

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street Quincy 62301
Number City Zip Code

County: Adams

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

HFS ID Number:

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

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Deandra Fallon Telephone Number: (570) 820-0301
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2024 to 09/30/2025 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) Matthew C. Dorian
(Title) CFO

Paid Preparer

(Signed) 03/02/26 (Date)
(Print Name and Title) Deandra Fallon Director
(Firm Name & Address) Baker Tilly Advisory Group, LP 100 Keystone Ave, Pittston, PA 18640
(Telephone) (570) 820-0301 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	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	31,025	1
2		Skilled Pediatric (SNF/PED)			2
3	118	Intermediate (ICF)	118	43,070	3
4		Intermediate/DD			4
5	28	Sheltered Care (SC)	28	10,220	5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	52	45	79	160	473	3,272	795	4,876	8
9	SNF/PED									9
10	ICF	3,541	2,710	5,208		19,667			31,126	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,593	2,755	5,287	160	20,140	3,272	795	36,002	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 42.70%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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 certified beds. number of certified beds 35

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: 09/30/25 Fiscal Year: 09/30/25
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2024 Ending: 09/30/2025

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

	Operating Expenses	Costs 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	
	A. General Services											
1	Dietary	1,501,198	53,407	27,559	1,582,164		1,582,164	(326,876)	1,255,288			1
2	Food Purchase		729,004		729,004	(72,465)	656,539	(226,243)	430,296			2
3	Housekeeping	656,629	66,184		722,813	(146,916)	575,897	(101,113)	474,784			3
4	Laundry		14,450		14,450	146,916	161,366	(31,368)	129,998			4
5	Heat and Other Utilities			621,826	621,826		621,826	(140,207)	481,619			5
6	Maintenance	563,541	38,449	297,492	899,482		899,482	(374,276)	525,206			6
7	Other (specify):*											7
8	TOTAL General Services	2,721,368	901,494	946,877	4,569,739	(72,465)	4,497,274	(1,200,083)	3,297,191			8
	B. Health Care and Programs											
9	Medical Director			11,400	11,400		11,400		11,400			9
10	Nursing and Medical Records	6,356,594	333,584	12,326	6,702,504	(4,605)	6,697,899	(2,340)	6,695,559			10
10a	Therapy	86,747	968		87,715		87,715		87,715			10a
11	Activities	356,613	15,851	462	372,926		372,926	(72,492)	300,434			11
12	Social Services	250,031	5,705	462	256,198	(2,030)	254,168	(51,170)	202,998			12
13	CNA Training					4,605	4,605		4,605			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,049,985	356,108	24,650	7,430,743	(2,030)	7,428,713	(126,002)	7,302,711			16
	C. General Administration											
17	Administrative	263,696			263,696		263,696	(58,584)	205,112			17
18	Directors Fees											18
19	Professional Services			121,385	121,385		121,385	(26,967)	94,418			19
20	Dues, Fees, Subscriptions & Promotions			45,143	45,143	2,030	47,173	(36,044)	11,129			20
21	Clerical & General Office Expenses	714,039	41,210	732,073	1,487,322	(55,183)	1,432,139	(881,293)	550,846			21
22	Employee Benefits & Payroll Taxes			3,621,853	3,621,853	72,465	3,694,318	(346,241)	3,348,077			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,306	12,306		12,306	(241)	12,065			24
25	Other Admin. Staff Transportation			16,984	16,984		16,984		16,984			25
26	Insurance-Prop.Liab.Malpractice			455,899	455,899		455,899	(101,285)	354,614			26
27	Other (specify):*											27
28	TOTAL General Administration	977,735	41,210	5,005,643	6,024,588	19,312	6,043,900	(1,450,655)	4,593,245			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,749,088	1,298,812	5,977,170	18,025,070	(55,183)	17,969,887	(2,776,740)	15,193,147			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 Home
0009258
Schedule of Other Admin Staff Transportation
09/30/2025

Auto Expense - Good Samaritan Home	\$ 16,984
Auto Expense - Related Parties - See Page 6	-
Auto Expense - Page 5 and 5a Adjustments	-
Auto Expense - Total	<u>\$ 16,984</u>

Good Samaritan Home of Quincy
Auto and Travel
Facility Vehicle
10/01/24-09/30/25

G/L Account #	Payee / Vendor	Personal Portion	Employee Related	Resident Transportation	Total Expense
01-76-543140-01	Hy-Vee Gas Expense	-	680.00	-	680.00
01-76-543140-01	Prairieland FS - Fuel Expense	-	16,136.00	-	16,136.00
01-76-543140-01	Other Fuel Expenses	-	168.00	-	168.00
		-	16,984.00	-	16,984.00

