

		FOR BHF USE				

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

<p>I. IDPH License ID Number: <u>0009258</u></p> <p>Facility Name: <u>Good Samaritan Home</u></p> <p>Address: <u>2130 Harrison Street</u> <u>Quincy</u> <u>62301</u> Number City Zip Code</p> <p>County: <u>Adams</u></p> <p>Telephone Number: <u>(217) 223-8717</u> Fax # <u>(217) 223-6015</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/22/1957</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/19</u> to <u>09/30/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ * Subject to the attached Accountants' Consulting Report (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ * Subject to the attached Accountants' Consulting Report (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Date) _____ * Subject to the attached Accountants' Consulting Report (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>							

Facility Name & ID Number Good Samaritan Home

0009258 Report Period Beginning: 10/01/19 Ending: 09/30/20

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	85	Skilled (SNF)	85	31,110	1
2		Skilled Pediatric (SNF/PED)			2
3	118	Intermediate (ICF)	118	43,188	3
4		Intermediate/DD			4
5	28	Sheltered Care (SC)	28	10,248	5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,546	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	776	2,849	3,763	7,388	8
9	SNF/PED					9
10	ICF	17,369	29,441		46,810	10
11	ICF/DD					11
12	SC	1,237	3,089		4,326	12
13	DD 16 OR LESS					13
14	TOTALS	19,382	35,379	3,763	58,524	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.22%

D. How many bed reserve days during this year were paid by the Department? None (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 7,611

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 35 and days of care provided 3,104

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 9/30/20 Fiscal Year: 9/30/20

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

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/19 Ending: 09/30/20

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	907,313	42,183	34,046	983,542		983,542		983,542		1
2	Food Purchase		748,114		748,114	(168,580)	579,534	(20,804)	558,730		2
3	Housekeeping	325,410	45,344		370,754		370,754		370,754		3
4	Laundry	160,822	11,220		172,042		172,042		172,042		4
5	Heat and Other Utilities			232,230	232,230		232,230	(27,481)	204,749		5
6	Maintenance	145,501	43,850	250,672	440,023		440,023	5,994	446,017		6
7	Other (specify):*										7
8	TOTAL General Services	1,539,046	890,711	516,948	2,946,705	(168,580)	2,778,125	(42,291)	2,735,834		8
	B. Health Care and Programs										
9	Medical Director			13,600	13,600		13,600		13,600		9
10	Nursing and Medical Records	5,933,874	507,627	16,739	6,458,240		6,458,240		6,458,240		10
10a	Therapy	216,708	5,647		222,355		222,355		222,355		10a
11	Activities	234,321	8,578	1,476	244,375		244,375		244,375		11
12	Social Services	276,971	4,468	4,187	285,626		285,626		285,626		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,661,874	526,320	36,002	7,224,196		7,224,196		7,224,196		16
	C. General Administration										
17	Administrative	285,309			285,309		285,309		285,309		17
18	Directors Fees										18
19	Professional Services			80,858	80,858		80,858	(12,504)	68,354		19
20	Dues, Fees, Subscriptions & Promotions			81,411	81,411		81,411	(40,547)	40,864		20
21	Clerical & General Office Expenses	347,046	41,262	870,635	1,258,943		1,258,943	(759,630)	499,313		21
22	Employee Benefits & Payroll Taxes			2,064,291	2,064,291	168,580	2,232,871		2,232,871		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,883	6,883		6,883		6,883		24
25	Other Admin. Staff Transportation			13,365	13,365		13,365		13,365		25
26	Insurance-Prop.Liab.Malpractice			84,008	84,008		84,008		84,008		26
27	Other (specify):*										27
28	TOTAL General Administration	632,355	41,262	3,201,451	3,875,068	168,580	4,043,648	(812,681)	3,230,967		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,833,275	1,458,293	3,754,401	14,045,969		14,045,969	(854,972)	13,190,997		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:

10/01/19

Ending:

