FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-8717 **Fax #** (217) 223-6015

HFS ID Number:

Date of Initial License for Current Owners: 02/22/1957

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
X	Trust		Partnership		County
IRS Exemption Code	501(c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Stephanie D Erwin **Telephone Number:** (217) 223-8717
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 10/1/16 to 9/30/17 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) Mr. Michael Duffy
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Camille B. Lockhart, Partner
(Firm Name & Address) BKD, LLP, P O Box 1190, Springfield, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	85	Skilled (SNF)	85	31,025	1
2		Skilled Pediatric (SNF/PED)			2
3	118	Intermediate (ICF)	118	43,070	3
4		Intermediate/DD			4
5	28	Sheltered Care (SC)	28	10,220	5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	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	1,161	1,301	7,566	10,028	8
9	SNF/PED					9
10	ICF	20,947	30,933		51,880	10
11	ICF/DD					11
12	SC	896	6,782		7,678	12
13	DD 16 OR LESS					13
14	TOTALS	23,004	39,016	7,566	69,586	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.53%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy - Pool Exercise Classes, Assisted Living Center days 9,483

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 [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/22/1957

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 35 and days of care provided 6,762

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: 9/30/17 Fiscal Year: 9/30/17

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	1,063,477	71,664	31,528	1,166,669		1,166,669		1,166,669			1
2	Food Purchase		933,260		933,260		933,260	(87,948)	845,312			2
3	Housekeeping	440,679	59,775		500,454		500,454	(5,000)	495,454			3
4	Laundry	137,329	18,518	(2,400)	153,447		153,447		153,447			4
5	Heat and Other Utilities			389,411	389,411		389,411		389,411			5
6	Maintenance	337,309	78,186	349,960	765,455		765,455		765,455			6
7	Other (specify):*											7
8	TOTAL General Services	1,978,794	1,161,403	768,499	3,908,696		3,908,696	(92,948)	3,815,748			8
	B. Health Care and Programs											
9	Medical Director			564	564		564		564			9
10	Nursing and Medical Records	5,687,377	326,989	19,735	6,034,101		6,034,101		6,034,101			10
10a	Therapy	99,213	4,713	574,452	678,378		678,378		678,378			10a
11	Activities	233,595	14,402	11,148	259,145		259,145		259,145			11
12	Social Services	197,105	(1,835)	743	196,013		196,013		196,013			12
13	CNA Training					16,915	16,915		16,915			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,217,290	344,269	606,642	7,168,201	16,915	7,185,116		7,185,116			16
	C. General Administration											
17	Administrative	267,657		8,814	276,471		276,471		276,471			17
18	Directors Fees											18
19	Professional Services			72,598	72,598		72,598	(4,750)	67,848			19
20	Dues, Fees, Subscriptions & Promotions			65,611	65,611		65,611	(3,101)	62,510			20
21	Clerical & General Office Expenses	597,343	70,893	351,810	1,020,046		1,020,046	(229,314)	790,732			21
22	Employee Benefits & Payroll Taxes			2,775,587	2,775,587	(16,915)	2,758,672	(21,550)	2,737,122			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,197	14,197		14,197	(2,722)	11,475			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			163,749	163,749		163,749		163,749			26
27	Other (specify):*											27
28	TOTAL General Administration	865,000	70,893	3,452,366	4,388,259	(16,915)	4,371,344	(261,437)	4,109,907			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,061,084	1,576,565	4,827,507	15,465,156		15,465,156	(354,385)	15,110,771			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 Home #0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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			1,129,226	1,129,226		1,129,226	(4,990)	1,124,236			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			219,341	219,341		219,341		219,341			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,348,567	1,348,567		1,348,567	(4,990)	1,343,577			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			389,833	389,833		389,833		389,833			39
40	Barber and Beauty Shops	74,590	6,351		80,941		80,941		80,941			40
41	Coffee and Gift Shops	24,872	46,155		71,027		71,027		71,027			41
42	Provider Participation Fee			443,423	443,423		443,423		443,423			42
43	Other (specify):*	242,940		924,569	1,167,509		1,167,509	(1,167,509)				43
44	**TOTAL Special Cost Centers**	342,402	52,506	1,757,825	2,152,733		2,152,733	(1,167,509)	985,224			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,403,486	1,629,071	7,933,899	18,966,456		18,966,456	(1,526,884)	17,439,572			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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(77,814)	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	(1,375)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(10,134)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,275)	43		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	(4,750)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(100)	20		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	(1,430,436)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,526,884)		$	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))**	$ (1,526,884)		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 Home

ID# 0009258

Report Period Beginning: 10/1/16

Ending: 9/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISCELLANEOUS INCOME	$ (36,305)	21	1
2	MANAGEMENT FEE INCOME	(120,000)	21	2
3	GUEST ROOM INCOME	(3,615)	30	3
4				4
5	SMOKING/PET CLEANING FEE	(5,000)	3	5
6	PUBLIC RELATIONS-SALARY	(73,009)	21	6
7	PUBLIC RELATIONS-EMP BENEFIT ALLOC	(21,550)	22	7
8	LOBBYING EXPENSE	(2,548)	20	8
9	DUES: CHAMBER OF COMMERCE/KIWANIS	(453)	20	9
10	ENDOWMENT EXPENSES	(71,309)	43	10
11	REAL ESTATE TAXES	(52,296)	43	11
12	FOUNDATION EXPENSES	(9,638)	43	12
13	RESIDENT CABLE	(40,540)	43	13
14	COTTAGE EXPENSES	(637,129)	43	14
15	ASSISTED LIVING SALARIES	(242,940)	43	15
16	ASSISTED LIVING DEPRECIATON	(111,345)	43	16
17	DEPRECIATION-RADIO STATION	(37)	43	17
18	SEMINARS-DEV DIRECTOR	(2,722)	24	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**	(1,430,436)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(87,948)	0	0	0	0	0	0	0	0	0	0	(87,948)	2
3	Housekeeping	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	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	(92,948)	0	0	0	0	0	0	0	0	0	0	(92,948)	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	(4,750)	0	0	0	0	0	0	0	0	0	0	(4,750)	19
20	Fees, Subscriptions & Promotions	(3,101)	0	0	0	0	0	0	0	0	0	0	(3,101)	20
21	Clerical & General Office Expenses	(229,314)	0	0	0	0	0	0	0	0	0	0	(229,314)	21
22	Employee Benefits & Payroll Taxes	(21,550)	0	0	0	0	0	0	0	0	0	0	(21,550)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,722)	0	0	0	0	0	0	0	0	0	0	(2,722)	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	(261,437)	0	0	0	0	0	0	0	0	0	0	(261,437)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(354,385)	0	0	0	0	0	0	0	0	0	0	(354,385)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/1/16 **Ending:** 9/30/17