		Schedule V Line #
To reclassify laundry salaries included in housekeeping		
Laundry Salaries in Housekeeping	146,916	
Increase Line 4	146,916	4
Decrease Line 3	(146,916)	3
To reclassify resident background checks posted to social services		
Patient Background Checks	2,030	
Increase Line 20	2,030	20
Decrease Line 12	(2,030)	12
To reclassify development salaries included in A&G		
Development Salaries	55,183	
Increase Line 43	55,183	43
Decrease Line 21	(55,183)	21
To reclassify cost of employee meals from raw food to employee benefits		
Employee Meals	72,465	
Increase Line 22	72,465	22
Decrease Line 2	(72,465)	2
To reclassify C.N.A. Training costs to correct cost report line		
C.N.A. Training Costs	4,605	
Increase Line 13	4,605	13
Decrease Line 10	(4,605)	10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,547,286	1,547,286		1,547,286	(282,558)	1,264,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,189	116,189		116,189	(74,798)	41,391			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			27,366	27,366		27,366	(27,366)				36
37	TOTAL Ownership			1,690,841	1,690,841		1,690,841	(384,722)	1,306,119			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,806	509,055	635,861		635,861		635,861			39
40	Barber and Beauty Shops	51,967	2,083		54,050		54,050	(38,590)	15,460			40
41	Coffee and Gift Shops	35,836	42,511		78,347		78,347	(60,595)	17,752			41
42	Provider Participation Fee			538,345	538,345		538,345		538,345			42
43	Other (specify):*	447,210	7,057	468,013	922,280	55,183	977,463	(977,463)				43
44	TOTAL Special Cost Centers	535,013	178,457	1,515,413	2,228,883	55,183	2,284,066	(1,076,648)	1,207,418			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	11,284,101	1,477,269	9,183,424	21,944,794		21,944,794	(4,238,110)	17,706,684			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

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	(104,070)	02		4
5	Telephone, TV & Radio in Resident Rooms	(31,030)	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	(282,558)	30		9
10	Interest and Other Investment Income	(3,400)	32		10
11	Discounts, Allowances, Rebates & Refunds	(975)	21		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	(37,898)	21		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	(289,751)	21		24
25	Fund Raising, Advertising and Promotional	(19,883)	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	(3,468,545)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,238,110)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,238,110)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (6,132)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Food Rebate Income	(10,125)	02	3
4	Miscellaneous Income	(1,410)	21	4
5	Miscellaneous Billing Late Fees	(6,867)	21	5
6	Management Fee Income	(200,000)	21	6
7	Guest Room Income	(2,340)	10	7
8	Smoking and Pet Cleaning Fee	(6,850)	43	8
9	Beauty Shop Income	(38,590)	40	9
10	Gift Shop Income	(633)	41	10
11	General Store Income	(59,962)	41	11
12	Decorating Income	(1,283)	12	12
13	Bank Charges	(10,943)	21	13
14	Credit Card Fees	(3,019)	21	14
15	Endowment Expense	(27,366)	36	15
16	Personal Use of Auto	(86)	12	16
17	Personal Use of Auto	(241)	24	17
18	Non-Nursing Costs - Dietary	(326,876)	01	18
19	Non-Nursing Costs - Food Purchases	(112,048)	02	19
20	Non-Nursing Costs - Housekeeping	(101,113)	03	20
21	Non-Nursing Costs - Utilities	(109,177)	05	21
22	Non-Nursing Costs - Maintenance	(374,276)	06	22
23	Non-Nursing Costs - Activities	(72,492)	11	23
24	Non-Nursing Costs - Social Services	(49,801)	12	24
25	Non-Nursing Costs - Interest	(71,398)	32	25
26	Non-Nursing Costs - Administrative	(58,584)	17	26
27	Non-Nursing Costs - Professional Services	(26,967)	19	27
28	Non-Nursing Costs - Dues, Fees, Subscriptions	(10,029)	20	28
29	Non-Nursing Costs - Clerical and General Office	(330,430)	21	29
30	Non-Nursing Costs - Prop. Liab. Malpractice	(101,285)	26	30
31	Non-Nursing Costs - Benefits	-346241	22	31
32	Non-Nursing Costs - Laundry	-31368	4	32
33	Other Non-Allowable Expenses	-970613	43	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	(3,468,545)		49

Summary A

09/30/2025

[illegible]

Summary B

09/30/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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)	
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

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			\$			\$ 0	\$ *	39

VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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

