

		FOR BHF USE				

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0009175

Facility Name: Golden Good Shepherd Home

Address: 101 Prairie Mills Road Golden 62339
 Number City Zip Code

County: Adams

Telephone Number: 217-696-4421 **Fax #** 217-696-4393

HFS ID Number: 37-0843671001

Date of Initial License for Current Owners: 12/9/63

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 c 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: James G. Hull, C.P.A. **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/05 to 10/31/06 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) <u>James G. Hull</u> <u>Vice President</u>	
	(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u>	
	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	

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

Facility Name & ID Number Golden Good Shepherd Home

0009175 Report Period Beginning: 11/01/05 Ending: 10/31/06

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	42	Skilled (SNF)	42	15,330	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	42	TOTALS	42	15,330	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	701	1,095		1,796	8
9	SNF/PED					9
10	ICF	4,588	6,835		11,423	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,289	7,930		13,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.23%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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 12/09/63

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/06 Fiscal Year: 10/31/06

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/05 Ending: 10/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	109,172	4,422	4,730	118,324		118,324		118,324		1
2	Food Purchase		71,472		71,472		71,472	(1,637)	69,835		2
3	Housekeeping	67,479	6,078		73,557		73,557		73,557		3
4	Laundry		3,903	25,029	28,932		28,932		28,932		4
5	Heat and Other Utilities			29,580	29,580		29,580		29,580		5
6	Maintenance	23,319	5,718	10,946	39,983		39,983		39,983		6
7	Other (specify):*										7
8	TOTAL General Services	199,970	91,593	70,285	361,848		361,848	(1,637)	360,211		8
	B. Health Care and Programs										
9	Medical Director			1,500	1,500		1,500		1,500		9
10	Nursing and Medical Records	566,011	33,630	2,409	602,050		602,050		602,050		10
10a	Therapy	50,532	860	4,370	55,762		55,762		55,762		10a
11	Activities	39,595	2,342	621	42,558	15	42,573	(118)	42,455		11
12	Social Services	22,754	11	634	23,399		23,399		23,399		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	678,892	36,843	9,534	725,269	15	725,284	(118)	725,166		16
	C. General Administration										
17	Administrative	44,000			44,000		44,000		44,000		17
18	Directors Fees										18
19	Professional Services			15,217	15,217		15,217		15,217		19
20	Dues, Fees, Subscriptions & Promotions			10,267	10,267		10,267	(5,659)	4,608		20
21	Clerical & General Office Expenses	29,526	6,001	6,915	42,442		42,442	(408)	42,034		21
22	Employee Benefits & Payroll Taxes			110,510	110,510		110,510		110,510		22
23	Inservice Training & Education			492	492		492		492		23
24	Travel and Seminar			2,983	2,983	(660)	2,323		2,323		24
25	Other Admin. Staff Transportation		2,461		2,461	645	3,106		3,106		25
26	Insurance-Prop.Liab.Malpractice			49,213	49,213		49,213		49,213		26
27	Other (specify):* Rounding			(1)	(1)		(1)		(1)		27
28	TOTAL General Administration	73,526	8,462	195,596	277,584	(15)	277,569	(6,067)	271,502		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	952,388	136,898	275,415	1,364,701		1,364,701	(7,822)	1,356,879		29

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

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

Facility Name & ID Number Golden Good Shepherd Home

#0009175

Report Period Beginning:

11/01/05

Ending:

10/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,238	31,238	31,238	(3)	31,235				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						(1,069)	(1,069)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,464	2,464	2,464		2,464				35
36	Other (specify):*											36
37	TOTAL Ownership			33,702	33,702	33,702	(1,072)	32,630				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			8,816	8,816	8,816		8,816				40
41	Coffee and Gift Shops		1,109		1,109	1,109		1,109				41
42	Provider Participation Fee			22,995	22,995	22,995		22,995				42
43	Other (specify):*			1,668	1,668	1,668	(1,668)					43
44	TOTAL Special Cost Centers		1,109	33,479	34,588	34,588	(1,668)	32,920				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	952,388	138,007	342,596	1,432,991	1,432,991	(10,562)	1,422,429				45

