437	$	11,229	$ 168,437	14

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

STATE OF ILLINOIS

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (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	$ 134,034	$	1
2	Cash-Patient Deposits	3,613		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 21,800)	501,928		3
4	Supply Inventory (priced at)	6,583		4
5	Short-Term Investments	107,432		5
6	Prepaid Insurance	5,297		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)**	$ 758,887	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	3,128,258		14
15	Leasehold Improvements, at Historical Cost	369,213		15
16	Equipment, at Historical Cost	1,150,513		16
17	Accumulated Depreciation (book methods)	(3,195,793)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	30,983		21
22	Other Long-Term Assets (spe**Assets M**	3,618		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,492,512	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,251,399	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 59,856	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,613		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,243		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 246,712	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Annuities	1,842		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,842	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 248,554	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,002,845	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,251,399	$	48

*(See instructions.)

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,363,997	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,363,997	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	117,774	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)**	$ 117,774	17	
	B. Transfers (Itemize):			
18	**Technology User Assessment NC**	(16,685)	18	
19	**Foundation Transfer**	(181,846)	19	
20	**Donor Funds**	17,290	20	
21	**Society business Account**	(1,297,685)	21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,478,926)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,002,845	24	*

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

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 3,753,829	1
2	Discounts and Allowances for all Levels	(1,118,716)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,635,113	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	654,661	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 654,661	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	4,500	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,839	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	120	16
17	Sale of Drugs	131,813	17
18	Sale of Supplies to Non-Patients	32	18
19	Laboratory	7,341	19
20	Radiology and X-Ray	260	20
21	Other Medical Services	1,410	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 153,315	23
	D. Non-Operating Revenue		
24	Contributions	145,748	24
25	Interest and Other Investment Income***	51,013	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 196,761	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NURSING & MEDICAL SUPPLIES	85,561	28
28a	MISC INCOME/PY SETTLEMENTS	(33,691)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,870	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,691,720	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	648,461	31
32	Health Care	1,564,438	32
33	General Administration	984,197	33
	B. Capital Expense		
34	Ownership	176,981	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	194,497	36
	D. Other Expenses (specify):		
37	OTHER	5,372	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,573,946	40
41	**Income before Income Taxes (line 30 minus line 40)****	117,774	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 117,774	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 936,780	44
45	Private Pay - Net Inpatient Revenue	1,704,664	45
46	Medicare - Net Inpatient Revenue	659,043	46
47	Other-(specify) MANAGED CARE	99,975	47
48	Other-(specify) HOSPICE/OTHER	353,367	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,753,829	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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,055	1,735	$ 58,112	$ 33.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,785	13,317	365,558	27.45	3
4	Licensed Practical Nurses	4,949	4,491	103,473	23.04	4
5	CNAs & Orderlies	53,627	46,651	604,528	12.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,827	1,599	26,547	16.60	9
10	Activity Assistants	3,768	3,389	32,122	9.48	10
11	Social Service Workers	1,979	1,848	34,833	18.85	11
12	Dietician					12
13	Food Service Supervisor	2,007	1,701	31,723	18.65	13
14	Head Cook	5,415	4,784	53,584	11.20	14
15	Cook Helpers/Assistants	11,224	9,854	105,083	10.66	15
16	Dishwashers					16
17	Maintenance Workers	3,064	2,727	43,214	15.85	17
18	Housekeepers	5,939	5,061	60,415	11.94	18
19	Laundry	3,829	3,482	33,101	9.51	19
20	Administrator	2,089	1,915	63,458	33.14	20
21	Assistant Administrator					21
22	Other Administrative	6,740	5,988	139,757	23.34	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,705	1,417	28,401	20.04	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	790	677	12,127	17.91	33
34	TOTAL (lines 1 - 33)	125,792	110,636	$ 1,796,036 *	$ 16.23	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		$		35
36	Medical Director		2,400	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		11,026	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	61	1,842	Ln 11, Col 3	44
45	Social Service Consultant	62	1,842	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	123	$ 17,110		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 SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Simkle	Administrator		$ 61,058
Vacation Accrual			2,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,458

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 172,577
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 172,577

C. Professional Services

Vendor/Payee	Type	Amount
Contract Services - Admin		$ 1,428
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,428

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,462
Unemployment Compensation Insurance	16,813
FICA Taxes	134,604
Employee Health Insurance	197,631
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	39,058
Taxable Gifts	151
Other	518
NCO Adjustments	(1,938)
Resource Development Expenses	(1,006)
Shared Employee benefits	(11,190)
TOTAL (agree to Schedule V, line 22, col.8)	$ 443,103

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,330
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues	5,814
Inter Reimbursement	
Newsletter	214
Publications	1,262
Less: Public Relations Expense	( )
Non-allowable advertising	(11,697)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,923

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,009
In-State Travel	1,115
Seminar Expense	
Out of State Travel	(5,009)
Travel Reimb. Marketing	(84)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,031

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	HEATING	01/02	1,738	10	174	174	174	174	174	174			
3	HEATING	04/02	1,288	10	129	129	129	129	129	129			
4	HEATING	01/01	219	10	22	22	22	22					
5	PLUMBING	02/01	910	10	91	91	91	91					
6	WALLPAPER	07/01	230	5	49								
7	PAINT	08/01	390	5	49								
8	AIR CONDITIONING	09/01	511	10	51	51	51	51	51				
9	AIR CONDITIONING	10/01	1,841	10	184	184	184	184	184				
10	AIR CONDITIONING	02/01	901	10	90	90	90	90	90				
11	PLUMBING	04/01	87	10	9	9	9	9	9				
12	PLUMBING	01/01	5,879	10	58	58	58	58	58				
13	HEATING	05/01	152	10	15	15	15	15	15				
14	PLUMBING	08/01	1,402	10	140	140	140	140	140				
15	PLUMBING	01/03	1,787	10	179	179	179	179	179	179	179		
16													
17													
18													
19													
20	TOTALS		$ 17,335		$ 1,240	$ 1,142	$ 1,142	$ 1,142	$ 1,029	$ 482	$ 179	$	$

Facility Name & ID Number GOOD SAM SOC-MT CARROLL # 0007344 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. LIFE SERVICE NETWORK

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8.78

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 20,438 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 194,497
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? YES Indicate the amount. $ 7,839

(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? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTONLARSONALLEN

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

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