FOR BHF USE

LL1

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.

I. IDPH License ID Number: 0054395

Facility Name: Good Samaritan Pontiac

Address: 1225 S Ewing Drive (Number) Pontiac (City) 61764 (Zip Code)

County: Livingston

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 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: Jeremy M. Brune, CPA **Telephone Number:** (779) 875 - 3979
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 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Jeremy M. Brune, CPA, Chief Executive Officer
(Firm Name & Address) Jeremy Brune & Associates, LLC, 2508 Riverwalk Drive Plainfield, Illinois 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	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	12,297	9,499	4,324	26,120	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,297	9,499	4,324	26,120	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.30%

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)
N/A

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

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

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 03/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 2,630

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	277,116	30,949	14,196	322,261		322,261		322,261			1
2	Food Purchase		203,808		203,808		203,808	(3,612)	200,196			2
3	Housekeeping	118,693	16,519		135,212		135,212		135,212			3
4	Laundry	40,786	8,987		49,773		49,773		49,773			4
5	Heat and Other Utilities			98,432	98,432		98,432		98,432			5
6	Maintenance	82,615	8,327	57,526	148,468		148,468		148,468			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	519,211	268,591	170,155	957,956		957,956	(3,612)	954,344			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	2,631,435	174,719	38,446	2,844,600		2,844,600	(50,220)	2,794,380			10
10a	Therapy											10a
11	Activities	135,449	3,463	4,286	143,198		143,198		143,198			11
12	Social Services	28,884		1,557	30,440		30,440		30,440			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,795,768	178,182	55,088	3,029,038		3,029,038	(50,220)	2,978,818			16
	C. General Administration											
17	Administrative	91,524			91,524		91,524		91,524			17
18	Directors Fees											18
19	Professional Services			55,549	55,549		55,549	(14,469)	41,080			19
20	Dues, Fees, Subscriptions & Promotions			3,420	3,420		3,420		3,420			20
21	Clerical & General Office Expenses	232,005	16,520	28,810	277,335		277,335	(27,400)	249,935			21
22	Employee Benefits & Payroll Taxes			501,771	501,771		501,771		501,771			22
23	Inservice Training & Education			9,042	9,042		9,042		9,042			23
24	Travel and Seminar			1,259	1,259		1,259		1,259			24
25	Other Admin. Staff Transportation			449	449		449		449			25
26	Insurance-Prop.Liab.Malpractice			237,753	237,753		237,753		237,753			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	323,530	16,520	838,053	1,178,103		1,178,103	(41,869)	1,136,234			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,638,508	463,292	1,063,296	5,165,097		5,165,097	(95,701)	5,069,396			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Good Samaritan Pontiac
Medicaid Cost Report
01/01/20 - 12/31/20

Page 3 Supplemental Schedule - Inservice Training & Education

				Expenses			
Vendor	**Employees**	**Location**	**Date**	**Education**	**Travel**	**Meals**	**Total**
Reliance	All Employees	Facility	Various	9,042			9,042
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
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							-
							-
							-
							-
							-
Total				9,042	-	-	9,042

Facility Name & ID Number Good Samaritan Pontiac #0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			502,023	502,023		502,023		502,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			104,355	104,355		104,355	(10)	104,345			32
33	Real Estate Taxes			131,642	131,642		131,642		131,642			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,260	6,260		6,260		6,260			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			744,279	744,279		744,279	(10)	744,269			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,446	456,767	566,213		566,213		566,213			39
40	Barber and Beauty Shops			833	833		833		833			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,800	187,800		187,800		187,800			42
43	Other (specify):* See Supplemental	45,990	7,911	188,054	241,955		241,955	(7,069)	234,886			43
44	**TOTAL Special Cost Centers**	45,990	117,357	833,454	996,800		996,800	(7,069)	989,731			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,684,498	580,649	2,641,029	6,906,176		6,906,176	(102,780)	6,803,396			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Good Samaritan Pontiac
Medicaid Cost Report
01/01/20 - 12/31/20

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Marketing	45,990	7,911	180,985	234,886
Farm			7,069	7,069
				-
				-
				-
				-
				-
Sub-Total	45,990	7,911	188,054	241,955

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,612)	02		4
5	Telephone, TV & Radio in Resident Rooms	(5,177)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,198)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(91,783)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (102,780)		$	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))**	$ (102,780)		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