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/05

Ending: 10/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,417)	2		4
5	Telephone, TV & Radio in Resident Rooms	(408)	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	(3)	30		9
10	Interest and Other Investment Income	(1,069)	32		10
11	Discounts, Allowances, Rebates & Refunds	(220)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,659)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,786)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,562)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (10,562)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Golden Good Shepherd Home

ID# 0009175

Report Period Beginning: 11/01/05

Ending: 10/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activities Program Income	\$ (118)	11	1
2	Misc. Exp	(1,668)	43	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,786)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05

Ending:

10/31/06

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	(1,637)	0	0	0	0	0	0	0	0	0	0	(1,637)	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	(1,637)	0	0	0	0	0	0	0	0	0	0	(1,637)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(118)	0	0	0	0	0	0	0	0	0	0	(118)	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	(118)	0	0	0	0	0	0	0	0	0	0	(118)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,659)	0	0	0	0	0	0	0	0	0	0	(5,659)	20
21	Clerical & General Office Expenses	(408)	0	0	0	0	0	0	0	0	0	0	(408)	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	(6,067)	0	0	0	0	0	0	0	0	0	0	(6,067)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,822)	0	0	0	0	0	0	0	0	0	0	(7,822)	29

STATE OF ILLINOIS

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05 Ending:

Summary B

10/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3)	0	0	0	0	0	0	0	0	0	0	(3)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,069)	0	0	0	0	0	0	0	0	0	0	(1,069)	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	(1,072)	0	(1,072)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,668)	0	0	0	0	0	0	0	0	0	0	(1,668)	43
44	TOTAL Special Cost Centers	(1,668)	0	(1,668)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,562)	0	(10,562)	45									

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05

Ending:

10/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/05 Ending: 10/31/06

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05

Ending: 10/31/06

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

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

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

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

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	n/a									1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	n/a									6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	n/a									10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	15										

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golden Good Shepherd Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009175

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 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Golden Good Shepherd Home

0009175 Report Period Beginning:

11/01/05 Ending:

10/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,748 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>475,705</u>		<u>\$ 37,727</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	475,705		\$ 37,727	3

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05

Ending:

10/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	42		1963	1963	\$ 163,629	\$ 3,273	50	\$ 3,273	\$ 0	\$ 140,721	4
5			1988	1988	208,384	5,210	40	5,210	0	94,641	5
6			1989	1989	84,694	2,117	40	2,117		37,230	6
7											7
8											8
		Improvement Type**									
9		Building Addidtion		1967	5,285		20			5,285	9
10		Building Addidtion		1973	25,841		20			25,841	10
11		Sprinkler System		1975	30,963		20			30,963	11
12		Building Addidtion		1975	18,103		20			18,103	12
13		Building Addidtion		1975	1,313		20			1,313	13
14		Building Addidtion		1976	15,380		20			15,380	14
15		Building Addidtion		1977	3,981		15			3,981	15
16		Doors		1978	900		20			900	16
17		Building Addidtion		180	3,165		15			3,165	17
18		Parking Lot		185	7,475		15			7,475	18
19		Building Addidtion		1983	4,174		15			4,174	19
20		Garage		1986	6,473		15			6,473	20
21		Landscaping		1988	620		10			620	21
22		Asphalt		1989	950		15			950	22
23		Building Addidtion		1990	655	33	20	33		527	23
24		Sprinkler System		1992	43,248	1,730	25	1,730		24,940	24
25		Floor & Foundation Improvements		1997	9,800	251	39	251		2,491	25
26		Parking Lot Expansion		1997	16,320	418	39	418		3,905	26
27		Owygen Room Venting		1998	2,880	72	40	72		624	27
28		Backflow Valve		1998	959	39	25	38	(1)	311	28
29		Laundry Door		1998	3,555	237	15	237		1,896	29
30		Backflow Preventor		1999	3,128	157	20	156	(1)	1,187	30
31		Ceiling		1999	4,657	233	20	233		1,649	31
32		Kitchen Floor		2000	1,167	117	10	117		788	32
33		New Roof Nursing Home		2001	38,956	999	39	999		5,161	33
34		Concrete Activity Room Entrance		2003	4,975	332	15	332		1,161	34
35		Remodel Kitchen		2004	5,085	341	15	339	(2)	906	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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05