SEE ACCOUNTANTS' PREPARATION REPORT

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	N/A								\$		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2024 Ending: 9/30/2025

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: 10/01/2024 Ending: 9/30/2025

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

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**		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	\$32,940.00	07/11/13	\$ 7,960,000	\$ 2,878,419			\$ 64,804	1	
2				Amortization of Loan Costs								2	
3												3	
4												4	
5												5	
	Working Capital												
6	Wells Fargo		X	Line of Credit				824,774			51,385	6	
7												7	
8												8	
9	TOTAL Facility Related				\$32,940.00		\$ 7,960,000	\$ 3,703,193			\$ 116,189	9	
	B. Non-Facility Related*												
10	Interest Income										(3,400)	10	
11	Allocation to AL/IL										(71,398)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (74,798)	14	
15	TOTALS (line 9+line14)						\$ 7,960,000	\$ 3,703,193			\$ 41,391	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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 2024 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 2025 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
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

- 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.

2024 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 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,970B. General Construction Type: Exterior BrickFrame SteelNumber 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).
Residenntial Cottage Apartments 180 units for 199,478 square feet
Assisted Living Facilities with 26 beds for 15,900 square feet

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2024

Ending:

09/30/2025

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			1,953,541	6	
7	231			2010	1,695,151		Various				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			274,365	11	
12	Various			1986	257,007		20			257,007	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			534,301	15	
16	Various			1993	316,353		20	15,818	15,818	303,716	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	2,075	2,075	35,792	21	
22	Various			1999	264,789		20	13,239	13,239	224,076	22	
23	Various			2000	77,036		20	3,852	3,852	69,682	23	
24	Various			2001	383,062		20	19,153	19,153	291,980	24	
25	Various			2002	5,278		20			5,278	25	
26	Various			2003	27,937		20			27,937	26	
27	Various			2004	107,316		20	17	17	107,316	27	
28	Various			2005	19,432		20	38	38	19,432	28	
29	Various			2006	273,693		20	13,685	13,685	265,613	29	
30	Various			2007	79,419		20	3,971	3,971	83,390	30	
31	Various			2008	183,238		20	2,459	2,459	183,238	31	
32	Various			2009	357,083		20	17,854	17,854	335,624	32	
33	Various			2010	8,891,511		20	444,576	444,576	5,563,664	33	
34	Various			2011	2,910,457		20	145,523	145,523	1,866,184	34	
35	Various			2012	1,924,747		20	96,237	96,237	1,080,960	35	
36	Various			2013	1,143,258		20	57,163	57,163	675,840	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

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	
37	Various	2014	\$ 139,458	\$	20	\$ 9,923	\$ 9,923	\$ 75,044	37
38	Various	2015	754,702		20	37,884	37,884	358,471	38
39	Various	2016	93,639		20	51,044	51,044	50,661	39
40	Various	2017	490,534		20	25,079	25,079	221,143	40
41	Various	2018	371,670		20	18,584	18,584	130,032	41
42	Various	2019	141,378		20	7,069	7,069	31,522	42
43	Various	2020	137,082		20	6,854	6,854	27,623	43
44	Various	2021	317,541		20	15,877	15,877	88,301	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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									67
68									68
69	Financial Statement Depreciation			1,547,286			(1,547,286)		69
70	TOTAL (lines 4 thru 69)		\$ 27,432,671	\$ 1,547,286		\$ 1,007,973	\$ (539,313)	\$ 18,407,930	70

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning:

