FOR BHF USE

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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.

I. IDPH License ID Number: 0050575

Facility Name: Good Samaritan Pontiac

Address: 14335 US Highway 66 (Number) Pontiac (City) 61764 (Zip Code)

County: Livingston

Telephone Number: 815-844-5121 **Fax #** 815-844-5690

HFS ID Number:

Date of Initial License for Current Owners: 03/01/10

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: Rob Schlicht **Telephone Number:** 414-431-9335
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Rob Schlicht, Director
(Firm Name & Address) Wipfli LLP, 10000 Innovation Drive, Suite 250, Milwaukee WI 53226
(Telephone) 414-431-9335 Fax # 414-431-9303

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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 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	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	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	1,095		535	1,630	8
9	SNF/PED					9
10	ICF	4,540	1,979		6,519	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,635	1,979	535	8,149	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 18.30%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 03/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 03/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 28 and days of care provided 535

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	121,005	7,382	1,819	130,206		130,206		130,206			1
2	Food Purchase		50,205		50,205		50,205	(1,644)	48,561			2
3	Housekeeping	39,542	11,541		51,083		51,083		51,083			3
4	Laundry	7,652	5,059		12,711		12,711		12,711			4
5	Heat and Other Utilities			157,863	157,863		157,863		157,863			5
6	Maintenance	81,684		33,577	115,261		115,261		115,261			6
7	Other (specify):*											7
8	TOTAL General Services	249,883	74,187	193,259	517,329		517,329	(1,644)	515,685			8
	B. Health Care and Programs											
9	Medical Director			3,500	3,500		3,500		3,500			9
10	Nursing and Medical Records	511,773	19,652	16,792	548,217		548,217		548,217			10
10a	Therapy											10a
11	Activities	7,845	419	1,457	9,721		9,721		9,721			11
12	Social Services	62		913	975		975		975			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	519,680	20,071	22,662	562,413		562,413		562,413			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			19,450	19,450		19,450		19,450			19
20	Dues, Fees, Subscriptions & Promotions			28,375	28,375		28,375		28,375			20
21	Clerical & General Office Expenses	71,717	1,443	76,860	150,020		150,020		150,020			21
22	Employee Benefits & Payroll Taxes			163,643	163,643		163,643		163,643			22
23	Inservice Training & Education											23
24	Travel and Seminar			691	691		691		691			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			7,733	7,733		7,733		7,733			26
27	Other (specify):*											27
28	TOTAL General Administration	71,717	1,443	296,752	369,912		369,912		369,912			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	841,280	95,701	512,673	1,449,654		1,449,654	(1,644)	1,448,010			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Good Samaritan Pontiac #0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

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							90,061	90,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			442	442		442		442			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			442	442		442	90,061	90,503			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,923	59,266	85,189		85,189		85,189			39
40	Barber and Beauty Shops			902	902		902		902			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,403	95,403		95,403		95,403			42
43	Other (specify):*			8,148	8,148		8,148	(8,148)				43
44	**TOTAL Special Cost Centers**		25,923	163,719	189,642		189,642	(8,148)	181,494			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	841,280	121,624	676,834	1,639,738		1,639,738	80,269	1,720,007			45

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 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.)

	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	(1,644)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	90,061	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,614)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,534)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 80,269		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 80,269		37

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

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

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

Good Samaritan Pontiac

ID# 0050575

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	laboratory	$ (5,534)	43	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,534)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Pontiac # 0050575 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,644)	0	0	0	0	0	0	0	0	0	0	(1,644)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,644)	0	0	0	0	0	0	0	0	0	0	(1,644)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,644)	0	0	0	0	0	0	0	0	0	0	(1,644)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Pontiac **#** 0050575 **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 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	90,061	0	0	0	0	0	0	0	0	0	0	90,061	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	90,061	0	0	0	0	0	0	0	0	0	0	90,061	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):*	(8,148)	0	0	0	0	0	0	0	0	0	0	(8,148)	43
44	**TOTAL Special Cost Centers**	(8,148)	0	0	0	0	0	0	0	0	0	0	(8,148)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	80,269	0	0	0	0	0	0	0	0	0	0	80,269	45

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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
x						

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 [x] 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	Total				$			$	$ *	14

