

		FOR BHF USE						

LL1

**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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.

<b>I. IDPH License ID Number:</b> <u>0050567</u>			<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>		
<b>Facility Name:</b> <u>Good Samaritan Flanagan</u>			<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</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>		
<b>Address:</b> <u>205 North Adams St</u> <u>Flanagan</u> <u>61740</u>					
Number City Zip Code					
<b>County:</b> <u>Livingston</u>					
<b>Telephone Number:</b> <u>(815) 796-2288</u> <b>Fax #</b> <u>(815) 796-2280</u>					
<b>HFS ID Number:</b> _____			<b>Officer or Administrator of Provider</b>		
<b>Date of Initial License for Current Owners:</b> <u>12/1/68</u>			(Signed) _____ (Date) _____		
<b>Type of Ownership:</b>			<b>(Type or Print Name)</b> _____		
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			<input type="checkbox"/> PROPRIETARY		
<input checked="" type="checkbox"/> Charitable Corp.			<input type="checkbox"/> Individual		
<input type="checkbox"/> Trust			<input type="checkbox"/> State		
<b>IRS Exemption Code</b> <u>501(c)(3)</u>			<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 _____		
<b>In the event there are further questions about this report, please contact:</b>			<b>Paid Preparer</b>		
<b>Name:</b> <u>Rob Schlicht</u>			(Print Name and Title) <u>Rob Schlicht</u> <u>Director</u>		
<b>Telephone Number:</b> <u>414-431-9335</u>			(Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250 Milwaukee WI 53226</u>		
<b>Email Address:</b> _____			(Telephone) <u>414-431-9335</u> <b>Fax #</b> <u>414-431-9303</u>		
			<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 <b>Phone # (217) 782-1630</b>		

Facility Name & ID Number Good Samaritan Flanagan

# 0050567 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	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	8,693	6,955	1,645	17,293	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,693	6,955	1,645	17,293	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.96%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Peace Meals

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

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

YES  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 12/1/1968

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified 60 and days of care provided 1,645

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: 12/31/14 Fiscal Year: 12/31/14

\* 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	185,967	5,903	3,227	195,097		195,097	195,097			1
2	Food Purchase		76,079		76,079		76,079	(4,404)	71,675		2
3	Housekeeping	46,727	4,665		51,392		51,392		51,392		3
4	Laundry	53,064			53,064		53,064		53,064		4
5	Heat and Other Utilities			44,002	44,002		44,002		44,002		5
6	Maintenance	91,004	4,141	120,644	215,789		215,789	(4,410)	211,379		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	376,762	90,788	167,873	635,423		635,423	(8,814)	626,609		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	929,013	37,034	7,386	973,433		973,433		973,433		10
10a	Therapy										10a
11	Activities	66,335	391	2,036	68,762		68,762		68,762		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	995,348	37,425	15,422	1,048,195		1,048,195		1,048,195		16
	<b>C. General Administration</b>										
17	Administrative	59,521			59,521		59,521		59,521		17
18	Directors Fees										18
19	Professional Services			49,132	49,132		49,132		49,132		19
20	Dues, Fees, Subscriptions & Promotions			9,559	9,559		9,559	(83)	9,476		20
21	Clerical & General Office Expenses	183,790	2,171	24,486	210,447		210,447		210,447		21
22	Employee Benefits & Payroll Taxes			138,082	138,082		138,082		138,082		22
23	Inservice Training & Education										23
24	Travel and Seminar			726	726		726		726		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,989	30,989		30,989		30,989		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	243,311	2,171	252,974	498,456		498,456	(83)	498,373		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,615,421	130,384	436,269	2,182,074		2,182,074	(8,897)	2,173,177		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 &amp; ID Number

Good Samaritan Flanagan

#0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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							64,932	64,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,176	13,176		13,176	(30)	13,146			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>			13,176	13,176		13,176	64,902	78,078			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,183	67,733	90,916		90,916	(90,916)				39
40	Barber and Beauty Shops			4,349	4,349		4,349		4,349			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,075	98,075		98,075		98,075			42
43	Other (specify):*			36,906	36,906		36,906	(36,906)				43
44	<b>TOTAL Special Cost Centers</b>		23,183	207,063	230,246		230,246	(127,822)	102,424			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,615,421	153,567	656,508	2,425,496		2,425,496	(71,817)	2,353,679			45