10/01/2024 Ending: 09/30/2025

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		\$ 27,432,671	\$ 1,547,286		\$ 1,007,973	\$ (539,313)	\$ 18,407,930	1
2	Repaired Roof Above Kitchen Area - Patch Holes, Replace Flashin	2022	4,044		20	202	202	808	2
3	Hvac Unit - Replace Coil & Charge System North Section West En	2022	7,623		20	381	381	1,524	3
4	Hvac Unit - Replace Compressor Anna Brown Daiken Unit	2022	4,856		20	243	243	972	4
5	Kitchen Sink Garbage Disposal	2022	6,483		20	324	324	1,296	5
6	Installation Of Duplex Water Softening System	2022	26,347		20	1,317	1,317	5,268	6
7	Hvac Unit - Replace Exv Valve Main Bldg	2022	5,796		20	290	290	1,160	7
8	Replace Discharge Air Thermistor In Alzheimers Wing	2022	15,353		20	768	768	3,072	8
9	2022 Limp Disposals	2022	(46,246)		20	(43,934)	(43,934)	(134,114)	9
10	Hva Unit - Replace Evap Coil In East Wing Unit	2022	6,817		20	341	341	1,364	10
11	Hvac Unit - Replace Valve And Charge Unit	2022	6,810		20	341	341	1,364	11
12	Hvac Unit - Repaired Leak On Refnet	2022	4,460		20	223	223	892	12
13	Hvac Unit - Replace Compressor In Rm 522	2022	4,400		20	220	220	880	13
14	Repair Hvac Pool Room Unit - Replace Bad Contractor	2022	3,897		20	195	195	780	14
15	Hvac Unit - Replace Exv Valve Coil On East Hall Unit	2022	3,700		20	185	185	740	15
16	Hvac Unit - Repair Pool Unit Leak	2022	3,275		20	164	164	656	16
17	Hvac Unit - Repair Pool Unit Coil Bypass Damper	2022	2,777		20	139	139	556	17
18	Hvac Unit - Repair Leak On Line At Bs Box In Room 608	2022	2,650		20	133	133	532	18
19	Rpz Repair-Replace Rubber Aquatic In Dietary Room & Resident	2022	2,925		20	146	146	439	19
20	Eastbrook South Hall Daiken Unit - Replaced Compressor	2022	2,963		20	148	148	444	20
21	East Nursing Hall - Replace Compressor On A/C Unit	2022	8,709		20	435	435	1,306	21
22	Replace Inverter Compressor On South Wing Unit	2022	6,303		20	315	315	945	22
23	Installation Of Flooring In Resident Room #13	2023	3,178		20	159	159	477	23
24	Special Care Hvac Unit - Replace Compressors & Invertor Board	2023	19,037		20	952	952	2,856	24
25	West System Hvac Unit - Replaced Compressor	2023	4,291		20	215	215	644	25
26	Replace Compressor On South Wing Hvac System B	2023	6,010		20	301	301	902	26
27	Landside Pool Hvac - Replace Heating Valve And Actuator	2023	2,937		20	147	147	441	27
28	South Hall Hvac - Replace Compressor	2023	5,817		20	291	291	873	28
29	Eastbrook Lane Hvac Unit - Replace South Wing Compressor	2023	4,314		20	216	216	647	29
30	Eber Wing Hvac System - Replace Compressor	2023	5,809		20	290	290	871	30
31	South Wing Master Hvac - Replace Compressor	2023	5,956		20	298	298	894	31
32	Replace Hvac Coil In North Section West End	2023	3,936		20	197	197	591	32
33	Main Entrance Drive - Patching & Sealing	2023	43,274		20	2,164	2,164	6,491	33
34	TOTAL (lines 1 thru 33)		\$ 27,621,172	\$ 1,547,286		\$ 975,779	\$ (571,507)	\$ 18,314,501	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

10/01/2024

Ending:

09/30/2025

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		\$ 27,621,172	\$ 1,547,286		\$ 975,779	\$ (571,507)	\$ 18,314,501	1
2	Main Bulding Parking Lot Expansion	2023	238,502		20	11,925	11,925	11,925	2
3	Phase Loss Monitors For Variable Refrigerant Flow (Vrf) System	2023	38,800		20	1,940	1,940	1,940	3
4	2023 Limp Disposals	2023	(36,781)		20	(3,678)	(3,678)	(3,678)	4
5	Room Refurbishing: Southern Court 624 - Painting, Flooring	2023	5,984		20	299	299	299	5
6	Room Refurbishing: Southern Court 621 - Painting, Flooring	2023	5,984		20	299	299	299	6
7	South Area Rooms 601,607,608 - Repair Hvac Leaks	2023	5,975		20	299	299	299	7
8	New Exhaust Bearings & Valve For Rtu In Special Care And Foos	2023	4,109		20	205	205	205	8
9	Install 2 Magnetic Door Holders For Fire Doors	2023	3,412		20	171	171	171	9
10	Repair Leak On Suction Line For South Hvac Unit	2023	3,265		20	163	163	163	10
11	Replace Hollow Metal Frame Kitchen Doors	2023	7,100		20	355	355	355	11
12	Repaired Roof On East Nursing Wing	2023	2,850		20	143	143	143	12
13	Hvac West System - Replace Compressor	2023	4,912		20	246	246	246	13
14	Replace Blown Fuses And Compressor On Eber Roof Unit	2023	3,150		20	158	158	158	14
15	Replaced Inverter Compressor On South Roof Unit	2023	6,807		20	340	340	340	15
16	South System Hvac - Replaced Compressor On Master Unit	2023	6,561		20	328	328	328	16
17	Replace Hot Water Storage Tank	2024	3,725		20	186	186	186	17
18	Install New Indoor Air Quality (Iaq) Devices	2024	134,000		20	6,700	6,700	6,700	18
19	Replace Inverter Compressor At Eber South Hallway	2024	6,087		20	304	304	304	19
20	Replace Compressor On Eber Roof Unit	2024	6,900		20	345	345	345	20
21	Supply And Install Bradley Mixing Valve	2024	2,545		20	127	127	127	21
22	Replace Compressor On Mcreynolds Master Unit	2024	4,050		20	203	203	203	22
23	Replace Power Switches At North Section	2024	3,329		20	166	166	166	23
24	Replace Compressor Eber Roof Unit	2024	7,604		20	380	380	380	24
25	Hvac Install - Vrf Equip,Doas Units,Controls,Ceiling Removal,Pipi	2024	1,390,368		20	69,518	69,518	69,518	25
26	Install New Compressor On Master Unit For West Hall	2024	4,660		20	233	233	233	26
27	Replace Compressor On Eber Hvac Unit	2024	5,455		20	273	273	273	27
28	Mcrcynolds Hvac Unit - Replace Compressor	2024	5,326		20	266	266	266	28
29	2024 Limp Disposals	2024	(186,826)		20	(9,341)	(9,341)	(9,341)	29
30	Replace Rotted Flooring Under Wheelchair Lift	2024	6,249		20	312	312	312	30
31	Replace Burner Control And Repair Air Damper On Boiler	2024	3,633		20	182	182	182	31
32	Replace Damper Arm Swivels On Cooling Tower	2024	4,094		20	205	205	205	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 29,323,001	\$ 1,547,286		\$ 1,059,031	\$ (488,255)	\$ 18,397,753	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XL OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 29,323,001	\$ 1,547,286		\$ 1,059,031	\$ (488,255)	\$ 18,397,753	1
2	Cooling Towers Fan Wheel Bearings	2025	72,100		10	4,807	4,807	4,807	2
3	McReynold's hot water re-pipe & pumps	2025	3,657		10	183	183	183	3
4	Cooling Tower Chemical control	2025	3,128		10	130	130	130	4
5	Eber/South HVAC system	2025	2,097,957		10				5
6	Food Services - Meat Reach-In Cooler	2025	3,397		10	85	85	85	6
7	Bizer Courtyard Stone	2025	10,000		25	233	233	233	7
8	Bizer Memorial Garden (Foosse Ctr)	2025	56,637		20	708	708	708	8
9	2025 Limp Disposals	2025	(1,057,558)		20				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)		\$ 30,512,319	\$ 1,547,286		\$ 1,065,177	\$ (482,109)	\$ 18,403,899	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 2,451,464	\$	\$ 166,042	\$ 166,042	10	\$ 2,357,559	71
72	Current Year Purchases	8,883		1,777	1,777	5	1,777	72
73	Fully Depreciated Assets	961,071				10	961,071	73
74								74
75	TOTALS	\$ 3,421,418	\$	\$ 167,819	\$ 167,819		\$ 3,320,407	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	\$	\$	\$		\$ 128,098	76
77		Dodge Grand Caravan	2015	39,255					39,255	77
78		Ford E-150	2015	11,056					11,056	78
79		See Attached		396,666		31,732	31,732		340,097	79
80	TOTALS			\$ 575,075	\$	\$ 31,732	\$ 31,732		\$ 518,506	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)	\$ 34,953,461	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,547,286	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,264,728	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (282,558)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 22,242,812	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 - 202	\$ 71,574	\$	\$	86
87	Cottage - Equipment - 2020	38,942			87
88	Cottage - Building Improvements - 2021	139,946			88
89	Cottage - Equipment - 2021	2,789			89
90	See Attached	3,307,077			90
91	TOTALS	\$ 3,560,328	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 811,917	92
93			93
94			94
95		\$ 811,917	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.

XI. OWNERSHIP COSTS (continued)

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	
79A		Snow Salt Spreader	2015	\$ 1,600	\$	\$	0	5	\$ 1,600	76
79B		Toro 8260XE Snow Blower	2014	1,189			0	5	1,189	77
79C		Landpride RB1584 Blade	2014	575			0	5	575	78
79D		Landpride RTR0550 Tiller	2015	1,950			0	5	1,950	
79E		Kubota L3430	2006	18,895			0	5	18,895	
79F		Ford F350	2007	30,224			0	5	30,224	
79G		Tractor with Cab JD 4320	2010	33,977			0	5	33,977	
79H		2010 GMC Sierra	2010	32,410			0	5	32,410	
79I		Various Mower/Snow EQ	2010	399			0	5	399	
79J		Kubota KQ163	2014	1,850			0	5	1,850	
79K		Kubota Tractor - Snow Removal	2017	10,000			0	5	10,000	
79L		2018 Ford Starcraft Bus	2018	65,140			0	5	65,140	
79M		2018 Dodge Caravan	2018	39,795			0	5	39,795	
79N		2022 Ford F250	2022	42,687		8,537	8,537	5	34,148	
79O		2024 Ford E450 Bus	2023	107,775		21,555	21,555	5	64,665	
79P		2007 Dodge Ram	2024	8,200		1,640	1,640	5	3,280	
79Q										
79	TOTALS			\$ 396,666	\$ 0	\$ 31,732	\$ 31,732		\$ 340,097	80

