

Facility Name & ID Number Golden Good Shepherd Home# 0009175 Report Period Beginning: 11/01/07 Ending: 10/31/08

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	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,372</u>	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	<u>42</u>	TOTALS	<u>42</u>	<u>15,372</u>	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	<u>2,101</u>	<u>2,675</u>	<u>1,131</u>	<u>5,907</u>	8
9	SNF/PED					9
10	ICF	<u>3,560</u>	<u>4,765</u>		<u>8,325</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,661</u>	<u>7,440</u>	<u>1,131</u>	<u>14,232</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.58%

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)

NoneF. 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 42 and days of care provided 1,131Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/31/07 Fiscal Year: 10/31/07

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/07 Ending: 10/31/08

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	125,732	7,948	6,853	140,533		140,533		140,533		1
2	Food Purchase		87,918		87,918		87,918	(1,702)	86,216		2
3	Housekeeping	55,292	6,804		62,096		62,096		62,096		3
4	Laundry	15,212	1,799	28,630	45,641		45,641		45,641		4
5	Heat and Other Utilities			35,259	35,259		35,259		35,259		5
6	Maintenance	26,300	7,823	27,962	62,085		62,085		62,085		6
7	Other (specify):*										7
8	TOTAL General Services	222,536	112,292	98,704	433,532		433,532	(1,702)	431,830		8
	B. Health Care and Programs										
9	Medical Director			1,500	1,500		1,500		1,500		9
10	Nursing and Medical Records	649,060	72,837	3,065	724,962		724,962	(456)	724,506		10
10a	Therapy	45,227	3,019	109,212	157,458		157,458		157,458		10a
11	Activities	65,298	4,351	627	70,276		70,276	(885)	69,391		11
12	Social Services	31,067		627	31,694		31,694		31,694		12
13	CNA Training										13
14	Program Transportation	36			36		36		36		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	790,688	80,207	115,031	985,926		985,926	(1,341)	984,585		16
	C. General Administration										
17	Administrative	48,321			48,321		48,321		48,321		17
18	Directors Fees										18
19	Professional Services			17,322	17,322		17,322		17,322		19
20	Dues, Fees, Subscriptions & Promotions			12,769	12,769	(1)	12,768	(5,520)	7,248		20
21	Clerical & General Office Expenses	33,705	9,044	8,302	51,051		51,051	(1,165)	49,886		21
22	Employee Benefits & Payroll Taxes			124,639	124,639	25	124,664		124,664		22
23	Inservice Training & Education			1,809	1,809	(15)	1,794		1,794		23
24	Travel and Seminar			2,365	2,365	1,204	3,569		3,569		24
25	Other Admin. Staff Transportation		5,394		5,394	(1,204)	4,190		4,190		25
26	Insurance-Prop.Liab.Malpractice			49,960	49,960	30	49,990		49,990		26
27	Other (specify):*										27
28	TOTAL General Administration	82,026	14,438	217,166	313,630	39	313,669	(6,685)	306,984		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,095,250	206,937	430,901	1,733,088	39	1,733,127	(9,728)	1,723,399		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: 11/01/07 Ending: 10/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			34,183	34,183	34,183	(3)	34,180			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						(1,369)	(1,369)			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			9,191	9,191	9,191		9,191			35
36	Other (specify):*										36
37	TOTAL Ownership			43,374	43,374	43,374	(1,372)	42,002			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops			9,573	9,573	9,573		9,573			40
41	Coffee and Gift Shops		1,544		1,544	1,544		1,544			41
42	Provider Participation Fee			23,058	23,058	23,058		23,058			42
43	Other (specify):*			3,127	3,127	3,088	(2,953)	135			43
44	TOTAL Special Cost Centers		1,544	35,758	37,302	37,263	(2,953)	34,310			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,095,250	208,481	510,033	1,813,764	1,813,764	(14,053)	1,799,711			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: 11/01/07

Ending: 10/31/08

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,491)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,165)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(456)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3)	30		9
10	Interest and Other Investment Income	(1,369)	32		10
11	Discounts, Allowances, Rebates & Refunds	(211)	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	(2,795)	43		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	(5,520)	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	(1,043)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,053)		\$	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))	\$ (14,053)		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.