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	(4,990)	0	0	0	0	0	0	0	0	0	0	(4,990)	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**	(4,990)	0	0	0	0	0	0	0	0	0	0	(4,990)	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):*	(1,167,509)	0	0	0	0	0	0	0	0	0	0	(1,167,509)	43
44	**TOTAL Special Cost Centers**	(1,167,509)	0	0	0	0	0	0	0	0	0	0	(1,167,509)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,526,884)	0	0	0	0	0	0	0	0	0	0	(1,526,884)	45

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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
N/A	N/A	N/A	N/A	N/A	N/A	N/A

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		N/A						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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V		N/A						17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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

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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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	Gary Blickhan	BOD						1
2	Andrew Cashman	BOD						2
3	Laura Ehrhart	BOD						3
4	John Heidbreder	BOD	N/A	N/A	N/A	N/A	N/A	4
5	Jerry Jackson	BOD						5
6	Paul Kemner	BOD						6
7	Rob Overholser	BOD						7
8	Alok Patel	BOD						8
9	Randy Riley	BOD						9
10	Larry Shepherd	BOD						10
11	Jeff Spear	BOD						11
12	Steve Wavering	BOD						12
13								13
14	Auxillary Representatives							14
15	Billie Menke	BOD						15
16	Janet Scheeberger	BOD						16
17								17
18	Uncle Sam Representatives							18
19	Richard Bowman	BOD						19
20	Richard Walz	BOD						20
21	Robert Young	BOD						21
22								22
23	Illinois Conference UCC Representatives							23
24	Sharon Higgins	BOD						24
25	Mike Oberdahlhoff	BOD						25
26	Raymond Scheiter	BOD						26
27								27
28								28
29								29
30								30

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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		N/A								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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 ☐

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Street Address
City / State / Zip Code
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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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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	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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization
Street Address
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Phone Number ( )
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	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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
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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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 ☐

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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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 ☐

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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 ☐

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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	SERIES 2013C BONDS		X	MORTGAGE	$44,540.00	7/11/13	$ 7,960,000	$ 5,483,641	8/1/33	3.0500	$ 212,099	1
2				AMORT OF LOAN COST				(60,723)			7,242	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$44,540.00		$ 7,960,000	$ 5,422,918			$ 219,341	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,960,000	$ 5,422,918			$ 219,341	15

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

*** 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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012	N/A	8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (217) 223-8717 FAX #: (217) 223-6015

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,970 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

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).

Residential Cottage Apartments 180 Units for 199,478 square feet

Assisted Living Facilties with 26 beds for 15,900 square feet Resident Days 9483

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	1,219,680	1956-2010	$ 114,502	1
2	Facility		2011	330,147	2
3	TOTALS	1,219,680		$ 444,649	3

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	48			1962	$ 683,823	$	40	$	$	$ 683,823	4
5	68			1973	1,683,761		40			1,683,761	5
6	91			1984	1,953,541	48,839	40	48,839		1,640,165	6
7	24			2010	1,695,151	73,166	Various	73,166		542,650	7
8											8
	Improvement Type**										
9	Building Service Equipment			1983	10,058		20			10,058	9
10	Land Improvements			1984	37,294		15			37,294	10
11	Building Service Equipment			1984	299,341		Various			299,341	11
12	Building Improvements			1985	250,935	6,273	40	6,273		202,423	12
13	Building Service Equipment			1985	23,430		Various			23,430	13
14	Building Improvements			1986	119,616	2,990	40	2,990		93,697	14
15	Building Service Equipment			1986	137,391		Various			137,391	15
16	Building Service Equipment			1987	10,451		20			10,451	16
17	Building Service Equipment - Disposal 2017			1988			15				17
18	Building Improvements			1989	130,612	4,354	30	4,354		126,256	18
19	Building Improvements State Audit Adjustments 10881+30372			1991	511,992	18,441	30	17,066	(1,375)	449,353	19
20	Building Services Equipment			1991	22,309		Various			22,309	20
21	Kitchen/Dining Room			1993	310,412	7,760	40	7,760		188,833	21
22	Building Services Equipment			1993	5,941	238	25	238		5,723	22
23	Parking Lot			1994	87,827		15			87,827	23
24	Sidewalk			1994	7,875		15			7,875	24
25	Dining Room			1994	6,305		Various			6,305	25
26	Building Services Equipment			1994	61,368		Various			61,368	26
27	Building Services Equipment			1995	12,183		15			12,183	27
28	Gutters			1996	10,817		20			10,817	28
29	Roof			1996	9,016		20			9,016	29
30	Roof - Anna Brown Wing			1996	70,800	295	20	295		70,800	30
31	Building Services Equipment			1996	38,438		various			38,438	31
32											32
33	Sprinkling System			1997	3,354		10			3,354	33
34	Tamper Detectors - Dispose of in 2016			1997							34
35	Sprinkler System			1997	102,875	4,715	20	4,715		102,875	35
36	Roof- Kitchen/Dining			1998	40,400	1,036	39	1,036		20,450	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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	Elevator Doors - Dietary	1998	$ 1,095	$	10	$	$	$ 1,095	37
38	Remodeling -Anna Brow Wing Walls, Ceiling, Floors,Lights	1999	199,131	4,978	39	4,978		90,646	38
39	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	538	39	538		10,153	39
40	Chapel Roof	1999	21,515	548	39	548		10,067	40
41	Fire Damper Alarm - Dispose of 2016	1999							41
42	Eber Parking Lot Lights	1999	5,495		15			5,495	42
43	Stainless Steel D/W Exhaust	1999	1,659		10			1,659	43
44	Wiring Chapel Roof	1999	332		10			332	44
45	Code Alert System - Disposal 2017	1999			5				45
46	Elevator Upgrade A/B East	1999	22,556		10			22,556	46
47	Elevator Upgrade - Special Care	1999	5,970		10			5,970	47
48	Fire Protection A/B	1999	4,500		10			4,500	48
49	Condensor Unit - Disposal 2017	1999			15				49
50	Fire Protection Pool Area	1999	776		10			776	50
51	Damper Duct Work - Disposal 2017	1999			15				51
52	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		6,288	52
53	Kitchen Remodeling - Sidewalls	2000	3,485		15			3,485	53
54	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601		15			2,601	54
55	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		11,567	55
56	Eber Wing Smoke Damper Dispose of 2016	2000							56
57	HVAC Rehab Eber Wing - Dispose of in 2016	2000							57
58	3 Ton Rooftop Unit A/C West Dining - Disposal 2017	2000			15				58
59	Elevator Up Grade East Wing	2000	12,776		15			12,776	59
60	Entrance Codelock Special Care	2000							60
61	Life Safety Code Sprinkler Drains	2000	7,000		15			7,000	61
62	Land Improvement New Sidewalk	2000	1,200	60	20	60		990	62
63	Renovation of East Nursing Wing	2001	369,213	9,230	39	9,230		149,608	63
64	Painting Kitchen Dispose of in 2016	2001							64
65	Kitchen Electrical Work	2000	611		15			611	65
66	HVAC Rehab Eber Wing - Dispose of in 2016	2000			15				66
67	Sprinklers	2000	4,151		15			4,151	67
68	Wet Chemical Fire Suppressor Work	2000	3,695		15			3,695	68
69	Electrical Work	2001	1,609		15			1,609	69
70	TOTAL (lines 4 thru 69)		$ 9,070,118	$ 184,499		$ 183,124	$ (1,375)	$ 6,945,896	70