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 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 PONTIAC		Good Samaritan - Flanagan	Flanagan				1
2								2
3	William Coffin	BOD						3
4	Richard Hiatt	BOD						4
5	Jeff Rients	BOD						5
6	Audrey Harlan	BOD						6
7								7
8								8
9								9
10	GOOD SAMARITAN GROUP		Good Samaritan - Flanagan	Flanagan				10
11								11
12	Richard Hiatt	BOD						12
13	William Coffin	BOD						13
14	Alrene Martin	BOD						14
15	Pastor Ryan Anderson	BOD						15
16	Jeff Rients	BOD						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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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	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	See Page 6 supplemental	Board Members	Administrative	0.00	n/a						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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 [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 Samaritan Pontiac # 0050575 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	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	State Bank of Graymont		x	working capital			50,000			4.5000	442	6
7												7
8												8
9	TOTAL Facility Related						$ 50,000	$			$ 442	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 50,000	$			$ 442	15

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

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

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

Facility Name & ID Number Good Samaritan Pontiac **#** 0050575 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 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. **(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:		
	2009	8
	2010	9
	2011	10
	2012	11
	2013	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Pontiac COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050575

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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) 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 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 Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (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. [x] (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 [x] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1968	$ 199,500	1
2					2
3	TOTALS			$ 199,500	3

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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 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	122			1968	$ 954,253	$		$ 19,085	$ 19,085	$ 919,230	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1968	57,846		20			57,846	9
10	Various			1969	4,376		20			4,376	10
11	Various			1973	2,959		20	59	59	2,458	11
12	Various			1977	15,710		20	282	282	12,051	12
13	Various			1978	61,749		20	435	435	56,097	13
14	Various			1979	63,068		20	1,151	1,151	46,955	14
15	Various			1980	11,757		20	57	57	10,897	15
16	Various			1981	16,455		20	156	156	13,963	16
17	Various			1982	14,538		20	28	28	14,050	17
18	Various			1983	25,807		20	233	233	21,608	18
19	Various			1984	41,685		20			41,685	19
20	Various			1985	10,183		20			10,183	20
21	Various			1986	14,031		20	85	85	12,237	21
22	Various			1987	28,935		20			28,935	22
23	Various			1988	6,621		20			6,621	23
24	Various			1989	116,257		20	2,169	2,169	64,285	24
25	Various			1990	20,708		20			20,708	25
26	Various			1991	31,573		20	766	766	18,524	26
27	Various			1992	391,614		20	8,966	8,966	193,862	27
28	Various			1993	563,498		20	10,153	10,153	245,357	28
29	Various			1994	27,223		20	726	726	14,226	29
30	Various			1995	173,018		20	3,377	3,377	69,005	30
31	Various			1996	19,810		20	414	414	8,245	31
32	Various			1997	17,298		20	751	751	13,453	32
33	Various			1998	13,384		20	642	642	10,412	33
34	Various			1999	453,866		20	9,611	9,611	148,931	34
35	Various			2000	31,996		20	1,601	1,601	23,183	35
36	Various			2001	74,897		20	3,745	3,745	46,293	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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	
37	Various	2002	$ 48,224	$	20	$ 2,411	$ 2,411	$ 30,457	37
38	Various	2003	5,662		20	450	450	5,056	38
39	Various	2004	17,148		20	774	774	17,148	39
40	Various	2005	1,829		20	91	91	851	40
41		2006							41
42	Alarm and keypad for door	2006	1,565		20	78	78	683	42
43	Paving and concrete	2006	23,550		20	1,178	1,178	10,208	43
44	Double door system	2006	5,747		20	287	287	2,489	44
45	A/C Parts	2006	4,659		20	233	233	1,922	45
46	Boiler and stack repairs	2006	5,950		20	298	298	2,482	46
47	Door alarm system	2006	40,131		20	2,007	2,007	16,389	47
48	Motion Lights	2006	1,174		20	59	59	525	48
49	Repipe and rewire kitchen	2006	1,409		20	70	70	626	49
50	Fire Doors	2006	6,281		20	314	314	2,722	50
51	Fire alarm control panel	2006	2,122		20	106	106	848	51
52	Smoke dampers	2007	5,504		20	275	275	2,086	52
53	Hot water tank repairs	2007	1,350		20	68	68	531	53
54	Roof top A/C unit	2007	4,596		20	383	383	2,809	54
55	Circuit breaker panel	2007	3,780		20	189	189	1,370	55
56	Well water pump	2007	2,013		20	101	101	715	56
57	Door alarm system - camera	2007	5,577		20	372	372	2,820	57
58	Door alarm system - voice page	2007	1,777		20	105	105	1,777	58
59	Coil for walk in cooler	2008	1,132		20	113	113	688	59
60	Thermostats	2008	3,350		20	335	335	2,038	60
61	Block Heater	2008	1,127		20	113	113	781	61
62	Thermostatic mixing valve	2008	14,000		20	1,400	1,400	8,517	62
63	Kitchen waste line	2008	5,900		20	590	590	3,638	63
64	HVAC System	2009	6,500		20	325	325	1,950	64
65	Boiler Work	2009	3,521		20	176	176	1,056	65
66	Boiler and plumbing repair	2010	9,435		20	472	472	2,124	66
67	Fire alarm	2010	5,404		20	270	270	1,215	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,505,532	$		$ 78,134	$ 78,134	$ 2,262,197	70