Ending:

10/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								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								69
70	TOTAL (lines 4 thru 69)	\$ 716,715	\$ 15,558		\$ 15,555	\$ (3)	\$ 442,761	70

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/05 Ending: 10/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 218,349	\$ 15,207	\$ 15,207	\$	7-15	\$ 120,249	71
72	Current Year Purchases	10,760	473	473		7-15	473	72
73	Fully Depreciated Assets	240,859				7-15	240,859	73
74								74
75	TOTALS	\$ 469,968	\$ 15,680	\$ 15,680	\$		\$ 361,581	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,224,410	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,238	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,235	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 804,342	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 & Medical Clinic	\$ 464,470	\$ 12,266	\$ 241,306	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 464,470	\$ 12,266	\$ 241,306	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/05

Ending: 10/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 2,464 Description: Copier Rent (994), Oxygen (1200), Trimmer (270)

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Golden Good Shepherd Home# 0009175Report Period Beginning: 11/01/05

Ending:

10/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 10/31/06

(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	\$ 62,889	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	97,795		3
4	Supply Inventory (priced at <u>FIFO</u>)	4,000		4
5	Short-Term Investments	26,623		5
6	Prepaid Insurance	14,840		6
7	Other Prepaid Expenses	356		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 206,503	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	205,223		12
13	Land	40,555		13
14	Buildings, at Historical Cost	1,165,153		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	486,000		16
17	Accumulated Depreciation (book methods)	(1,045,648)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 851,283	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,057,786	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,812	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,836		30
31	Accrued Taxes Payable (excluding real estate taxes)	327		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,963		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Ins. Withholding</u>	1,774		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 74,712	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 74,712	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 983,074	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,057,786	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,056,200	1
2	Restatements (describe):		2
3	Prior Year Adjustments	(101,978)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 954,222	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	22,770	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) Duplex Profit/(Loss)	6,082	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 28,852	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)	\$ 983,074	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Golden Good Shepherd Home# 0009175Report Period Beginning: 11/01/05Ending: 10/31/06**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,398,175	1
2	Discounts and Allowances for all Levels	(234)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,397,941	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	40	6
7	Oxygen	1,173	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,213	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	641	12
13	Barber and Beauty Care	7,266	13
14	Non-Patient Meals	1,848	14
15	Telephone, Television and Radio	408	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	563	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,891	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,617	23
D. Non-Operating Revenue			
24	Contributions	8,678	24
25	Interest and Other Investment Income***	1,069	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,747	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	495	28
28a	See Attached	31,748	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,243	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,455,761	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	361,848	31
32	Health Care	725,269	32
33	General Administration	277,584	33
B. Capital Expense			
34	Ownership	33,702	34
C. Ancillary Expense			
35	Special Cost Centers	11,593	35
36	Provider Participation Fee	22,995	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,432,991	40
41	Income before Income Taxes (line 30 minus line 40)**	22,770	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 22,770	43

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/05

Ending:

10/31/06

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	1,821	1,920	\$ 42,194	\$ 21.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	11,631	12,481	186,629	14.95	4
5	CNAs & Orderlies	28,162	29,804	309,313	10.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,678	3,917	50,532	12.90	8
9	Activity Director	2,080	2,080	21,595	10.38	9
10	Activity Assistants	2,276	2,383	18,000	7.55	10
11	Social Service Workers	2,545	2,688	22,754	8.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,004	2,130	21,946	10.30	14
15	Cook Helpers/Assistants	7,863	8,438	65,285	7.74	15
16	Dishwashers	3,016	3,111	21,941	7.05	16
17	Maintenance Workers	2,069	2,185	23,319	10.67	17
18	Housekeepers	8,337	8,753	67,479	7.71	18
19	Laundry					19
20	Administrator	1,968	2,080	44,000	21.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,868	2,029	29,526	14.55	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 Care Plan Coord	1,555	1,709	27,875	16.31	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	80,873	85,708	\$ 952,388 *	\$ 11.11	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	118	\$ 4,730	1-3	35
36	Medical Director	Contract	1,500	9-3	36
37	Medical Records Consultant	16	1,530	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	879	10-3	39
40	Physical Therapy Consultant	72	4,320	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	50	10a-3	43
44	Activity Consultant	9	621	11-3	44
45	Social Service Consultant	9	634	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	225	\$ 14,264		49

C. CONTRACT NURSES

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/05

Ending: 10/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sandra Fenn	Administrator	0	\$ 44,000	Workers' Compensation Insurance	\$ 22,500	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	11,487	Advertising: Employee Recruitment	276	
				FICA Taxes	72,308	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed <u>12</u>)	144	
				Employee Meals	2,500	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations/Adv.	5,659	
				Employee Fringe Benefits		Annual Report Filing Fee	5	
				Small W/C Claims	1,715	LSD Dues	1,780	
						Misc Dues & Subscriptions	413	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 44,000			Less: Public Relations Expense	(2,605)	
(List each licensed administrator separately.)						Non-allowable advertising	(3,054)	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
N/A			\$ 0	\$ 110,510			\$ 4,608	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description			Description	
				Line #			Amount	
C. Professional Services				Amount			Amount	
Vendor/Payee	Type	Amount		N/A			\$ 0	
Chad Passley	Accounting	\$ 2,385					Out-of-State Travel	
Accumed	Software Support	3,160						
WDM Computer Services	Data Processing	9,672					In-State Travel	
							Seminar Expense	
							See Schedule Attached	
							2,323	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 15,217	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							\$ 2,323	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Netwok, 1780.20
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,610 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 22,995
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,500 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,417
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/a
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: No The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Golden Good Shepherd
#0009175
11/01/05 to 10/31/06

Board Members

David Stephens
2876 East 2400th
Bowen, IL 62316

Virgil Flesner
407 Albers
Golden, IL 62339

Marilyn Aden
113 Congress, PO Box 85
Golden, IL 62339

Kenneth Miller
Box 218
Golden, IL 62339

Cindy Keyes
2941 East 2600th
LaPrairie, IL 62346

Jim Taylor
511 West 4th
Golden, IL 62339-1005

Eric Cassens
2071 East 2200th
Camp Point, IL 62320

Sherri Young
2498 East 2700th
Golden, IL 62339

Golden Good Shepherd
#0009175
11/01/05 to 10/31/06

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$702.31
REPAIRS & MAINT BUILDING	\$621.58
REPAIRS & MAINT EQUIP	\$1,282.00
REPAIRS & MAINT GROUNDS	\$417.00
REPAIRS & MAINT LAUNDRY	\$44.44
REPAIRS & MAINT HSK	\$0.00
REPAIRS & MAINT GEN/ADM	\$249.96
OUTSIDE SERVICES	\$2,748.48
Alarm	\$1,170.60
REFUSE	\$2,780.00
EXTERMITATOR	\$930.00
TOTAL	<u>\$10,946.37</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$6,914.72
TOTAL	<u>\$6,914.72</u>