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,070,118	$ 184,499		$ 183,124	$ (1,375)	$ 6,945,896	1
2	Smoke/ Fire Damper East, South and Eber - Dispose in 2016	2001			15				2
3	3D Detectors in Elevators	2001	4,916		10			4,916	3
4	Compensators	2001	2,724		10			2,724	4
5	33 Lever Passage Locks	2002	2,904		10			2,904	5
6	Exit Lights and Hold Opens	2002	966		10			966	6
7	16 Lever Passage Locks	2002	1,408		10			1,408	7
8	Water Piping	2001	4,600	115	39	115		1,826	8
9	Buffet in Dining Area	2003	2,977	198	15	198		2,913	9
10	Door - code alert and keypad	2003	2,489		10			2,489	10
11	Fire Collars	2003	3,619		10			3,619	11
12	Main Breaker	2003	3,291	219	15	219		3,089	12
13	Elevator Master Door Operator	2003	4,278		10			4,278	13
14	Annunciators	2004	51,494		10			51,494	14
15	Sewer Lines	2003	5,801	387	15	387		5,382	15
16	Smoke Damper - Eber	2003	698	47	15	47		644	16
17	Beauty Shop Wiring	2003	2,272	151	15	151		2,083	17
18	Dietary Doors	2004	3,801	253	15	253		3,463	18
19	Roof	2004	4,028	269	15	269		3,626	19
20	Remote Annunciator Dispose of 2016	2004							20
21	Cooler Expansion	2004	6,120	408	15	408		5,440	21
22	Parking Lot	2004	6,800	453	15	453		6,006	22
23	Ambulance Garage Doors	2004	1,070		10			1,070	23
24	Kitchen Remodel	2004	6,425		10			6,425	24
25	Plumbing wok in Eber/South	2004	5,147	343	15	343		4,403	25
26	Water Softener System	2004	15,642		10			15,642	26
27	Kitchen Electrical Work	2004	247	12	20	12		160	27
28	Kitchen Remodel	2004	1,248	62	20	62		806	28
29	Sprinkler System	2004	980	49	20	49		629	29
30	Sprinkler System	2005	2,373	119	20	119		1,503	30
31	Perry Suite Renovations	2005	2,470	165	15	165		2,072	31
32	Water Heater	2006	723		10			723	32
33	Telephone System	2006	50,625	3,375	15	3,375		39,093	33
34	TOTAL (lines 1 thru 33)		$ 9,272,254	$ 191,124		$ 189,749	$ (1,375)	$ 7,127,692	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,272,254	$ 191,124		$ 189,749	$ (1,375)	$ 7,127,692	1
2	Sprinkler System Pipes	2006	1,645	126	various	126		1,557	2
3	Overhead Door	2005	1,400		10			1,400	3
4	Concrete Work	2005	9,936	662	15	662		7,838	4
5	Fire Walls	2006	14,948	747	20	747		8,470	5
6	Fire Alarm System	2006	23,500	1,567	15	1,567		18,278	6
7	Life Safety Code Renovations	2006	1,905		10			1,905	7
8	Renovations to Building Front Entrance	2006	38,611	1,931	20	1,931		21,880	8
9	Telephone System Wiring	2006	35,781		10			35,781	9
10	Pool Area Renovations	2006	98,370	4,919	20	4,919		56,153	10
11	Concrete Work	2006	3,850	257	15	257		2,931	11
12	Lighting in the Hallway	2006	7,872	394	20	394		4,428	12
13	Laundry Renovations- Air System	2006	9,841	492	20	492		5,536	13
14	Smoke/Fire Dampers Special Care Area	2006	14,683	734	20	734		8,259	14
15	Eber Elevator Remodel	2006	12,769	851	15	851		9,292	15
16	Sprinkler System Heads	2006	20,456	1,364	15	1,364		14,660	16
17	South Wing Fiber Server	2007	2,526	168	15	168		1,810	17
18	Smoke/Fire Detectors	2007	10,431	348	10	348		10,431	18
19	Repairs to Boiler Motor	2007	954	31	10	31		953	19
20	Smoke/Fire Dampers	2007	1,125	37	10	37		1,125	20
21	CO Detectors	2007	1,483	25	10	25		1,385	21
22	Call Lights - Dining Hall	2007	823	6	10	6		753	22
23	Hot Water Tank	2007	2,588	43	10	43		2,415	23
24	Repairs to Hot Water Shower Area	2007	1,113	111	10	111		1,113	24
25	Compressor - Walk in	2007	2,922	292	10	292		2,921	25
26	Repairs to Wiring in Chapel Area	2007	14,516	968	15	968		9,677	26
27	HVAC Controllers	2007	11,952	797	15	797		7,968	27
28	Physical Therapy Ductwork Repairs	2006	2,254	150	15	150		1,640	28
29	Alarm Stations Repairs	2006	27,685	1,846	15	1,846		19,841	29
30	Dining Hall Electric	2007	890	59	15	59		637	30
31	Chapel Roof Repair	2007	3,528	235	15	235		2,528	31
32	Dining Hall Paint	2007	7,401	308	10	308		7,401	32
33	Dinning Hall Roof Repairs	2007	573	38	15	38		401	33
34	TOTAL (lines 1 thru 33)		$ 9,660,585	$ 210,630		$ 209,255	$ (1,375)	$ 7,399,059	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,660,585	$ 210,630		$ 209,255	$ (1,375)	$ 7,399,059	1
2	Storm Sewer Line	2007	3,459	231	15	231		2,384	2
3	Dietary Doors	2007	1,485	149	10	149		1,485	3
4	Alarm System at Stations	2007	4,450	445	10	445		4,376	4
5	Roof South Eber Diposal 2017	2007	9,587	639	15	639		6,285	5
6	Fiber Project Improvements	2008	10,646	710	15	710		6,743	6
7	Door Closers	2008	10,180	1,018	10	1,018		9,162	7
8	Elevator Renovation	2008	122,827	8,188	15	8,188		76,425	8
9	Wanderer Alert System	2008	1,968	197	10	197		1,869	9
10	CO System Detectors	2008	1,395	140	10	140		1,314	10
11	Improvements Fire Protection	2009	35,300	2,353	15	2,353		20,395	11
12	New Doors Alarm	2008	8,704	435	20	435		3,808	12
13	Improvements to Elevator	2008	27,518	1,835	15	1,835		16,359	13
14	Improvement to Alarms	2009	14,985	749	20	749		6,431	14
15	Eber Water Project	2009	3,795	190	20	190		1,613	15
16	Improvements Fire Protection	2009	1,640	82	20	82		663	16
17	Hot Water Heater	2009	5,577	558	10	558		4,741	17
18	Improvements to Heater in Pool	2009	14,325	1,433	10	1,433		12,057	18
19	Run Fiber - Anna Brown to switch in Maint. For Phone Sys.	2009	1,040		5			1,040	19
20	IDCS 500 Release - Wiring & Cabinet for Phone System	2009	7,099		5			7,099	20
21	Addition to Walking Freezer	2009	88,733	5,916	20	5,916		43,874	21
22	Roof Repair to the East Circle and Chapel	2009	61,810	3,091	20	3,091		24,209	22
23	East Circle Laundry- Labor, Plumbing Materials,	2009	11,420	571	20	571		4,425	23
24	Install Upgrade to Code Alert System - Wiring and Labor	2009	85,645	8,564	10	8,564		63,519	24
25	Wiring for the Facility Phone System	2010	10,951	1,095	10	1,095		8,030	25
26	Replace the Transfer Switch - Wiring and Labor	2009	12,414	621	20	621		4,501	26
27	Install Water Value in Meter Pit/ Fire Hydrant	2009	13,300	1,330	10	1,330		10,345	27
28	Concrete Work for Ambulance Garage,Sidewalks, & Drives	2010	24,818	1,241	20	1,241		9,307	28