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

Facility Name & ID Number Good Samaritan Flanagan

# 0050567

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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	(4,404)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,410)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,932	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 56,088		\$	30

**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>	\$ 56,088		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

BHF USE ONLY						
48		49		50		51
						52

Good Samaritan Flanagan

ID# 0050567

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	public relatios	\$ (83)	20	1
2	apartments/duplexes/marketing/xray/lab	(36,906)	43	2
3	therapies	(67,733)	39	3
4	pharmacy, oxygen	(23,183)	39	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>		(127,905)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Flanagan# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,404)	0	0	0	0	0	0	0	0	0	0	(4,404)	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	(4,410)	0	0	0	0	0	0	0	0	0	0	(4,410)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,814)</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>(8,814)</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	(83)	0	0	0	0	0	0	0	0	0	0	(83)	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>(83)</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>(83)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(8,897)</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>(8,897)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Flanagan# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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	64,932	0	0	0	0	0	0	0	0	0	0	64,932	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	0	0	0	0	0	0	0	0	0	0	(30)	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>64,902</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>64,902</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	(90,916)	0	0	0	0	0	0	0	0	0	0	(90,916)	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):*	(36,906)	0	0	0	0	0	0	0	0	0	0	(36,906)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(127,822)</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>(127,822)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(71,817)</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>(71,817)</b>	<b>45</b>

Facility Name & ID Number Good Samaritan Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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			\$			\$	\$	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 Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GOOD SAMARITAN FLANAGAN BOARD		Good Samaritan - Pontiac	Pontiac IL				1
2	Richard Hiatt	BOD						2
3	Dennis Jones	BOD						3
4	Jeff Rients	BOD						4
5	Pastor Ryan Anderson	BOD						5
6	Arlene Martin	BOD						6
7	Gene Simmons	BOD						7
8	Janice Weber	BOD						8
9	Debra Sculley	BOD						9
10								10
11								11
12	GOOD SAMARITAN GROUP BOARD							12
13	Richard Hiatt	BOD	Good Samaritan - Pontiac	Pontiac IL				13
14	William Coffin	BOD						14
15	Arlene Martin	BOD						15
16	Pastor Ryan Anderson	BOD						16
17	Jeff Rients	BOD						17
18								18
19	No member of either board provides services to the facility nor owns or has interest in a business that provides services to the facility							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 Flanagan # 0050567 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 of Directors	Administrative	0.00	n/a	1	2.00	n/a	n/a	n/a	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Good Samaritan Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Good Samaritan Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	Flanagan State Bank		x	Mortgage	Int & Princip	4/18/08	\$ 361,000	\$ 237,584	4/25/18	6.0000	\$ 13,176						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6																	
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$ 361,000	\$ 237,584			\$ 13,176						
<b>B. Non-Facility Related*</b>																	
10																	
11																	
12																	
13									interest income		(30)						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (30)						
15	<b>TOTALS (line 9+line14)</b>						\$ 361,000	\$ 237,584			\$ 13,146						

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 2013 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 2014 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:	2009 _____	8	<b>FOR BHF USE ONLY</b>		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Flanagan COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050567

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 2013 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 2013.