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
90A	Cottage - Disposals - 2021	\$ (171,402)	\$	\$	86
90B	Cottage - Building Improvements - 2022	146,367			87
90C	Cottage - Disposals - 2022	(36,775)			88
90D	Cottage - Building Improvements - 2023	141,740			89
90E	Cottage - Disposals - 2023	(2,520)			
90F	Cottage - Building Improvements - 2024	1,994,394			
90G	Cottage - Equipment Disposals - 2024	(20,417)			
90H	Cottage - Disposals - 2024	(35,091)			
90I	Cottage - Building Improvements - 2025	1,282,223			
90J	Cottage - Land Improvements - 2025	8,558			90
91	TOTALS	\$ 3,307,077	\$	\$	91

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		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:

YESNO

Terms:*

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

15. Is Movable equipment rental included in building rental?

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

☐ 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	\$ 1,404	\$ 2,808	\$	\$ 4,212
2	Books and Supplies	131	262		393
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	\$ 1,535	\$ 3,070	\$	\$ 4,605
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,605			

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

(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		hrs	\$	3,671	\$ 181,963	\$	3,671	\$ 181,963	1
2	Licensed Speech and Language Development Therapist		hrs		335	28,734		335	28,734	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,803	277,330		3,803	277,330	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				126,806		126,806	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See attached					21,028			21,028	13
14	TOTAL			\$	7,809	\$ 509,055	\$ 126,806	7,809	\$ 635,861	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

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE	
Special Services - Salary (Column 3 - Staff)	Amount
13A	
13B	
13C	
13D	
13E	
13F	
	0
Special Services - Outside Practitioner (Column 5 - Other)	
13G Office Visits/Wound Clinic	199
13H Lab Services	10,570
13I X-Ray/Echo Services	10,259
13J Ambulance Services	0
13K	
13L	
13M	
13N	
	21,028
Special Services - Supplies (Column 6 - Other)	
13O	
13P	
13Q	
13R	
13S	
13T	
13U	
13V	
	0

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	\$ 345,117	\$	1
2	Cash-Patient Deposits	160,888		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,005,213		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,035		6
7	Other Prepaid Expenses	13,143		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached</u>	1,773		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,621,169	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,291,613		12
13	Land	1,135,036		13
14	Buildings, at Historical Cost	36,317,464		14
15	Leasehold Improvements, at Historical Cost	15,624,766		15
16	Equipment, at Historical Cost	4,350,869		16
17	Accumulated Depreciation (book methods)	(32,745,886)		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): <u>See attached</u>	811,917		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,785,779	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 31,406,948	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,448,198	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	160,888		28
29	Short-Term Notes Payable	1,162,336		29
30	Accrued Salaries Payable	1,100,563		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	964,499		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,836,484	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,540,857		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	1,892,062		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,432,919	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,269,403	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 22,137,545	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 31,406,948	\$	48

Facility Name & ID Number		STATE OF ILLINOIS		Page 17 - SUPP	
Good Samaritan Home		#	0009258	Report Period Beg 10/01/2024	Ending: 09/30/2025
Supplemental Schedule of Other Assets and Other Liabilities					
Other Current Assets (Line 9)		Amount		Other Current Liabilities (Line 36)	
09A St Disability Payable - Employee		1,773		36A Real Estate Taxes Payable	
09B				36B Employee Assist Fund Withholding	
09C				36C Miscellaneous Liabilities	
09D				36D Resident Credit Balance	
09E				36E Prepaid Rent - Current	
09F				36F	
		1,773		964,499	
Other Non-Current Assets (Line 23)				Other Non-Current Liabilities (Line 43)	
23A Construction in Progress - Operating		801,715		43A Prepaid Rent - Long-Term	
23B Construction in Progress - Cottages		10,202		43B	
23C				43C	
23D				43D	
23E				43E	
23F				43F	
23G				43G	
23H				43H	
		811,917		1,892,062	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,000,729	1
2	Restatements (describe):		2
3	Equity Adjustment	(322,950)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 20,677,779	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,433,319	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	75,300	11
12	Expenditures for Specific Purposes	(48,853)	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)	\$ 1,459,766	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)	\$ 22,137,545	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Good Samaritan Home