29	Alzheimer's Unit -Landscaping	2010	51,508	3,434	15	3,434		25,468	29
30	Alzheimer's Unit -Parking Lot	2010	154,072	10,271	15	10,271		76,180	30
31	New Alzheimer Building	2010	4,789,401	119,735	40	119,735		888,035	31
32	New Alzheimer Building -Unit Mechanical	2010	838,272	41,914	20	41,914		310,860	32
33	New Alzheimer Building -Unit Roofing	2010	223,472	8,939	25	8,939		66,297	33
34	TOTAL (lines 1 thru 33)		$ 16,312,381	$ 436,704		$ 435,329	$ (1,375)	$ 9,118,358	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 16,312,381	$ 436,704		$ 435,329	$ (1,375)	$ 9,118,358	1
2	New Alzheimer -Mega Plant	2010	1,405,351	46,845	30	46,845		347,434	2
3	New Alzheimer -Unit Generator	2010	383,839	19,192	20	19,192		142,340	3
4	New Alzheimer - Unit Elevator	2010	117,455	7,830	15	7,830		58,075	4
5	New Alzheimer -Counter Tops and Cabinets	2010	354,518	17,726	20	17,726		131,467	5
6	New Alzheimer -Floor Coverings & Carpet	2010	209,459	13,964	15	13,964		103,566	6
7	Office Building	2010	167,615	4,190	40	4,190		30,380	7
8	Handicapped Doors for South Hall	2010	5,872	294	20	294		2,129	8
9	Air Curtain -Dietary	2010	1,455	146	10	146		1,043	9
10	Code Alert -Eber South	2010	105,708	10,571	10	10,571		74,877	10
11	Patios & sidewalk -Foose	2010	11,290	565	20	565		3,952	11
12	Windows-Dinning Room	2010	2,672	134	20	134		924	12
13	Elevator Kitchen - Door Operator	2010	3,335	334	10	334		2,335	13
14	Installing Ballast (Dimming)	2010	4,350	435	10	435		3,009	14
15	Transfer Switch - Eber	2010	8,600	860	10	860		5,948	15
16	Sprinkler Heads - West Nursing	2010	2,688	269	10	269		1,815	16
17	Code Alert - Eber/ South	2011	10,751	1,075	10	1,075		6,630	17
18	Plumbing Rehab. East Circle	2011	33,362	3,336	10	3,336		21,685	18
19	Walk-in-Freezer	2011	3,245	325	10	325		2,083	19
20	Foose & AB Unit Room Controllers	2011	75,000	3,750	20	3,750		22,500	20
21	Wash Station for the eye	2011	18,800	1,880	10	1,880		11,750	21
22	Land Improvement New Bldg-Crubs, Sidewalks, Sewers etc	2011	392,571	26,171	15	26,171		157,028	22
23	Renovations to Special Care Unit	2012	1,152,325	28,808	40	28,808		146,441	23
24	Special Care Mechanical	2012	609,108	30,455	20	30,455		154,815	24
25	Administration Office and AL	2011	1,673,695	41,842	40	41,842		251,054	25
26	Roof for Administration Bldg & AL	2011	50,491	1,262	40	1,262		7,573	26
27	Mechanical for Administration and AL	2011	383,112	19,156	20	19,156		114,934	27
28	New Roof Ambulance Bay	2012	54,200	2,710	20	2,710		13,776	28
29	New Roof West Nursing	2011	52,290	2,615	20	2,615		15,252	29
30	Electrical Work Remodel for signs & wiring for Medicare unit	2012	13,070	523	25	523		2,745	30
31	Doors- Remodel electric doors closers in nursing facility	2012	10,437	417	25	417		2,087	31
32	Controls for Individual Rooms	2012	62,000	6,200	10	6,200		35,650	32
33	Dry Pipe System Remodeling	2011	12,582	1,258	10	1,258		7,235	33
34	TOTAL (lines 1 thru 33)		$ 23,703,627	$ 731,842		$ 730,467	$ (1,375)	$ 11,000,890	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 23,703,627	$ 731,842		$ 730,467	$ (1,375)	$ 11,000,890	1
2	Addressable Pull Stations	2012	2,366	237	10	237		1,361	2
3	Laundry Control System	2011	2,890	289	10	289		1,662	3
4	Water Heater Barber Shop	2011	8,971	897	10	897		5,233	4
5	Data Connections Administration Building	2011	5,262	526	10	526		3,113	5
6	Water Heater Dietary Department	2011	9,510	951	10	951		5,706	6
7	Floor coverings Special Care Unit	2011	123,277	12,328	10	12,328		62,666	7
8	Floor coverings Administration	2011	55,207	5,521	10	5,521		33,125	8
9	HVAC Roof Unit	2011	7,845	785	10	785		4,315	9
10	Flooring Ann Brown	2011	10,249	1,025	10	1,025		6,064	10
11	Chapel Renovations - Phase III	2013	135,247	5,410	25	5,410		23,894	11
12	Rounda Renovation Phase III	2013	19,306	772	25	772		3,410	12
13	Can Lights - Medicare Unit	2012	2,750	110	25	110		550	13
14	Exit Lighting Panel- Medicare Unit	2012	2,779	111	25	111		556	14
15	Painting - Ecircle Eber South Ct	2013	35,753	1,430	25	1,430		6,316	15
16	Neighborhoods - Phase III	2013	691,456	27,658	25	27,658		122,157	16
17	Sunnydale Transition	2013	2,895	72	40	72		331	17
18	Convert Foose Singles	2013	9,698	485	20	485		2,061	18
19	Eastbrook Lane	2013	13,087	654	20	654		2,781	19
20	Sunny Dale Tile Project	2013	16,955	848	20	848		3,391	20
21	Courtyard Railing	2012	4,292	172	25	172		830	21
22	Fire Alarm - Social Room	2012	3,237	129	25	129		636	22
23	Paging System - Nursing	2013	10,826	722	15	722		3,429	23
24	Code Alert - E Circle, Social Room	2013	2,792	186	15	186		838	24
25	Voice, Dara, Video - Nursing	2013	11,551	770	15	770		3,465	25
26	Bradley HL80 Mixing Valves	2013	5,376	358	15	358		1,672	26
27	Power Assis Dooes - Medicare	2013	5,000	333	15	333		1,500	27
28	SS Sink & Eyewash - Special Care	2013	2,943	196	15	196		883	28
29	Flooring Covering -Phase III	2013	122,252	8,150	15	8,150		35,996	29
30	Window Treatment - Phase III	2013	6,416	428	15	428		1,889	30
31	Code Alert - E Circle, Social Room	2013	1,536	154	10	154		666	31
32	Eber Roof Unit	2013	8,244	824	10	824		3,503	32
33	Rheem Hot Water Tank - Dietary	2013	3,754	375	10	375		1,595	33
34	TOTAL (lines 1 thru 33)		$ 25,047,348	$ 804,748		$ 803,373	$ (1,375)	$ 11,346,484	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 25,047,348	$ 804,748		$ 803,373	$ (1,375)	$ 11,346,484	1
2	E Circle Water & Sewer Lines	2013	1,473	147	10	147		601	2
3	RTU - Social Services	2013	5,570	557	10	557		2,274	3
4	Water Heater AO Smith - Dietary & Laundry Area)	2014	11,452	1,145	10	1,145		4,103	4
5	Installation and equipment for Wander Management System	2014	14,800	1,480	10	1,480		5,303	5
6	Eber/Southnurseing wings HVAC Replacement	2014	58,997	3,933	15	3,933		11,799	6
7	Condenser Unit for Laundry Area	2014	1,850	185	10	185		617	7