SEE ACCOUNTANTS' PREPARATION REPORT

Good Samaritan Pontiac

ID# 0054395

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (20,025)	21	1
2	Farm Income	(7,069)	43	2
3	Legal - Collections	(14,469)	19	3
4	HFS Cares Act Grant Funds - Supplies	(19,598)	10	4
5	HFS Cares Act Grant Funds - Hazard Pay	(30,622)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(91,783)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,612)	0	0	0	0	0	0	0	0	0	0	(3,612)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,612)	0	0	0	0	0	0	0	0	0	0	(3,612)	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	(50,220)	0	0	0	0	0	0	0	0	0	0	(50,220)	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**	(50,220)	0	0	0	0	0	0	0	0	0	0	(50,220)	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	(14,469)	0	0	0	0	0	0	0	0	0	0	(14,469)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(27,400)	0	0	0	0	0	0	0	0	0	0	(27,400)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(41,869)	0	0	0	0	0	0	0	0	0	0	(41,869)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,701)	0	0	0	0	0	0	0	0	0	0	(95,701)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Pontiac **#** 0054395 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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**	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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):*	(7,069)	0	0	0	0	0	0	0	0	0	0	(7,069)	43
44	**TOTAL Special Cost Centers**	(7,069)	0	0	0	0	0	0	0	0	0	0	(7,069)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(102,780)	0	0	0	0	0	0	0	0	0	0	(102,780)	45

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Board of Directors							1
2								2
3	Richard Hiatt							3
4	William Coffin							4
5	Jeff Rients							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
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	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	USDA		X	Mortgage	$35,730.00	11/14/14	$ 8,941,399	$ 8,941,399	11/14/54	3.5000%	$ 45,707	1
2	USDA		X	Mortgage	$15,072.00	11/14/14	3,771,609	3,771,609	11/14/54	3.5000%	19,280	2
3	USDA		X	Mortgage	$2,135.00	09/18/14	491,768	491,768	09/08/24	4.0000%	2,514	3
4												4
5												5
	Working Capital											
6	State Bank of Graymont		X	Line of Credit				523,083		6.0000%	32,009	6
7												7
8	Interest - Vendors		X								4,845	8
9	TOTAL Facility Related				$52,937.00		$ 13,204,776	$ 13,727,859			$ 104,355	9
	B. Non-Facility Related*											
10	Interest Income		X								(10)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10)	14
15	TOTALS (line 9+line14)						$ 13,204,776	$ 13,727,859			$ 104,345	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 132,596	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.)		$ 132,596	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.)		$ 131,642	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.		$ 131,642	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018	175,713	11
	2019	132,596	12

2020 RE Tax Accrual = Provider kept approx. the same real estate tax accrual equivalent with 2019 RE Tax Accrual

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Pontiac COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0054395

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15 - 15 - 29 - 100 - 015	Nursing Home	$ 132,596.58	$ 132,596.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 132,596.58	$ 132,596.58

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 X 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.

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

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

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

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

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

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

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	653,400	2014	$ 480,000	1
2					2
3	TOTALS	653,400		$ 480,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	90		2016	2016	$ 12,473,792	$ 415,794	30	$ 415,794	$	$ 1,732,472	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 790,062	$ 79,006	$ 79,006	$	10	$ 329,192	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 790,062	$ 79,006	$ 79,006	$		$ 329,192	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	Bus	2017	$ 65,010	$ 7,223	$ 7,223	$	9	$ 23,476	76
77										77
78										78
79										79
80	TOTALS			$ 65,010	$ 7,223	$ 7,223	$		$ 23,476	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)	$ 13,808,864	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 502,023	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 502,023	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,085,140	85	

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

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

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 6,260 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Good Samaritan Pontiac
Medicaid Cost Report
01/01/20 - 12/31/20

Page 14 Supplemental Schedule

Desciption		Amount		Total
Building Rental				
				-
N/A				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-		-
Equipment Rental				
Konica Minolta - Copier		6,260		6,260
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		6,260		6,260

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	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	$		$ 165,894	$		$ 165,894	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			49,298			49,298	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			181,335			181,335	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				105,133		105,133	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					4,313		4,313	12
13	Other (specify): See Supplemental	39 - 03				60,240			60,240	13
14	TOTAL			$		$ 456,767	$ 109,446		$ 566,213	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Good Samaritan Pontiac
Medicaid Cost Report
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		4,313		4,313
Laboratory			47,238	47,238
Radiology			5,596	5,596
Dental			7,406	7,406
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
				-
Total	-	4,313	60,240	64,553