0009258

Report Period Beginning: 10/01/2024

Ending: 09/30/2025

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	\$ 11,771,657	1
2	Discounts and Allowances for all Levels	(1,427,146)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,344,511	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	688,846	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 688,846	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	104,070	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	241,495	17
18	Sale of Supplies to Non-Patients	21,704	18
19	Laboratory	21,274	19
20	Radiology and X-Ray	19,491	20
21	Other Medical Services	102,128	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 510,162	23
	D. Non-Operating Revenue		
24	Contributions	7,252,742	24
25	Interest and Other Investment Income***	3,400	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,256,142	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,578,452	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,578,452	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,378,113	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,569,739	31
32	Health Care	7,430,743	32
33	General Administration	6,024,588	33
	B. Capital Expense		
34	Ownership	1,690,841	34
	C. Ancillary Expense		
35	Special Cost Centers	1,690,538	35
36	Provider Participation Fee	538,345	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,944,794	40
41	Income before Income Taxes (line 30 minus line 40)**	1,433,319	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,433,319	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 976,405.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	748,677.00	45
46	MMAI-Medicaid is the Primary Payer	1,436,753.00	46
47	MMAI-Medicare is the Primary Payer	43,480.00	47
48	Private Pay	5,763,385.00	48
49	Medicare Part A	1,140,174.00	49
50	Other-(specify) <u>Advantage A</u>	235,637.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,344,511	56

SEE ACCOUNTANTS' PREPARATION REPORT

Supplemental Schedule of Revenues	
Description	Amount
28A Miscellaneous Income	1,410
28B Management Fee Income from Foundation	200,000
28C Memorials/Membership Income and Next Gen ACO Participation Fee	42,608
28D Guest Room Income	2,340
28E Miscellaneous Billing Late Fees	6,867
28F Gain (Loss) on Disposal of Assets	-570,224
28G Cottage Improvement Income & Room Rental Fee	36,472
28H Grants and Bequest Income	9,676
28I Pool Usage Income - Outreach/Cottagers	15,385
28J Discounts Earned Income	975
28K Cottage Rent - Harrison (related expenses adjusted on p 5A)	2,975,669
28L Private Room Fee & Van Transportation Charges	133,138
28M Pneumonia Shot Income	60
28N Beauty Shop Income	38,590
28O Gift Shop Income	633
28P General Store Income	59,962
28Q Transfer Charge to New Cottage	1,000
28R Fun/Decorating Committee Income (adj 5A)	1,283
28S Room and Board - AL (related expenses adjusted on p 5A)	1,693,969
28T Food Rebate Income	10,125
28U Smoking And/or Pet Cleaming Fee	6,850
28V Net Assets Released from Restrictions	48,853
28W Unrealized Gain (Loss)	-137,189
	4,578,452

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	1,935	2,176	\$ 116,078	\$ 53.34	1
2	Assistant Director of Nursing	1,973	2,067	104,487	50.55	2
3	Registered Nurses	25,959	28,383	1,127,923	39.74	3
4	Licensed Practical Nurses	19,743	22,191	715,551	32.25	4
5	CNAs & Orderlies	159,779	175,496	3,776,082	21.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,242	3,720	86,747	23.32	8
9	Activity Director	1,838	2,096	65,674	31.33	9
10	Activity Assistants	14,180	15,622	290,939	18.62	10
11	Social Service Workers	11,922	13,468	250,031	18.56	11
12	Dietician					12
13	Food Service Supervisor	5,509	6,157	189,165	30.72	13
14	Head Cook	15,237	16,535	320,936	19.41	14
15	Cook Helpers/Assistants	39,371	43,356	773,994	17.85	15
16	Dishwashers	11,817	12,845	217,103	16.90	16
17	Maintenance Workers	22,079	24,483	563,541	23.02	17
18	Housekeepers	25,297	28,476	509,713	17.90	18
19	Laundry	7,443	8,347	146,916	17.60	19
20	Administrator	1,880	2,096	158,907	75.81	20
21	Assistant Administrator	1,900	2,128	104,789	49.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,584	25,748	658,856	25.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator	9,055	10,049	423,515	42.14	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,358	4,671	92,958	19.90	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	19,343	21,363	590,196	27.63	33
34	TOTAL (lines 1 - 33)	426,444	471,473	\$ 11,284,101 *	\$ 23.93	34