8	Nursing Area Compressor Unit	2014	8,497	850	10	850		2,620	8
9	Dietary Area Sprinkler System Upgrade	2014	1,895	190	10	190		585	9
10	Sunny Dale - Install Wallcovering and Painting	2013	20,595	1,030	20	1,030		4,033	10
11	Sunny Dale Painting the Exterior and West Kitchen Vestibule	2013	5,856	293	20	293		1,123	11
12	Sunny Dale Projest Counter Tops, Cabinet Cover and Cabinets	2014	11,472	574	20	574		2,104	12
13	Sunny Dale Improvements - Install Handrails	2014	5,200	260	20	260		953	13
14	Nursing Station Improv. Wallcovering and Painting	2014	18,850	943	20	943		3,221	14
15	Eber & South - Room Refurbishing Wallcovering/Painting	2014	29,920	1,496	20	1,496		4,987	15
16	Eber & South - Room Refurbishing Wallcovering/Painting	2014	11,968	598	20	598		1,895	16
17	Eber & South - Room Refurbishing Wallcovering/Painting	2014	5,984	299	20	299		897	17
18	New Sewer Line installed in the Dietary Labor/Materials	2013	4,677	234	20	234		877	18
19	East Circle Light Fixtures Wiring and Installation	2014	2,855	143	20	143		476	19
20	Accounting firm reclassification items 9/30/2013								20
21	Floor Title in Kitchen	1999	2,455		10			2,455	21
22	Ductwork 213OH	2004	1,760		10			1,760	22
23	Flooring - Beauty Shop	2003	2,512		10			2,512	23
24	Junction Box Linal	2004	10,383		10			10,383	24
25	Carpet - Perry Suite	2005	1,916		10			1,916	25
26	Flooring - Medical Records	2005	1,337		10			1,337	26
27	Carpet - Exercise Room	2006	890		10			890	27
28	Base Cabinets - Dietary	2006	1,117	18	10	18		1,117	28
29	ABS Single Basin Sink - East Nursing	2007	1,141	9	10	9		1,045	29
30	Flooring - Rooms	2010	4,563	456	10	456		3,422	30
31	Dinning Floor - Eber * South Court	2010	14,397	1,440	10	1,440		10,678	31
32	Dinning Floor - Sunny Dale	2010	3,638	364	10	364		2,698	32
33	Floor - East Laundry	2010	1,003	100	10	100		744	33
34	TOTAL (lines 1 thru 33)		$ 25,316,371	$ 821,492		$ 820,117	$ (1,375)	$ 11,435,909	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 25,316,371	$ 821,492		$ 820,117	$ (1,375)	$ 11,435,909	1
2	Dinning Floor - Main Dinning	2010	9,586	959	10	959		7,110	2
3	Eber Gardens Carpet	2011	27,615	2,762	10	2,762		16,570	3
4	Carpeting	2011	3,436	344	10	344		2,291	4
5	Floor Covering Room 451	2012	1,794	179	10	179		896	5
6	21 Showers Doors Anna Brown Section	2012	3,826	383	10	383		2,009	6
7	Floor Covering Room 447	2012	2,563	256	10	256		1,452	7
8	Floor Covering Room 126,/132	2011	787	79	10	79		459	8
9	Eber & South	2015	95,744	4,787	20	4,787		11,569	9
10	Anna Brown - Roof	2015	50,480	2,524	20	2,524		5,889	10
11	Door Project - Automatic	2015	38,598	1,930	20	1,930		4,825	11
12	Door Alarm Fire Foose Section	2015	1,253	125	10	125		334	12
13	2 Jeld-Wen Casement Windows	2015	2,271	227	10	227		549	13
14	New Doors East Circle	2015	4,795	480	10	480		1,039	14
15	Eber and South Halls Lighting	2015	19,845	992	20	992		2,067	15
16	New Doors Chapel	2015	2,811	281	10	281		562	16
17	New Doors - Kitchen/Dinning	2015	2,721	272	10	272		544	17
18	Additional Recepticals Kitchen	2015	7,876	394	20	394		788	18
19	Cooling Tower Refurbish	2014	2,983	149	20	149		435	19
20	Hot Water Storage Tank - Dietary	2014	2,933	293	10	293		830	20
21	Fusible Links in Dampers	2014	8,800	587	15	587		1,614	21
22	Rebuild Mixing Valves	2015	2,167	217	10	217		596	22
23	Replace Inverter	2015	4,445	445	10	445		1,186	23
24	Anna Brown HVAC Upgrade	2015	5,692	569	10	569		1,518	24
25	Steel Pipe Epsilon Plant	2015	1,950	195	10	195		520	25
26	Wiring / Sprinkler Correction Plan	2015	17,979	1,798	10	1,798		4,345	26
27	Landscaping - Eber/South	2015	11,577	772	15	772		1,351	27
28	Parking Lot Jercho Road	2015	244,373	16,292	15	16,292		20,365	28
29	Room 601 - Painting and Refurbishing	2015	5,984	299	20	299		598	29
30	East Circle/ Chaple - wrining of receptacles to generator	2015	5,602	280	20	280		537	30
31	Eber Parking Lot Drain - Concrete work	2015	2,000	133	15	133		255	31
32	Rooms 516,517,521 Painting and Refurbishing	2015	17,952	898	20	898		1,721	32
33	Room 514 - Painting and Refurbishing	2015	5,984	299	20	299		523	33
34	TOTAL (lines 1 thru 33)		$ 25,932,793	$ 861,692		$ 860,317	$ (1,375)	$ 11,531,256	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 25,932,793	$ 861,692		$ 860,317	$ (1,375)	$ 11,531,256	1
2	Room 515 - Painting and Refurbishing	2016	5,984	299	20	299		523	2
3	Room 609 - Painting and Refurbishing	2016	5,984	299	20	299		498	3
4	Room 501 - Painting and Refurbishing	2016	5,984	299	20	299		474	4
5	Staff Restroom - Eber South Patch and replace sinks	2015	2,268	227	10	227		416	5
6	HVAC Eber South	2016	927,249	46,362	20	46,362		50,226	6
7	Emergency Power Project	2015	195,687	9,784	20	9,784		17,122	7
8	Call Light System	2015	7,631	763	10	763		1,399	8
9	Emergency Call System Anna Brown	2016	50,856	5,086	10	5,086		8,053	9
10	Gas Line - Eber South	2016	15,000	750	20	750		1,125	10
11	Commercial Water Heater	2016	9,831	983	10	983		1,147	11
12	IDPH Code Electric Upgrades	2017	23,535	686	20	686		686	12
13	Pool Roof	2017	24,200	1,412	10	1,412		1,412	13
14	Eber Roof	2017	112,800	3,760	10	3,760		3,760	14
15	Dining Room Remodel	2017	63,235	1,054	15	1,054		1,054	15
16	Reburbish Southern Court Rooms	2017	35,904	598	15	598		598	16
17	Foose Center Wall Protection/Nurse Sun	2017	13,997	2,100	5	2,100		2,100	17
18	Water Heater-Maint Dept	2017	4,934	164	10	164		164	18
19	Breakroom HVAC	2017	8,421	140	10	140		140	19
20	Call Light System	2017	14,572	729	10	729		729	20
21	Replace Chiller & Pump	2017	100,488	4,221	15	4,221		4,221	21
22	HVAC-Eber/South, Anna Brown & Compresser	2017	50,569	2,379	10	2,379		2,379	22
23	Electric Water Heaters & Explansion Tank	2017	28,428		10				23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	Guest Room Income Offset					(3,615)	(3,615)		33
34	TOTAL (lines 1 thru 33)		$ 27,640,350	$ 943,787		$ 938,797	$ (4,990)	$ 11,629,482	34