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

BHF USE ONLY						
48		49		50		51
						52

Golden Good Shepherd Home

ID# 0009175

Report Period Beginning: 11/01/07

Ending: 10/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Activities Income	\$ (885)	11
2	Bank Fees	(158)	43
3			
4			
5			
6			
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10			
11			
12			
13			
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15			
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46			
47			
48	Total	(1,043)	
49			

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/07

Ending:

10/31/08

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	(1,702)	0	0	0	0	0	0	0	0	0	0	(1,702)	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	(1,702)	0	0	0	0	0	0	0	0	0	0	(1,702)	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	(456)	0	0	0	0	0	0	0	0	0	0	(456)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(885)	0	0	0	0	0	0	0	0	0	0	(885)	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	(1,341)	0	0	0	0	0	0	0	0	0	0	(1,341)	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	(5,520)	0	0	0	0	0	0	0	0	0	0	(5,520)	20
21	Clerical & General Office Expenses	(1,165)	0	0	0	0	0	0	0	0	0	0	(1,165)	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	(6,685)	0	0	0	0	0	0	0	0	0	0	(6,685)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,728)	0	0	0	0	0	0	0	0	0	0	(9,728)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/07 Ending:

10/31/08

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	(1,369)	0	0	0	0	0	0	0	0	0	0	(1,369)	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	(1,372)	0	(1,372)	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):*	(2,953)	0	0	0	0	0	0	0	0	0	0	(2,953)	43
44	TOTAL Special Cost Centers	(2,953)	0	(2,953)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,053)	0	(14,053)	45									

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/07

Ending:

10/31/08

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

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: 11/01/07 Ending: 10/31/08

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.

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/07

Ending: 10/31/08

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										6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10										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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

11/01/07 Ending:

10/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,748 B. General Construction Type: Exterior Brcik 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</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:

11/01/07

Ending:

10/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	42		1963	1963	\$ 163,629	\$ 3,273	50	\$ 3,273		\$ 147,266	4
5			1988	1988	208,384	5,210	40	5,210		105,060	5
6			1989	1989	84,694	2,117	40	2,117		41,465	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		592	23
24	Sprinkler System		1992		43,248	1,730	25	1,730		28,400	24
25	Floor & Foundation Improvements		1997		9,800	251	39	251		2,994	25
26	Parking Lot Expansion		1997		16,320	418	39	418		4,742	26
27	Owygen Room Venting		1998		2,880	72	40	72		769	27
28	Backflow Valve		1998		959	39	25	38	(1)	388	28
29	Laundry Door		1998		3,555	237	15	237		2,370	29
30	Backflow Preventor		1999		3,128	157	20	156	(1)	1,502	30
31	Ceiling		1999		4,657	233	20	233		2,114	31
32	Kitchen Floor		2000		1,167	117	10	117		1,021	32
33	New Roof Nursing Home		2001		38,956	999	39	999		7,159	33
34	Concrete Activity Room Entrance		2003		4,975	332	15	332		1,824	34
35	Remodel Kitchen		2004		5,085	341	15	339	(2)	1,588	35
36	Concrete Correction		2007		6,500	432	15	433	1	816	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:

11/01/07

Ending:

10/31/08

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 Fire suppression System	2007	\$ 2,369	\$ 237	10	\$ 237	\$	\$ 415	37
38 New Doors	2007	1,584	106	15	106		167	38
39 Parking lot Improvements	2007	6,868	458	15	458		496	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)		\$ 734,036	\$ 16,792		\$ 16,789	\$ (3)	\$ 475,771	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: 11/01/07 Ending: 10/31/08