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	437	\$ 27,559	01-03	35
36	Medical Director	57	11,400	09-03	36
37	Medical Records Consultant	35	2,638	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,688	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	462	11-03	44
45	Social Service Consultant	Monthly	462	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	529	\$ 52,209		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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Supplemental Schedule of Staffing and Salary Costs				
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
33A Beautician	2,000	2,256	51,967	23.04
33B General Store	1,971	2,062	35,836	17.38
33C ALU/ILU Salaries	12,256	13,652	402,664	29.49
33D Director of Public Relations	1,918	2,088	55,183	26.43
33E Developmental	1,198	1,305	44,546	34.13
33F				
33G				
33H				
33I				
33J				
33K				
33L				
33M				
33N				
33O				
33P				
33Q				
33R				
33S				
33T				
Total	19,343	21,363	590,196	27.63

STATE OF ILLINOIS

Facility Name & ID Number

Good Samaritan Home

0009258

Report Period Beginning: 10/01/2024

Page 21

Ending: 09/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Emma McLeod

CEO/Asst Admin

0

\$ 158,907

Matthew Dorian

CFO/Asst Admin

0

104,789

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 263,696

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

CBIZ

Financial Expense

\$ 88,896

See attached

Legal Expenses

32,489

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 121,385

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 210,630

Unemployment Compensation Insurance

24,235

FICA Taxes

766,717

Employee Health Insurance

2,438,229

Employee Meals

72,465

Illinois Municipal Retirement Fund (IMRF)*

Pension Plan

123,066

Life Insurance

25,058

Special Events

3,356

Recognition Expense

30,412

Other Employee Benefits

150

Allocation to Non-Nursing

(346,241)

TOTAL (agree to Schedule V, line 22, col.8)

\$ 3,348,077

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

\$ 2,514

Advertising: Employee Recruitment

1,000

Health Care Worker Background Check

(Indicate # of checks performed)

2,256

Patient Background Checks

2,030

Association Dues (total from pg 22, #4)

19,490

Allocation to Non-Nursing

(10,029)

Less: Public Relations Expense

()

PAC and Lobbying payments

(6,132)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 11,129

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

12,065

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 12,065

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Good Samaritan Home of Quincy
Legal Expenses
10/01/24-09/30/25

Date	G/L Account #	Payee / Vendor	Type of Services Provided	Amount	Adjustment	Adjusted Amount
10/2024	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	840.00		840.00
12/2024	01-66-540195-01	Polsinelli PC	Annual Survey	320.00		320.00
12/2024	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	Employment Matters	483.00		483.00
12/2024	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	550.00		550.00
12/2024	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	136.50		136.50
01/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	126.00		126.00
01/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	388.50		388.50
02/2025	01-66-540195-01	Polsinelli PC,	General Counsel	3,929.50		3,929.50
02/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	Employment Matters	105.00		105.00
02/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	1,104.50		1,104.50
03/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	997.50		997.50
03/2025	01-66-540195-01	Airdo Werwas, LLC,	Annual Survey	9,689.50		9,689.50
04/2025	01-66-540195-01	Airdo Werwas, LLC,	Annual Survey	348.00		348.00
04/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	315.00		315.00
06/2025	01-66-540195-01	Airdo Werwas, LLC,	General Counsel	3,036.00		3,036.00
06/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	168.00		168.00
06/2025	01-66-540195-01	Airdo Werwas, LLC,	General Counsel	631.20		631.20
07/2025	01-66-540195-01	Airdo Werwas, LLC,	General Counsel	1,009.20		1,009.20
08/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	231.00		231.00
09/2025	01-66-540195-01	Airdo Werwas, LLC,	Annual Survey	2,845.50		2,845.50
09/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	138.00		138.00
09/2025	01-66-540195-01	Schmiedeskamp, Robertson, Neu & Mitchell	General Counsel	111.00		111.00
09/2025	01-66-540195-01	Airdo Werwas, LLC,	Annual Survey	4,986.00		4,986.00
				32,488.90	-	32,488.90

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

13,358

13,358

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)

6,132

6,132

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

19,490

19,490

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$

106,775

Line

10

(6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$

538,345

This amount is to be recorded on line 42 of Schedule V.

(8)

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.

(9)

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

(10)

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.

(11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$

72,465

Has any meal income been offset against
related costs?

Yes

Indicate the amount.

\$

104,070

(12)

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?

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?

Yes

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such
transportation during this reporting period.

\$

N/A

No

(13)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Baker Tilly US, LLP

(14)

Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V?

Yes

(15)

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.