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 1,128,858	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	598,547		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,893		6
7	Other Prepaid Expenses	3,980		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	142,858		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,884,136	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	480,000		13
14	Buildings, at Historical Cost	12,473,792		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	853,572		16
17	Accumulated Depreciation (book methods)	(2,085,140)		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): See Supplemental			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,722,224	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,606,361	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,155,765	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,686		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	131,642		32
33	Accrued Interest Payable	1,198,303		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	584,632		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,150,027	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	523,084		39
40	Mortgage Payable	13,204,776		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 13,727,860	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 16,877,888	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,271,527)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,606,361	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Good Samaritan Pontiac
Medicaid Cost Report
01/01/20 - 12/31/20

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Intercompany Receivable	142,858		142,858
			-
			-
			-
			-
Sub-Total	142,858	-	142,858
Line 23 - Long Term Assets			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 36 - Other Current Liability			
SBA Paycheck Protection Prg. Loan	584,632		584,632
			-
			-
			-
			-
Sub-Total	584,632	-	584,632
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,860,911)	1
2	Restatements (describe):		2
3	**Post Cost Report Adjustments**	30,404	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,830,507)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	558,980	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)**	$ 558,980	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,271,527)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,370,222	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,370,222	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,042	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 184,042	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	766,919	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	441	13
14	Non-Patient Meals	3,612	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	82,604	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 853,576	23
	D. Non-Operating Revenue		
24	Contributions	30,212	24
25	Interest and Other Investment Income***	10	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,222	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental	27,094	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,094	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,465,156	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	957,956	31
32	Health Care	3,029,038	32
33	General Administration	1,178,103	33
	B. Capital Expense		
34	Ownership	744,279	34
	C. Ancillary Expense		
35	Special Cost Centers	809,000	35
36	Provider Participation Fee	187,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,906,176	40
41	**Income before Income Taxes (line 30 minus line 40)****	558,980	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 558,980	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,861,229	44
45	Private Pay - Net Inpatient Revenue	2,795,625	45
46	Medicare - Net Inpatient Revenue	1,489,683	46
47	Other-(specify) Insurance - Net Inpatient Revenue	223,685	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,370,222	49

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Good Samaritan Pontiac
Medicaid Cost Report
01/01/20 - 12/31/20

Page 19 Supplemental Schedule

Description	Amount	Total
Miscellaneous Income	20,025	20,025
Farm Income	7,069	7,069
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
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		-
		-
		-
		-
		-
Total	27,094	27,094

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 105,805	$ 50.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,827	18,711	760,735	40.66	3
4	Licensed Practical Nurses	13,730	14,676	459,644	31.32	4
5	CNAs & Orderlies	66,161	69,420	1,305,252	18.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,805	1,908	31,853	16.69	9
10	Activity Assistants	8,462	8,664	103,596	11.96	10
11	Social Service Workers	1,385	1,546	28,884	18.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,505	19,494	277,116	14.22	15
16	Dishwashers					16
17	Maintenance Workers	3,331	3,587	82,615	23.03	17
18	Housekeepers	8,827	9,272	118,693	12.80	18
19	Laundry	3,090	3,272	40,786	12.47	19
20	Administrator	1,974	2,080	91,524	44.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,035	10,827	232,005	21.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,044	2,206	45,990	20.85	33
34	TOTAL (lines 1 - 33)	159,176	167,743	$ 3,684,498 *	$ 21.97	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 14,196	01 - 03	35
36	Medical Director		10,800	09 - 03	36
37	Medical Records Consultant		2,321	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,800	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		1,557	11 - 03	44
45	Social Service Consultant		1,557	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 35,231		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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Good Samaritan Pontiac
Medicaid Cost Report
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Marketing	43	2,044	2,206	45,990	20.85		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		2,044	2,206	45,990	20.85		
Contracted Services							
Total						-	-

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Wittenberg	Administrator	0	$ 91,524
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,524

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
Hartweg, Turner,		$
Wood & DeVary, P.C.	Collections	14,469
Jeremy Brune & Associates	Cost Reports	4,050
APS Workspace Management	Data Processing	18,006
Ability Network	Data Processing	8,165
PointClickCare Technologies	Data Processing	10,859
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 55,549

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,294
Unemployment Compensation Insurance	11,178
FICA Taxes	274,515
Employee Health Insurance	149,399
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	10,397
Life Insurance	1,046
Other	11,942
TOTAL (agree to Schedule V, line 22, col.8)	$ 501,771

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	826
(Indicate # of checks performed)	
Patient Background Checks	213
Licenses and Dues	391
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,420

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,259
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,259

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Pontiac # 0054395 Report Period Beginning: 01/01/20 Ending: 12/31/20

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,823** Line **10 - 02**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **187,800**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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? **See Pg. 2 Q. E** 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. $ **3,612**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln. 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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.