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	$ 1,905,959	$ 144,541	$ 144,541	$	3-20 yrs	$ 835,853	71
72	Current Year Purchases	134,683	5,748	5,748		5-15 yrs	5,748	72
73	Fully Depreciated Assets	971,025				3-20 yrs	971,025	73
74								74
75	TOTALS	$ 3,011,667	$ 150,289	$ 150,289	$		$ 1,812,626	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	Ford Starcraft Bus 2015 (2)	2015	$ 128,098	$ 12,810	$ 12,810	$	10 yrs.	$ 30,957	76
77	Facility	Dodge Grand Carvan 2014	2015	39,255	7,851	7,851		5 yrs.	19,627	77
78	Maintenance	Ford E-150 2014	2015	11,056	2,211	2,211		5 yrs.	6,633	78
79	See Attach Sch 13A	Various	Various	178,238	12,278	12,278		5-10 yrs	144,033	79
80	TOTALS			$ 356,647	$ 35,150	$ 35,150	$		$ 201,250	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)	$ 31,453,313	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,129,226	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,124,236	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,990)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,643,358	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	Cottage Land				87
88	Cottage Fixed Assets				88
89	Rental Property & Radio Station				89
90	Assisted Living				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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ 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	N/A		$	$	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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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? [X] YES [ ] 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 [X]
- COMMUNITY COLLEGE [X]
- HOURS PER CNA 104

