FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0050567

Facility Name: Good Samaritan Flanagan

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

County: Livingston

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

HFS ID Number:

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

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		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 _____ to _____ and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,833	4,263	847	8,943	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,833	4,263	847	8,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.72%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/68

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 60 and days of care provided 847

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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	532,893	30,428	30,060	593,381		593,381		593,381			1
2	Food Purchase		330,125		330,125		330,125	(29,769)	300,356			2
3	Housekeeping	200,421	30,993		231,414		231,414		231,414			3
4	Laundry		20,902	1,005	21,907		21,907		21,907			4
5	Heat and Other Utilities			290,184	290,184		290,184		290,184			5
6	Maintenance	213,006	13,510	325,880	552,396		552,396		552,396			6
7	Other (specify):*											7
8	TOTAL General Services	946,320	425,958	647,129	2,019,407		2,019,407	(29,769)	1,989,638			8
	B. Health Care and Programs											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	2,427,829	87,415	139,100	2,654,344		2,654,344		2,654,344			10
10a	Therapy											10a
11	Activities	184,293	12,488	1,834	198,615		198,615		198,615			11
12	Social Services	9,883		388	10,271		10,271		10,271			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,622,005	99,903	159,822	2,881,730		2,881,730		2,881,730			16
	C. General Administration											
17	Administrative	106,426			106,426		106,426		106,426			17
18	Directors Fees											18
19	Professional Services			90,092	90,092		90,092		90,092			19
20	Dues, Fees, Subscriptions & Promotions			64,388	64,388		64,388		64,388			20
21	Clerical & General Office Expenses	532,425	13,909	220,758	767,092		767,092	(614)	766,478			21
22	Employee Benefits & Payroll Taxes			580,471	580,471		580,471		580,471			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,634	9,634		9,634		9,634			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			603,274	603,274		603,274		603,274			26
27	Other (specify):*											27
28	TOTAL General Administration	638,851	13,909	1,568,617	2,221,377		2,221,377	(614)	2,220,763			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,207,176	539,770	2,375,568	7,122,514		7,122,514	(30,383)	7,092,131			29

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

Facility Name & ID Number Good Samaritan Flanagan #0050567 Report Period Beginning: Ending:

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			(184,078)	(184,078)		(184,078)	205,120	21,042			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,513	25,513		25,513		25,513			32
33	Real Estate Taxes			245,838	245,838		245,838		245,838			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			87,273	87,273		87,273	205,120	292,393			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	119,262	81,648	354,328	555,238		555,238	(555,238)				39
40	Barber and Beauty Shops			25,195	25,195		25,195		25,195			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			264,638	264,638		264,638		264,638			42
43	Other (specify):* **xray/lab/mkt**			39,181	39,181		39,181	(39,181)				43
44	**TOTAL Special Cost Centers**	119,262	81,648	683,342	884,252		884,252	(594,419)	289,833			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,326,438	621,418	3,146,183	8,094,039		8,094,039	(419,682)	7,674,357			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: Ending:

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	(29,769)	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	205,120	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				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	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 175,351		$	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	(595,033)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (595,033)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (419,682)		37

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

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

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

Good Samaritan Flanagan

ID# 0050567

Report Period Beginning:

Ending:

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Public Relations	$ (614)	21	1
2	xray, lab, farm, fundraising	(39,181)	43	2
3	therapies	(473,590)	39	3
4	pharmacy	(81,648)	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	**Total**	(595,033)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Flanagan **#** 0050567 **Report Period Beginning:** **Ending:**

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	(29,769)	0	0	0	0	0	0	0	0	0	0	(29,769)	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**	(29,769)	0	0	0	0	0	0	0	0	0	0	(29,769)	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	(614)	0	0	0	0	0	0	0	0	0	0	(614)	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**	(614)	0	0	0	0	0	0	0	0	0	0	(614)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,383)	0	0	0	0	0	0	0	0	0	0	(30,383)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Flanagan # 0050567 **Report Period Beginning:** **Ending:**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	205,120	0	0	0	0	0	0	0	0	0	0	205,120	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**	205,120	0	0	0	0	0	0	0	0	0	0	205,120	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	(555,238)	0	0	0	0	0	0	0	0	0	0	(555,238)	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):*	(39,181)	0	0	0	0	0	0	0	0	0	0	(39,181)	43
44	**TOTAL Special Cost Centers**	(594,419)	0	0	0	0	0	0	0	0	0	0	(594,419)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(419,682)	0	0	0	0	0	0	0	0	0	0	(419,682)	45