	(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.	_____	_____	\$ _____	\$ _____
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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**PLEASE NOTE:** *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Good Samaritan Flanagan

# 0050567 Report Period Beginning:

1/1/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (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).  
independent living facilities - duplexes and congregate living apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</u>	<u>14 acres</u>	<u>1966</u>	<u>\$ 22,917</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 22,917</b>	3

Facility Name & ID Number Good Samaritan Flanagan# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14**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	60		1968	1968	\$ 754,053	\$	40	\$	\$	\$ 754,053	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1980		49,983		20	584	584	28,537	9
10	Various		1981		4,961		20			4,961	10
11	Various		1982		7,246		20			7,246	11
12	Various		1991		58,000		20			58,000	12
13	Various		1992		49,137		20			49,137	13
14	Various		1995		257,361		20	6,454	6,454	124,451	14
15	Various		1996		30,610		20	765	765	14,539	15
16	Various		1997		29,894		20	766	766	13,314	16
17	Various		2000		34,290		20	1,040	1,040	15,351	17
18	Various		2001		150,943		20			150,943	18
19	Kitchen and office addition		2000		739,459		10			669,456	19
20	Painting		2000		2,680		10			2,390	20
21	None		2000		1,629		10			1,629	21
22	New Floors		2000		872		10			872	22
23	Air conditioner compressor		2000		6,651		10			6,651	23
24	Cabling		2003		1,541		10			1,541	24
25	Windows		2003		6,350		10			6,350	25
26	Brass plaques		2003		884		15	59	59	708	26
27	Dishwasher rack		2003		160		7			160	27
28	Kitchen addition		2003		60,663		7			60,663	28
29	Kitchen addition		2003		6,019		7			6,019	29
30	Kitchen addition		2003		113,993		7			113,993	30
31	Kitchen addition		2003		2,086		7			2,086	31
32	Mini blinds		2003		616		10			616	32
33	Mini blinds		2003		2,236		10			2,236	33
34	Telephone system		2003		(4,707)		10			(4,707)	34
35	Kitchen addition		2003		60,514		7			60,514	35
36	Kitchen addition		2003		9,492		7			9,492	36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Good Samaritan Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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	Kitchen Addition	2003	\$ 5,377	\$	7	\$	\$	\$ 5,377	37
38	Mc Cable	2003	589		10			589	38
39	Kitchen Addition	2003	2,562		7			2,562	39
40	Wire	2003	2,045		10			2,045	40
41	Backflow preventer	2003	398		10			398	41
42	HVAC	2003	865		10			865	42
43	Kitchen & Office addition	2003	480		20	24	24	266	43
44	Phone Switch	2003	150		10	14	14	150	44
45	Paint rooms	2004	1,120		10	112	112	1,106	45
46	Am carad for boiler	2004	816		10	81	81	804	46
47	Door alarm service	2004	597		5			597	47
48	Repair south chiller/fans	2004	440		5			440	48
49	Blacktop home	2005	1,176		20	59	59	557	49
50	Painting	2005	2,200		10	220	220	2,163	50
51	Nurses station	2005	5,000		20	250	250	2,292	51
52									52
53	Nurses station upgdate	2006	1,279		20	32	32	288	53
54	General project parts - nurses station	2006	1,127		20	28	28	252	54
55	Fire safety systems additions	2006	2,977		20	74	74	666	55
56	Phone lines	2006	344		10	17	17	153	56
57	Annunciation panel	2006	5,554		10	278	278	2,502	57
58	Entryway flooring, wallcovering, and countertop replace	2007	6,024		10	409	409	3,272	58
59	Water heater install and plumbing	2007	10,500		10	788	788	6,304	59
60	Doorlock system	2007	13,986		10	466	466	3,728	60
61	Water heater replacement	2007	18,612		10	1,396	1,396	11,168	61
62	Landscaping - painting and patch wrok	2008	3,332		10	333	333	2,331	62
63	Heat pump	2009	6,478		10	648	648	3,564	63
64	Fire alarm upgrade	2009	15,977		10	1,065	1,065	5,857	64
65	New roof - nursing home	2010	93,753		15	2,344	2,344	10,157	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,641,374	\$		\$ 18,306	\$ 18,306	\$ 2,231,654	70

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

Facility Name & ID Number Good Samaritan Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,641,374	\$		\$ 18,306	\$ 18,306	\$ 2,231,654	1
2	Sprinkler System	2011	22,847		15	1,523	1,523	4,950	2
3	HVAC Compressor	2011	10,722		12	894	894	3,278	3
4	Installation new indoor & outdoor lighting, new wiring, outlets	2011	7,463		10	746	746	2,611	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,682,406	\$		\$ 21,469	\$ 21,469	\$ 2,242,493	34