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 13,173	$	$ 13,173
2	Books and Supplies		3,677		3,677
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		65		65
9	TOTALS	$	$ 16,915	$	$ 16,915
10	SUM OF line 9, col. 1 and 2 (e)	$ 16,915			

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	9
2. From other facilities (f)	3
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

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

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

	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	L. 10a C. 3	hrs	$	3,428	$ 178,491	$	3,428	$ 178,491	1
2	Licensed Speech and Language Development Therapist	L. 10a C. 3	hrs		434	26,289		434	26,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C. 3	hrs		6,315	369,672	4,713	6,315	374,385	4
5	Physician Care		visits							5
6	Dental Care	L.10aC2,3	visits			2,400	277		2,677	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C 3	# of prescrpts				342,152		342,152	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-ray	L. 39 C 3					47,681		47,681	12
13	Other (specify):									13
14	TOTAL			$	10,177	$ 576,852	$ 394,823	10,177	$ 971,675	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 Home **#** 0009258 **Report Period Beginning:** 10/1/16 **Ending:** 9/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/17 **(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	$ 676,049	$	1
2	Cash-Patient Deposits	80,220		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 406,060)	1,767,429		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	213,991		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM OTHERS	333,701		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,071,390	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,405,357		12
13	Land	3,821,996		13
14	Buildings, at Historical Cost	41,437,062		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,841,572		16
17	Accumulated Depreciation (book methods)	(21,053,893)		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):	54,137		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,506,231	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 40,577,621	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,050,922	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	80,220		28
29	Short-Term Notes Payable	270,842		29
30	Accrued Salaries Payable	614,225		30
31	Accrued Taxes Payable (excluding real estate taxes)	100,551		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,122		32
33	Accrued Interest Payable	8,903		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER LIAB	379,690		36
37	PREPAID RESIDENT RENT	2,632,448		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,176,923	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,152,076		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)**	$ 5,152,076	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,328,999	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 30,248,622	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 40,577,621	$	48

***(See instructions.)**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 29,411,627	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT	371,968	3
4	ROUNDING	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 29,783,598	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	347,711	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) NET ASSETS-RESTRICTED	117,313	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 465,024	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)**	$ 30,248,622	24 *