09/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,600,000	1,600,000		1,600,000	(169,054)	1,430,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,436	148,436		148,436	(146,110)	2,326			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			39,386	39,386		39,386	(39,386)				36
37	TOTAL Ownership			1,787,822	1,787,822		1,787,822	(354,550)	1,433,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,687	410,576	570,263		570,263		570,263			39
40	Barber and Beauty Shops	68,632	2,626		71,258		71,258	(31,177)	40,082			40
41	Coffee and Gift Shops	26,089	35,594		61,683		61,683	(44,146)	17,537			41
42	Provider Participation Fee			414,560	414,560		414,560		414,560			42
43	Other (specify):*	1,086,730	170,816	738,479	1,996,025		1,996,025	(1,996,025)	(0)			43
44	TOTAL Special Cost Centers	1,181,451	368,723	1,563,615	3,113,789		3,113,789	(2,071,348)	1,042,441			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,014,726	1,827,016	7,105,838	18,947,580		18,947,580	(3,280,870)	15,666,710			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:

10/01/19

Ending:

09/30/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,900)	02		4
5	Telephone, TV & Radio in Resident Rooms	(27,481)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(169,054)	30		9
10	Interest and Other Investment Income	(146,110)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,904)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(650)	21		18
19	Entertainment				19
20	Contributions	(115)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,787)	21		24
25	Fund Raising, Advertising and Promotional	(37,931)	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	(2,867,938)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,280,870)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,280,870)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/19

Ending: 09/30/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (321)	21	1
2	Management Fee Income	(200,000)	21	2
3	Guest Room Income	(1,280)	21	3
4	Misc. Billing Late Fees	(4,506)	21	4
5	Assisted Living & Cottage Salaries	(1,060,174)	43	5
6	Assisted Living Employee Benefits	(16,079)	43	6
7	Other Cottage & Assisted Living Expenses	(893,216)	43	7
8	Sequestration Expense	(25,437)	21	8
9	Endowment Expense	(39,386)	36	9
10	Charitable Care Account	(1,000)	21	10
11	Charitable Care Write-Off	(515,308)	21	11
12	Additional R&M	8,983	06	12
13	Public Relations - Salary	(26,557)	43	13
14	Non-Allowable Legal	(12,504)	19	14
15	Chamber of Commerce	(281)	20	15
16	PAC Dues	(2,335)	20	16
17	Capitalized R&M	(2,989)	06	17
18	Beauty Shop Income	(31,177)	40	18
19	Gift Shop Income	(1,392)	41	19
20	Bank Charges	(227)	21	20
21	General Store Income	(42,754)	41	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	(2,867,938)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending:

09/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(20,804)											(20,804)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(27,481)											(27,481)	5
6	Maintenance	5,994											5,994	6
7	Other (specify):*													7
8	TOTAL General Services	(42,291)											(42,291)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(12,504)											(12,504)	19
20	Fees, Subscriptions & Promotions	(40,547)											(40,547)	20
21	Clerical & General Office Expenses	(759,630)											(759,630)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(812,681)											(812,681)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(854,972)											(854,972)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(169,054)											(169,054)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(146,110)											(146,110)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(39,386)											(39,386)	36
37	TOTAL Ownership	(354,550)											(354,550)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(31,177)											(31,177)	40
41	Coffee and Gift Shops	(44,146)											(44,146)	41
42	Provider Participation Fee													42
43	Other (specify):*	(1,996,025)											(1,996,025)	43
44	TOTAL Special Cost Centers	(2,071,348)											(2,071,348)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,280,870)											(3,280,870)	45

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1
2								2
3								3
4								4
5								5
6								6
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30								30

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending:

09/30/20

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		\$			\$	\$ *	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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		\$			\$	\$ *	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: 10/01/19 Ending: 09/30/20

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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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:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending: 09/30/20

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending:

09/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	SERIES 2013C Bonds		X	Mortgage	\$44,540.00	7/11/13	\$ 7,960,000	\$ 4,462,398	8/1/33	3.0500	\$ 141,444	1						
2				Amort of Loan Cost							11,000	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	\$ 4,462,398			\$ 152,444	9						
B. Non-Facility Related*																		
10	Interest Income		X								(146,109)	10						
11	Allocation to AL/IL										(4,008)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (150,117)	14						
15	TOTALS (line 9+line14)						\$ 7,960,000	\$ 4,462,398			\$ 2,327	15						