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 245,836	$	$ 11,927	$ 11,927		$ 257,763	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	398,724					398,724	73
74								74
75	TOTALS	$ 644,560	$	$ 11,927	$ 11,927		$ 656,487	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1883 Taurus	1993	$ 14,704	$	$	$		$ 14,704	76
77	Facility Use	Bus	1996	45,146					45,146	77
78										78
79										79
80	TOTALS			$ 59,850	$	$	$		$ 59,850	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,409,442	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,061	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 90,061	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,978,534	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 [x] 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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	43-3	hrs	$		$ 21,199	$		$ 21,199	1
2	Licensed Speech and Language Development Therapist	43-3	hrs			5,804			5,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	43-3	hrs			37,263			37,263	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				14,718		14,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): oxygen	39-3					11,205		11,205	12
13	Other (specify):									13
14	TOTAL			$		$ 64,266	$ 25,923		$ 90,189	14

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

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan Pontiac **#** 0050575 **Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 111,451	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	453,717		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,818		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)**	$ 566,986	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	150,062		16
17	Accumulated Depreciation (book methods)			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): CIP	397,052		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 547,114	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,114,100	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,206,023	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,336,141		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	other liabilities	190,850		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,733,014	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,733,014	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,618,914)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,114,100	$	48

***(See instructions.)**

Facility Name & ID Number Good Samaritan Pontiac **#** 0050575 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (549,533)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (549,533)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(285,666)	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)**	$ (285,666)	17
	B. Transfers (Itemize):		
18	**equity adjustment**	(783,715)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (783,715)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,618,914)	24 *

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 1,054,594	1
2	Discounts and Allowances for all Levels	(82,965)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 971,629	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,328	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 101,328	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,645	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,988	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,667	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,300	23
	D. Non-Operating Revenue		
24	Contributions	1,783	24
25	Interest and Other Investment Income***	7,212	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,995	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other revenue (see grouping)	253,820	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 253,820	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,354,072	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	517,329	31
32	Health Care	562,413	32
33	General Administration	369,912	33
	B. Capital Expense		
34	Ownership	442	34
	C. Ancillary Expense		
35	Special Cost Centers	94,239	35
36	Provider Participation Fee	95,403	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,639,738	40
41	**Income before Income Taxes (line 30 minus line 40)****	(285,666)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (285,666)	43

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

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

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

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

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,160	$ 56,086	$ 25.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,003	5,465	125,765	23.01	3
4	Licensed Practical Nurses	5,259	6,183	129,256	20.91	4
5	CNAs & Orderlies	15,348	16,586	200,666	12.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	639	780	7,845	10.06	10
11	Social Service Workers	2	2	62	31.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,422	2,767	53,505	19.34	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,144	4,436	81,684	18.41	17
18	Housekeepers	3,548	4,173	39,542	9.48	18
19	Laundry	271	692	7,652	11.06	19
20	Administrator	2,080	2,080	67,500	32.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,657	5,160	71,717	13.90	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)					33
34	TOTAL (lines 1 - 33)	45,405	50,484	$ 841,280 *	$ 16.66	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	monthly	$ 1,741	1-3	35
36	Medical Director	monthly	3,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,440	10-3	39
40	Physical Therapy Consultant		37,263	43-3	40
41	Occupational Therapy Consultant		16,199	43-3	41
42	Respiratory Therapy Consultant		5,804	43-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	880	11-3	44
45	Social Service Consultant	12	913	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	$ 67,740		49

C. CONTRACT NURSES

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

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Infinisource	payroll processing	$ 1,781
Hartweg	legal fees	15,392
Wipfli/McGladrey	accounting	2,277
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 19,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,861
Unemployment Compensation Insurance	9,846
FICA Taxes	24,521
Employee Health Insurance	55,313
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Medicare	5,735
physicals	1,251
staff appreciation	648
life/vision/dental	4,468
TOTAL (agree to Schedule V, line 22, col.8)	$ 163,643

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	351
(Indicate # of checks performed)	
Patient Background Checks	
dues and fees	28,024
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,375

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	691
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 691

**See instructions.

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Good Samaritan Pontiac # 0050575 Report Period Beginning: 1/1/14 Ending: 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 - 3000**

(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. $ **9,119** 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. $ **95,403**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **none** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **1,645**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.