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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	Total			$			$	$ *	14

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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	Richard Hiatt	BOD						1
2	Dennis Jones	BOD						2
3	Jeff Rients	BOD						3
4	Ryan Anderson	BOD						4
5	Arlene Martin	BOD						5
6	Janice Weber	BOD						6
7								7
8	Good Samaritan Group Board							8
9	Richard Hiatt	BOD						9
10	William Coffin	BOD						10
11	Arlene Martin	BOD						11
12	Ryan Anderson	BOD						12
13	Jeff Rients	BOD						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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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	0						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: Ending:

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 Flanagan # 0050567 Report Period Beginning: Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Flanagan State Bank		x	Mortgage	$2,880.00	4/18/08	$ 213,612	$ 133,693	4/25/18	4.7500	$ 12,106	1
2	State Bank of Graymont		x	Mortgage		7/25/13	426,361	0	7/25/23	4.0000	10,892	2
3	State Bank of Graymont		x	Mortgage	$27,810.00	10/25/16	902,700	549,132	11/18/16	4.0000	1,427	3
4	State Bank of Graymont		x	Mortgage		07/26/16	109,266	0	10/25/16	4.0000	1,088	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$30,690.00		$ 1,651,939	$ 682,825			$ 25,513	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,651,939	$ 682,825			$ 25,513	15

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

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

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: Ending:

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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	facility		1966	$ 22,917	1
2					2
3	TOTALS			$ 22,917	3

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1968	1968	$ 754,053	$	40	$	$	$ 754,053	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	49,983		20	584	584	29,705	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	137,359	14
15	Various			1996	30,610		20	765	765	16,069	15
16	Various			1997	29,894		20	766	766	14,846	16
17	Various			2000	34,290		20	1,040	1,040	17,431	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	826	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 & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Kitchen Addition	2003	$ 5,377	$	7	$	$	$ 5,377	37
38	Mc Cable	2003	589		10			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	314	43
44	Phone Switch	2003	150		10			150	44
45	Paint rooms	2004	1,120		10			1,120	45
46	Am carad for boiler	2004	816		10			816	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	675	49
50	Painting	2005	2,200		10			2,200	50
51	Nurses station	2005	5,000		20	250	250	2,792	51
52									52
53	Nurses station updgrade	2006	1,279		20	32	32	352	53
54	General project parts - nurses station	2006	1,127		20	28	28	308	54
55	Fire safety systems additions	2006	2,977		20	74	74	814	55
56	Phone lines	2006	344		10	17	17	187	56
57	Annunciation panel	2006	5,554		10	278	278	3,058	57
58	Entryway flooring, wallcovering, and countertop replace	2007	6,024		10	409	409	4,090	58
59	Water heater install and plumbing	2007	10,500		10	788	788	7,880	59
60	Doorlock system	2007	13,986		10	466	466	4,660	60
61	Water heater replacement	2007	18,612		10	1,396	1,396	13,960	61
62	Landscaping - painting and patch wrok	2008	3,332		10	333	333	2,997	62
63	Heat pump	2009	6,478		10	648	648	4,860	63
64	Fire alarm upgrade	2009	15,977		10	1,065	1,065	7,987	64
65	New roof - nursing home	2010	93,753		15	2,344	2,344	14,845	65
66	Sprinkler System	2011	22,847		15	1,523	1,523	7,996	66
67	HVAC Compressor	2011	10,722		12	894	894	5,066	67
68	Installation new indoor & outdoor lighting, new wiring, outlets	2011	7,463		10	746	746	4,103	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,682,406	$		$ 21,042	$ 21,042	$ 2,284,640	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: Ending:

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	$	$	$		$ 405,912	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	664,595					664,595	73
74								74
75	TOTALS	$ 1,070,507	$	$	$		$ 1,070,507	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	$	$	$		$ 48859	76
77	Resident Care	Brake Repairs Ford E450	2006	1,792					1792	77
78	Resident Care	Dodge Sprinter Van	2007	47,092					47092	78
79										79
80	TOTALS			$ 97,743	$	$	$		$ 97,743	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)	$ 21,042	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,042	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,452,890	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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 [x] 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.	/2017	$
13.	/2018	$
14.	/2019	$

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 Flanagan # 0050567 Report Period Beginning: Ending:

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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	39-3	hrs	$ 26,770		$ 55,447	$		$ 82,217	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,975			13,975	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	92,492		264,532			357,024	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				77,456		77,456	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 119,262		$ 333,954	$ 77,456		$ 530,672	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 **#** 0050567 **Report Period Beginning:** **Ending:**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** _____ **(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	$ (75,433)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,108,796		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(50,937)		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)**	$ 982,426	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,309,117		13
14	Buildings, at Historical Cost	5,750,312		14
15	Leasehold Improvements, at Historical Cost	104,555		15
16	Equipment, at Historical Cost	1,080,098		16
17	Accumulated Depreciation (book methods)	(4,006,520)		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): LSNRRG Insurance Prog.	111,293		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,348,855	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,331,281	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	241,266		29
30	Accrued Salaries Payable	158,866		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,160		32
33	Accrued Interest Payable			33
34	Deferred Compensation	662,410		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,126,702	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,987		39
40	Mortgage Payable	446,677		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)**	$ 492,664	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,619,366	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,711,915	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,331,281	$	48

***(See instructions.)**

Facility Name & ID Number Good Samaritan Flanagan **#** 0050567 **Report Period Beginning:** **Ending:**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,039,596	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,039,596	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	672,320	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)**	$ 672,320	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,711,916	24 *

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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	$ 7,487,941	1
2	Discounts and Allowances for all Levels	(285,454)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,202,487	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	231,487	6
7	Oxygen	3,220	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 234,707	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	10,793	13
14	Non-Patient Meals	29,769	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,063	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,509	19
20	Radiology and X-Ray		20
21	Other Medical Services	375,489	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 431,623	23
	D. Non-Operating Revenue		
24	Contributions	627,607	24
25	Interest and Other Investment Income***	414	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 628,021	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	summerfest, farm, benefit, misc, resident trust	269,521	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 269,521	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,766,359	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,019,407	31
32	Health Care	2,881,730	32
33	General Administration	2,221,377	33
	B. Capital Expense		
34	Ownership	87,273	34
	C. Ancillary Expense		
35	Special Cost Centers	619,614	35
36	Provider Participation Fee	264,638	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,094,039	40
41	**Income before Income Taxes (line 30 minus line 40)****	672,320	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 672,320	43

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

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

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

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

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,823	2,025	$ 96,981	$ 47.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,165	19,072	477,938	25.06	3
4	Licensed Practical Nurses	42,265	46,960	788,474	16.79	4
5	CNAs & Orderlies	84,108	93,453	1,064,435	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,093	2,171	119,262	54.93	8
9	Activity Director	5,448	6,053	95,634	15.80	9
10	Activity Assistants	8,797	9,775	88,659	9.07	10
11	Social Service Workers	550	550	9,883	17.97	11
12	Dietician					12
13	Food Service Supervisor	5,861	6,513	85,381	13.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,361	39,290	447,512	11.39	15
16	Dishwashers					16
17	Maintenance Workers	8,203	9,115	213,006	23.37	17
18	Housekeepers	17,966	19,963	200,421	10.04	18
19	Laundry					19
20	Administrator	2,096	2,543	106,426	41.85	20
21	Assistant Administrator					21
22	Other Administrative	37,790	41,989	532,426	12.68	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)					33
34	TOTAL (lines 1 - 33)	269,526	299,472	$ 4,326,438 *	$ 14.45	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		$ 14,989	1-3	35
36	Medical Director				36
37	Medical Records Consultant		8,160	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,270	10-3	39
40	Physical Therapy Consultant		264,018	39-3	40
41	Occupational Therapy Consultant		55,447	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		1,377	39-3	43
44	Activity Consultant		149	11-3	44
45	Social Service Consultant		149	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 350,559		49

C. CONTRACT NURSES

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

Facility Name & ID Number Good Samaritan Flanagan # 0050567 Report Period Beginning: Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jordan Post/Glenda Tannahill	administrator	0	$ 106,426
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,426

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
mcgladrey/wipfli	accounting	$ 42,619
hertweg	legal	34,776
infinisource	payroll processing	12,697
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 90,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	88,177
FICA Taxes	328,376
Employee Health Insurance	116,543
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff appreciation	8,577
Life insurnace	7,880
Vision	6,661
Dental	34,223
Vaccines	697
Uniforms	(17,179)
drug testing/physicals	6,516
TOTAL (agree to Schedule V, line 22, col.8)	$ 580,471

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,403
(Indicate # of checks performed)	
Patient Background Checks	910
Dues/Fees	62,075
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 64,388

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,634
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,634

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Good Samaritan Flanagan # 0050567 **Report Period Beginning:** **Ending:**

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. **Leading Age IL $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?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,994** 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. $ **264,638**
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. $ **no** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **29,769**

(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? **100**
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? **no**
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