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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 2020 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:	2015	8
	2016	9
	2017	10
	2018	11
	2019	12

N/A

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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:

10/01/19 Ending:

09/30/20

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Residential Cottage Apartments 180 Units for 199,478 square feet

Assisted Living Facilities with 26 beds for 15,900 square feet Resident Days 7,611

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>1,219,680</u>	<u>1956</u>	<u>\$ 114,502</u>	<u>1</u>
2	<u>Facility</u>		<u>2011</u>	<u>330,147</u>	<u>2</u>
3	TOTALS	1,219,680		\$ 444,649	3

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/19

Ending:

09/30/20

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1962	\$ 683,823	\$	40	\$	\$	\$ 683,823	4
5			1973	1,683,761		40			1,683,761	5
6			1984	1,953,541		40	48,839	48,839	1,786,682	6
7	231		2010	1,695,151		Various	73,166	73,166	762,148	7
8										8
	Improvement Type**									
9	Various		1983	10,058		20			10,058	9
10	Various		1984	336,635		20			336,635	10
11	Various		1985	274,365		20	12,547	12,547	250,946	11
12	Various		1986	257,007		20	5,981	5,981	243,049	12
13	Various		1987	10,451		20			10,451	13
14	Various		1989	130,612		20			130,612	14
15	Various		1991	534,301		20	25,600	25,600	531,394	15
16	Various		1993	316,353		20	15,521	15,521	225,815	16
17	Various		1994	163,375		20			163,375	17
18	Various		1995	12,183		20			12,183	18
19	Various		1996	129,071		20			129,071	19
20	Various		1997	106,229		20			106,229	20
21	Various		1998	41,495		20	2,020	2,020	25,637	21
22	Various		1999	286,304		20	12,128	12,128	178,865	22
23	Various		2000	77,036		20	2,136	2,136	57,496	23
24	Various		2001	383,062		20	18,691	18,691	198,064	24
25	Various		2002	5,278		20			5,278	25
26	Various		2003	27,937		20			27,937	26
27	Various		2004	115,145		20	182	182	114,635	27
28	Various		2005	19,432		20	683	683	18,641	28
29	Various		2006	367,525		20	16,273	16,273	306,049	29
30	Various		2007	82,947		20	2,587	2,587	76,190	30
31	Various		2008	183,238		20	8,485	8,485	147,699	31
32	Various		2009	357,083		20	16,082	16,082	271,032	32
33	Various		2010	8,909,888		20	445,494	445,494	3,390,223	33
34	Various		2011	2,960,948		20	148,047	148,047	1,163,329	34
35	Various		2012	1,924,747		20	96,237	96,237	601,421	35
36	Various		2013	1,143,258		20	57,163		390,020	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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2014	\$ 198,456	\$	20	\$ 9,923	\$ 9,923	\$ 78,612	37
38	Various	2015	757,685		20	37,884	37,884	208,468	38
39	Various	2016	1,020,888		20	51,044	51,044	221,246	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			1,600,000			(1,600,000)		69
70	TOTAL (lines 4 thru 69)		\$ 27,159,268	\$ 1,600,000		\$ 1,106,712	\$ (550,451)	\$ 14,547,074	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:

10/01/19

Ending:

09/30/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 27,159,268	\$ 1,600,000		\$ 1,106,712	\$ (493,288)	\$ 14,547,074	1
2	Idph Code Electric Upgrades	2017	23,535		20	1,177	1,177	4,217	2
3	Pool Roof	2017	24,200		20	1,210	1,210	7,462	3
4	Eber Roof	2017	112,800		20	5,640	5,640	31,960	4
5	Dining Room Remodel-Removal/Rebuild Wall & Windows	2017	63,235		20	3,162	3,162	12,648	5
6	Refurb.Southern Court Rms-Paint, Trim/Molding, Redo Ceilings	2017	35,904		20	1,795	1,795	7,181	6
7	Foose Center Wall Protection/Nurse Sun	2017	13,997		20	700	700	8,398	7
8	Water Heater-Maint Dept	2017	4,934		20	247	247	1,397	8
9	Breakroom Hvac	2017	8,421		20	421	421	2,245	9
10	Call Light System	2017	14,572		20	729	729	4,372	10
11	Replace Chiller & Pump	2017	100,488		20	5,024	5,024	22,643	11
12	Hvac-Eber/South, Anna Brown & Compressor	2017	50,569		20	2,528	2,528	15,021	12
13	Electric Water Heaters & Explansion Tank	2017	28,428		20	1,421	1,421	7,107	13
14	Employee Lounge-Painting,Drywalling	2017	7,212		20	361	361	3,245	14
15	Electric For Water Heaters	2017	4,475		20	224	224	1,118	15
16	Anna Brown 425 - Replaced Bx Box Heating & Air	2017	4,885		20	244	244	786	16
17	Mixing Valve & Circulation Pump-Anna Brown East & Mc Reynol	2017	3,927		20	196	196	786	17
18	Eber & South Shower Rooms-Removal/Rebuild Wall, Tile Floor, I	2018	186,812		20	9,341	9,341	31,425	18
19	Eber 523 & 526 -Updates-Lighting, Wall Repair, Railings,Bathroo	2018	11,968		20	598	598	4,787	19
20	Employee Lounge-Cabinets/Countertops, Sink, Plumbing	2018	4,065		20	203	203	644	20
21	Dietary Doors Replacement	2018	9,122		20	456	456	1,824	21
22	Heating & Air Main Dining Room	2018	29,915		20	1,496	1,496	3,117	22
23	Epsilon Plant Pump Kit Heat/Cooling	2018	3,865		20	193	193	773	23
24	Water Softener	2018	19,600		20	980	980	4,328	24
25	80 Gal Storage Tank	2018	4,081		20	204	204	527	25
26	Compressor Unit Eastbrook Nursing	2018	10,945		20	547	547	1,620	26
27	Carrier Hvac - Laundry	2018	5,210		20	261	261	666	27
28	Anna Brown Daiken System (Hvac) Repairs	2018	17,755		20	888	888	2,960	28
29	Tubs For South/Eber	2018	37,467		20	1,873	1,873	6,036	29
30	Barn Door In Accounting	2018	2,950		20	148	148	566	30
31	Compressor - Master Unit	2018	4,981		20	249	249	526	31
32	Door Replacement - Eastbrooke/Dietary	2018	27,800		20	1,390	1,390	4,170	32
33	Hvac Sunnydale	2019	3,898		20	195	195	347	33
34	TOTAL (lines 1 thru 33)		\$ 28,041,284	\$ 1,600,000		\$ 1,150,813	\$ (449,187)	\$ 14,741,976	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:

10/01/19

Ending:

09/30/20**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 28,041,284	\$ 1,600,000		\$ 1,150,813	\$ (449,187)	\$ 14,741,976	1
2	Roof Replacement In Dining/Social Room	2019	48,000		20	2,400	2,400	4,400	2
3	Hvac Compressor - Foose	2019	5,855		20	293	293	456	3
4	Hvac Repair - Eastbrooke	2019	3,295		20	165	165	302	4
5	Mc Reynolds/Foose Door Levers	2019	5,580		20	279	279	372	5
6	Excavations - Drain Line, Manholes	2019	7,080		20	354	354	413	6
7	Hvac Repair - Southern Court	2019	3,762		20	188	188	219	7
8	Foose Bathrooms Levers	2019	2,880		20	144	144	144	8
9	Replace Compressor And Inverter Board	2019	5,252		20	263	263	467	9
10	Replace Fire Dampers	2019	2,608		20	130	130	231	10
11	Replace Wheel & Shaft, Blower Tower	2019	18,674		20	934	934	1,556	11
12	Hvac Repair Anna Brown 427	2019	2,690		20	135	135	247	12
13	Replace Compressor And Inverter Board - Foose	2019	6,500		20	325	325	433	13
14	Replace Compressor - Anna Brown	2019	7,927		20	396	396	496	14
15	Water Heater - Aquatic Center	2019	2,645		20	132	132	154	15
16	Install Led Ceiling Lights In Cafeteria	2019	5,475		20	274	274	274	16
17	Installation Of 130Ft Commercial Aluminum Fence	2019	8,188		20	409	409	409	17
18	Replace 2 Hot Water Storage Tanks	2019	11,348		20	567	567	567	18
19	Compressor Replacement - West Side Of Building	2019	3,867		20	193	193	193	19
20	Hvac Repair - S. Court Nursing Unit	2019	3,247		20	162	162	162	20
21	Compressor Replacement - Alzheimer Unit	2019	4,281		20	214	214	214	21
22	Floor Replacement - Installation Of Vinyl	2020	2,984		20	149	149	149	22
23	Compressor Replacement - Alzheimer East Section	2020	4,166		20	208	208	208	23
24	Cooling Tower Pump/Overflow Installation	2020	2,691		20	135	135	135	24
25	Compressor Replacement - West Side Of Building	2020	4,156		20	208	208	208	25
26	Program Front Door Rekey Cyliner	2020	4,329		20	216	216	216	26
27	Compressor Repair - Foose	2020	4,178		20	209	209	209	27
28	Ac Repair - Center Hallway & Dining Unit	2020	4,284		20	214	214	214	28
29	Install New Carrier Roof Top Unit	2020	6,085		20	304	304	304	29
30	Nurse Station - Alarm Installation	2020	3,195		20	160	160	160	30
31	Roller Shades - Rms 353,325,327,329	2020	2,989		20	149	149	149	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 28,239,496	\$ 1,600,000		\$ 1,160,724	\$ (439,276)	\$ 14,755,638	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:

10/01/19

Ending:

09/30/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 28,239,496	\$ 1,600,000		\$ 1,160,724	\$ (439,276)	\$ 14,755,638	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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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		\$ 28,239,496	\$ 1,600,000		\$ 1,160,724	\$ (439,276)	\$ 14,755,638	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:

10/01/19

Ending:

09/30/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 28,239,496	\$ 1,600,000		\$ 1,160,724	\$ (439,276)	\$ 14,755,638	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 28,239,496	\$ 1,600,000		\$ 1,160,724	\$ (439,276)	\$ 14,755,638	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:

10/01/19

Ending:

09/30/20

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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:

10/01/19

Ending:

09/30/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
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:

10/01/19

Ending:

09/30/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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:

10/01/19

Ending:

09/30/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,245,996	\$	\$ 224,600	\$ 224,600	10	\$ 1,356,727	71
72	Current Year Purchases	22,816		2,282	2,282	10	2,282	72
73	Fully Depreciated Assets	971,025				10	971,025	73
74								74
75	TOTALS	\$ 3,239,837	\$	\$ 226,881	\$ 226,881		\$ 2,330,033	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		Ford Starcraft Bus (2)	2015	\$ 128,098	\$	\$ 11,315	\$ 11,315	5	\$ 67,892	76
77		Dodge Grand Caravan	2015	39,255		3,925	3,925	5	39,255	77
78		Ford E-150	2015	11,056				5	11,056	78
79		See Attached		263,435		28,101	28,101		205,692	79
80	TOTALS			\$ 441,844	\$	\$ 43,341	\$ 43,341		\$ 323,895	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)	\$ 32,365,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,600,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,430,946	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (169,054)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,409,567	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	Cottage - Building Improvements - 201	\$ 71,574	\$	\$ 3,579	86
87	Cottage - Equipment - 2020	38,942		3,894	87
88					88
89					89
90					90
91	TOTALS	\$ 110,516	\$	\$ 7,473	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2021 \$ _____

13. _____ /2022 \$ _____

14. _____ /2023 \$ _____

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 126,126	\$		\$ 126,126	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			45,035			45,035	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			220,799			220,799	4
5	Physician Care		visits							5
6	Dental Care	39 - 02	visits				5,073		5,073	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				154,427		154,427	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					18,616	187		18,803	13
14	TOTAL			\$		\$ 410,576	\$ 159,687		\$ 570,263	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: **10/01/19**

Ending:

09/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **09/30/20**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,838,034	\$	1
2	Cash-Patient Deposits	140,797		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	377,061		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,184		6
7	Other Prepaid Expenses	12,655		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,426,731	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,205,188		12
13	Land	1,135,037		13
14	Buildings, at Historical Cost	36,128,379		14
15	Leasehold Improvements, at Historical Cost	8,962,174		15
16	Equipment, at Historical Cost	4,291,590		16
17	Accumulated Depreciation (book methods)	(25,947,898)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	24,906		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,799,376	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 35,226,107	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 305,138	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	140,797		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	700,160		30
31	Accrued Taxes Payable (excluding real estate taxes)	185,369		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	8,903		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	3,837,521		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,177,888	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,462,398		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)	\$ 4,462,398	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,640,286	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 25,585,821	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 35,226,107	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 25,732,523	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 25,732,526	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(146,705)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (146,705)	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)	\$ 25,585,821	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/19

Ending:

09/30/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,170,475	1
2	Discounts and Allowances for all Levels	(612,787)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,557,688	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	863,800	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 863,800	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,900	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	292,992	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,758	19
20	Radiology and X-Ray	11,000	20
21	Other Medical Services	228,422	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 607,072	23
D. Non-Operating Revenue			
24	Contributions	43,444	24
25	Interest and Other Investment Income***	146,110	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 189,554	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	5,582,761	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,582,761	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,800,875	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,946,705	31
32	Health Care	7,224,196	32
33	General Administration	3,875,068	33
B. Capital Expense			
34	Ownership	1,787,822	34
C. Ancillary Expense			
35	Special Cost Centers	2,699,229	35
36	Provider Participation Fee	414,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,947,580	40
41	Income before Income Taxes (line 30 minus line 40)**	(146,705)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (146,705)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,218,607	44
45	Private Pay - Net Inpatient Revenue	7,328,822	45
46	Medicare - Net Inpatient Revenue	634,177	46
47	Other-(specify) <u>Medicare B/Advantage A</u>	(11,031)	47
48	Other-(specify) <u>Shelter Care</u>	387,113	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,557,688	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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:

10/01/19

Ending:

09/30/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,940	2,160	\$ 89,009	\$ 41.21	1
2	Assistant Director of Nursing	1,500	2,100	68,782	32.75	2
3	Registered Nurses	58,494	63,629	1,725,092	27.11	3
4	Licensed Practical Nurses	38,986	42,808	933,819	21.81	4
5	CNAs & Orderlies	175,960	190,985	3,078,351	16.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,324	13,391	216,708	16.18	8
9	Activity Director	1,777	1,911	49,095	25.69	9
10	Activity Assistants	14,512	15,605	185,226	11.87	10
11	Social Service Workers	17,570	18,893	276,971	14.66	11
12	Dietician					12
13	Food Service Supervisor	5,589	6,520	141,423	21.69	13
14	Head Cook	7,821	8,753	120,205	13.73	14
15	Cook Helpers/Assistants	28,617	40,492	521,542	12.88	15
16	Dishwashers	10,204	11,155	124,143	11.13	16
17	Maintenance Workers	9,033	9,713	145,501	14.98	17
18	Housekeepers	25,240	27,140	325,410	11.99	18
19	Laundry	12,949	13,924	160,822	11.55	19
20	Administrator	1,329	1,429	127,721	89.38	20
21	Assistant Administrator	3,700	3,876	157,588	40.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,413	24,100	347,046	14.40	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	2,115	2,288	38,821	16.97	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	66,631	71,685	1,181,452	16.48	33
34	TOTAL (lines 1 - 33)	518,704	572,557	\$ 10,014,727 *	\$ 17.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	638	\$ 34,046	01-03	35
36	Medical Director	68	13,600	09-03	36
37	Medical Records Consultant	34	2,559	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,380	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,476	11-03	44
45	Social Service Consultant	Monthly	4,187	12-03	45
46	Other(specify)				46
47	<u>Dental Consultant</u>	Per Visit	800	10-03	47
48					48
49	TOTAL (lines 35 - 48)	740	\$ 70,048		49

C. CONTRACT NURSES

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

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/19

Ending: 09/30/20

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Leading Age - \$16,677, CHHS - \$9,698
- (3) Did the nursing home make political contributions or payments to a political 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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 84,987 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 414,560
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 168,580 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,900
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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: Marcum LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.