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	$ 13,666,217	1
2	Discounts and Allowances for all Levels	(3,191,839)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,474,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,298,234	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,298,234	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	47,518	12
13	Barber and Beauty Care	57,781	13
14	Non-Patient Meals	77,814	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	585,146	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,685	19
20	Radiology and X-Ray	30,414	20
21	Other Medical Services	222,131	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,059,489	23
	D. Non-Operating Revenue		
24	Contributions	1,956,248	24
25	Interest and Other Investment Income***	681,107	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,637,355	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	479,772	28
28a	COTTAGE & RENTAL PROPERTY INCOME	3,364,939	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,844,711	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,314,167	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,908,696	31
32	Health Care	7,168,201	32
33	General Administration	4,388,259	33
	B. Capital Expense		
34	Ownership	1,348,567	34
	C. Ancillary Expense		
35	Special Cost Centers	1,709,310	35
36	Provider Participation Fee	443,423	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,966,456	40
41	**Income before Income Taxes (line 30 minus line 40)****	347,711	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 347,711	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,211,879	44
45	Private Pay - Net Inpatient Revenue	6,792,728	45
46	Medicare - Net Inpatient Revenue	1,146,644	46
47	Other-(specify) MCR B ADJ/BAD DEBTS	(676,873)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,474,378	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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	1,824	2,080	$ 81,137	$ 39.01	1
2	Assistant Director of Nursing	2,024	2,511	80,073	31.89	2
3	Registered Nurses	47,885	52,059	1,385,355	26.61	3
4	Licensed Practical Nurses	48,993	53,248	1,141,347	21.43	4
5	CNAs & Orderlies	201,482	218,292	2,756,114	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,935	6,494	84,832	13.06	8
9	Activity Director	1,944	2,080	48,679	23.40	9
10	Activity Assistants	15,051	16,742	184,916	11.05	10
11	Social Service Workers	14,772	16,408	197,105	12.01	11
12	Dietician					12
13	Food Service Supervisor	5,825	6,345	140,503	22.14	13
14	Head Cook	6,182	6,731	90,131	13.39	14
15	Cook Helpers/Assistants	61,599	66,351	739,971	11.15	15
16	Dishwashers	7,874	8,700	92,872	10.67	16
17	Maintenance Workers	20,063	22,156	337,709	15.24	17
18	Housekeepers	36,032	39,290	440,679	11.22	18
19	Laundry	11,769	12,892	137,329	10.65	19
20	Administrator	1,867	2,091	154,530	73.90	20
21	Assistant Administrator	2,384	2,845	113,127	39.76	21
22	Other Administrative	6,224	7,054	149,871	21.25	22
23	Office Manager					23
24	Clerical	24,409	26,414	447,472	16.94	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	2,150	2,363	41,691	17.64	31
32	Other Health Care(specify)	15,186	16,779	216,041	12.88	32
33	Other(specify)	21,826	23,839	342,002	14.35	33
34	TOTAL (lines 1 - 33)	563,300	613,764	$ 9,403,486 *	$ 15.32	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	561	$ 31,528	L. 1 C3	35
36	Medical Director	4	564	L. 9 C3	36
37	Medical Records Consultant	33	2,467	L. 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,495	L. 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	743	L. 11 C3	44
45	Social Service Consultant	10	743	L. 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	618	$ 50,540		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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Micahel Duffy	Admin		$ 154,530
Judy Graham	Asst Admin		113,127
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 267,657

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
Schmiedeskamp Robertson	Legal	$ 21,970
Littler Mendelson	Legal	4,750
Dennis Koch	Accounting	31,250
Ronald Cournaya	Cost Reports	12,500
RMS	Accounting	635
ACH	Payroll Services	684
Various		809
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 72,598

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 181,462
Unemployment Compensation Insurance	
FICA Taxes	672,851
Employee Health Insurance	1,557,062
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Tuition	37,032
Pension Plan	283,516
Employee Medical	(15,014)
Life Insurance	4,441
Employee Recognition	37,322
Public Relations Benefits	(21,550)
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,737,122

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	30,386
Health Care Worker Background Check	
(Indicate # of checks performed 95)	4,364
Patient Background Checks 251	2,510
Council for Health and Human Services	9,871
Various Dues, Licenses, and Permits	2,003
Leading Age Illinois	15,924
Less Lobbying Expense	(2,548)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,510

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14,197
Dev Dir	(2,722)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,475

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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 Home # 0009258 Report Period Beginning: 10/1/16 Ending: 9/30/17

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. **LeadingAge $15,924; CHHS $9,871**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **82,329** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

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

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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 Departmen
during this cost report period. $ **443,423**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **Yes** 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. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **77,814**

(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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD, LLP**

(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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number | Good Samaritan Home of Quincy | # 0009258 | Report Period Beginning: 10/1/16 | Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	$	$	$	$ 0		$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	41

D. Vehicle Depreciation (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	
42	Facility	Snow Salt Spreader	2015	1,600	320	320	0	5 yrs	560	42
43	Facility	Toro 8260XE Snow Blower	2014	1,189	119	119	0	10 yrs	337	43
44	Facility	Landpride RB1584 Blade	2014	575	57	57	0	10 yrs	163	44
44a	Facility	Landpride RTR0550 Tiller	2015	1,950	195	195	0	10 yrs	488	44a
44c	Facility	Toro Titan MX5400	2015	6,150	615	615	0	10 yrs	1,538	44c
44d	Facility	Toro Titan MX5400	2015	6,150	615	615	0	10 yrs	1,538	44d
44e	Facility	Toro Mower - Disposal 2017	2005				0	5 yrs		44g
44f	Facility	2005 Chrysler Town	2005	21,931			0	5 yrs	21,931	44f
44g	Facility	Kubota L3430	2006	18,895	315	315	0	10 yrs	18,895	44g
44h	Facility	Ford F350	2007	30,224	2,267	2,267	0	10 yrs	30,224	44h
44i	Facility	Toro Mower - Disposal 2017	2009				0	5 yrs		44i
44j	Facility	Toro Mower - Disposal 2017	2009				0	5 yrs		44j
44k	Facility	Golf Cart	2008	1,200			0	5 yrs	1,200	44k
44l	Facility	Tractor with Cab JD 4320	2010	33,977	3,398	3,398	0	10 yrs	23,501	44l
44m	Facility	2010 GMC Sierra	2010	32,410	0	0	0	5 yrs	32,410	44m
44n	Facility	Various Mower/Snow EQ	Various	6,637	584	584	0	10 yrs	5,500	44n
44o	Facility	2003 Ford F150	2013	3,500	700	700	0	5 yrs	3,267	44o
44p	Facility	Toro 30" Mower - Disposal 2017	2013		200	200	0	5 yrs		44p
44q	Maintenance	Kubota KQ163	2014	1,850	185	185	0	10 yrs	648	44q
44r	Maintenance	YS 200UTV - Disposal 2017	2014		325	325	0	10 yrs		44r
44s	Maintenance	Kubota BX 1800 - Disposal 2017	2013		550	550	0	10 yrs		44s
45	Maintenance	Kubota Tractor-Snow Removal	2017	10,000	1,833	1,833	0	5 yrs	1,833	45
46	TOTALS			$ 178,238	$ 12,278	$ 12,278	$ 0		$ 144,033	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* 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.