\*\*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	\$ 405,912	\$	\$ 37,694	\$ 37,694	5-15	\$ 437,051	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	664,595					664,595	73
74								74
75	TOTALS	\$ 1,070,507	\$	\$ 37,694	\$ 37,694		\$ 1,101,646	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Ford E450	1998	\$ 48,859	\$	\$			\$ 48,859	76
77	Resident Care	Brake Repairs Ford E450	2006	1,792					1,792	77
78	Resident Care	Dodge Sprinter Van	2007	47,092		5,769	5,769		42,398	78
79										79
80	TOTALS			\$ 97,743	\$	\$ 5,769	\$ 5,769		\$ 93,049	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,873,573	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,932	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 64,932	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,437,188	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ n/a Description: n/a

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	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 Flanagan # 0050567 Report Period Beginning: 1/1/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		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	<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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	1,188	\$		\$	1,188	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				1,892				1,892	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				64,654				64,654	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescrpts					22,855			22,855	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	<b>TOTAL</b>			\$		\$	67,734	\$	22,855	\$	90,589	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 Flanagan# 0050567Report Period Beginning: 1/1/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(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	\$ 916,120	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,127,840		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	339,801		6
7	Other Prepaid Expenses			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>	\$ 2,383,761	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,397,493		12
13	Land	22,917		13
14	Buildings, at Historical Cost	5,854,272		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,074,232		16
17	Accumulated Depreciation (book methods)	(4,257,014)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,091,900	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,475,661	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 289,589	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,673		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,112		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>other current liabilities</u>	117,688		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 605,062	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,012,675		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>	\$ 1,012,675	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,617,737	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,857,924	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,475,661	\$	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,039,850</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">adjust balance sheet</a>	<b>4,243,570</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>7,283,420</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(2,425,496)</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>(2,425,496)</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>4,857,924</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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	635,423	31
32	Health Care	1,048,195	32
33	General Administration	498,456	33
<b>B. Capital Expense</b>			
34	Ownership	13,176	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	132,171	35
36	Provider Participation Fee	98,075	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,425,496	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,425,496)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,425,496)	43

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

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

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

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

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

Facility Name & ID Number Good Samaritan Flanagan

# 0050567

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,109	2,257	\$ 62,839	\$ 27.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,067	4,434	111,466	25.14	3
4	Licensed Practical Nurses	11,013	11,680	283,672	24.29	4
5	CNAs & Orderlies	40,015	42,978	471,035	10.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,098	3,116	36,077	11.58	9
10	Activity Assistants	2,799	3,371	30,258	8.98	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,874	2,025	33,037	16.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,284	16,494	152,930	9.27	15
16	Dishwashers					16
17	Maintenance Workers	4,301	4,670	89,189	19.10	17
18	Housekeepers	4,983	5,329	46,727	8.77	18
19	Laundry	4,830	5,550	53,064	9.56	19
20	Administrator	2,028	2,172	59,521	27.40	20
21	Assistant Administrator					21
22	Other Administrative	7,797	8,466	183,791	21.71	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>transport</u>	212	212	1,815	8.56	33
34	TOTAL (lines 1 - 33)	103,410	112,754	\$ 1,615,421 *	\$ 14.33	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	\$ 2,275	1-2	35
36	Medical Director	6,000	9-3	36
37	Medical Records Consultant	2,957	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,303	10-3	39
40	Physical Therapy Consultant	64,654	39-3	40
41	Occupational Therapy Consultant	1,188	39-3	41
42	Respiratory Therapy Consultant	1,892	39-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 82,269		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-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 Flanagan# 0050567Report Period Beginning: 1/1/14Ending: 12/31/14**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. LSN - \$5000
- (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. \$ 12,345 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.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,075  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? yes Indicate the amount. \$ 4,404
- (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? n/a
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Mcgladrey
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes  
Attach invoices and a summary of services for all architect and appraisal fees.