Schedule V. Line 25, Column 2

Auto Exp. & Service	\$327.70
Auto Gas & Oil	\$43.00
Business Mileage Expense	<u>\$1,952.93</u>
	\$2,323.63

Schedule V. Line 43, Column3

Misc. Exp.	\$1,668.25
Rounding	\$0.00
Charitable Contributions	<u>\$0.00</u>
	\$1,668.25

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Management Fee	\$18,000.00
Admissions	\$40.00
Dietary Suppliments	\$6,356.60
Activities Income	\$117.86
Personal Purchases	\$94.50
Rebates	\$89.98
Gain on Sale of Assets	\$5,591.48
Discounts	\$130.00
Misc	\$1,326.95
Rounding	\$1.00
	<u>\$31,748.37</u>

Golden Good Shepherd
#0009175
11/01/05 to 10/31/06

Reclassifications

1 Reclassify \$644.75 out of seminar expense and into business mileage. Meeting r

2 Reclassify \$15.00 out of seminar expense and into activity supplies. Supplies

3

4

5

Golden Good Shepherd

#0009175

11/01/05 to 10/31/06

	<u>Pvt Skilled</u>	<u>Pvt Int.</u>	<u>PA Skilled</u>	<u>PA Int.</u>	<u>Total</u>
Nov	90	498	88	385	1061
Dec	93	517	62	401	1073
Jan	93	578	62	427	1160
Feb	84	504	56	392	1036
Mar	93	555	87	433	1168
Apr	90	523	66	396	1075
May	93	566	62	398	1119
Jun	90	566	60	360	1076
Jul	93	596	42	372	1103
Aug	93	620	31	387	1131
Sep	90	633	30	347	1100
Oct	93	679	55	290	1117
	<u>1095</u>	<u>6835</u>	<u>701</u>	<u>4588</u>	

Golden Good Shepherd
 #0009175
 11/01/05 to 10/31/06

Schedule V, Line 24 Column 3

Date	Seminar	Location	Who Attended	Mileage/			Hotel	Total
				Regist.	Auto Exp.	Meals		
12/15/2005	Powerful Team Building	Springfield, IL	S. Fenn	\$179.00	\$92.15	\$7.89		\$279.04
	5-Dec Essentials of the MDS	Springfield, IL	D. HILAND W. Keller	\$190.00				\$190.00
	6-Mar Brag Seminar	Quincy, IL	M. Bruns	\$45.00				\$45.00
3/6/2006	Learn for Wound Care	Quincy, IL	C. Palmer W. Keller	\$50.00				\$50.00
3/8/2006	Springfield Seminar	Springfield, IL	S. Fenn		\$92.00	\$17.00	\$93.49	\$202.49
4/17/2006	John Wood Training Sem.	Quincy, IL		\$10.00				\$10.00
6/19/2006	SSD Basic Training	Quincy, IL	H. Whitaker	\$76.50				\$76.50
7/13/2006	Just Add One-Restorative	Springfield, IL	S. Fenn	\$99.00			\$77.75	\$176.75
8/31/2006	Deminsions of Demintia	Quincy, IL	S. Fenn C. Palmer M. Bruns H. Whitaker	\$140.00				\$140.00
8/10/2006		Springfield, IL	S. Fenn		\$267.00		\$152.90	\$419.90
10/11/2006	Impact Activities	Quincy, IL	S. Fenn J. Roosa T. Henniger	\$20.00				\$20.00
10/13/2006	Celebrate Aging	Quincy, IL	M. Bruns C. Palmer H. Whitaker	\$150.00				\$150.00
*	5/5/2006 SIU		S. Fenn	\$50.00	\$87.30			\$137.30
	9/25/2006 JWCC Training	Quincy, IL	S. Fenn	\$25.00	\$26.85			\$51.85
*	9/1/2006		S. Fenn	\$195.00	\$179.00			\$374.00
Totals							<u>\$2,322.83</u>	

* Some specific details are not available as S. Fenn has left employment and not available for details