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	\$ 202,545	\$ 15,479	\$ 15,479	\$	9	\$ 106,594	71
72	Current Year Purchases	19,869	912	912		9	912	72
73	Fully Depreciated Assets	285,628					285,436	73
74								74
75	TOTALS	\$ 508,042	\$ 16,391	\$ 16,391	\$		\$ 392,942	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	Resident Transportation	95 Ford Bus	2006	\$ 5,000	\$ 1,000	\$ 1,000	\$	5	\$ 2,083	76
77										77
78										78
79										79
80	TOTALS			\$ 5,000	\$ 1,000	\$ 1,000	\$		\$ 2,083	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)	\$ 1,284,805	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,183	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,180	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)	\$ 870,796	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	\$ 465,949	\$ 12,239	\$ 265,745	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 465,949	\$ 12,239	\$ 265,745	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: 11/01/07

Ending: 10/31/08

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.

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 9,191 Description: Oxygen Lease \$6,681.01. Copier Rental \$2,510.08

(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? <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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			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	10-3	# of prescripts	470	1,410				470	1,410	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify):										12	
13	Other (specify):										13	
14	TOTAL			\$	1,410	\$	\$		470	\$	1,410	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: 11/01/07

Ending:

10/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 10/31/08

(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	\$ 6,402	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	303,926		3
4	Supply Inventory (priced at <u>FIFO</u>)	4,000		4
5	Short-Term Investments	37,580		5
6	Prepaid Insurance	13,562		6
7	Other Prepaid Expenses	395		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 365,865	\$	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	1,191,384		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	521,643		16
17	Accumulated Depreciation (book methods)	(1,136,541)		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)	\$ 822,264	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,188,129	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,997	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,688		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,282		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,433		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Uniforms Withheld</u>	8		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 73,408	\$	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	<u>Roudnding</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 73,408	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,114,721	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,188,129	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,011,865	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,011,865	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	95,330	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Income from Duplexes	7,526	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 102,856	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)	\$ 1,114,721	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Golden Good Shepherd Home# 0009175Report Period Beginning: 11/01/07Ending: 10/31/08**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	\$ 1,817,621	1
2	Discounts and Allowances for all Levels	(5,989)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,811,632	3
B. Ancillary Revenue			
4	Day Care	1,914	4
5	Other Care for Outpatients		5
6	Therapy	8,208	6
7	Oxygen	1,197	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 11,319	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	2,741	12
13	Barber and Beauty Care	9,257	13
14	Non-Patient Meals	1,491	14
15	Telephone, Television and Radio	1,165	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	456	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,760	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,870	23
D. Non-Operating Revenue			
24	Contributions	14,947	24
25	Interest and Other Investment Income***	1,369	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,316	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	1,050	28
28a	See Attached	49,907	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 50,957	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,909,094	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	433,532	31
32	Health Care	985,926	32
33	General Administration	313,630	33
B. Capital Expense			
34	Ownership	43,374	34
C. Ancillary Expense			
35	Special Cost Centers	14,244	35
36	Provider Participation Fee	23,058	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,813,764	40
41	Income before Income Taxes (line 30 minus line 40)**	95,330	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 95,330	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:

11/01/07

Ending:

10/31/08

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	1,729	1,866	\$ 42,713	\$ 22.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	332	332	6,889	20.75	3
4	Licensed Practical Nurses	11,693	12,510	200,384	16.02	4
5	CNAs & Orderlies	29,824	32,009	347,161	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,980	3,175	45,227	14.24	8
9	Activity Director	1,581	1,795	23,183	12.92	9
10	Activity Assistants	4,982	5,221	42,115	8.07	10
11	Social Service Workers	3,077	3,261	31,066	9.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,997	2,186	24,012	10.98	14
15	Cook Helpers/Assistants	8,622	9,198	79,350	8.63	15
16	Dishwashers	2,698	2,781	22,370	8.04	16
17	Maintenance Workers	2,140	2,250	26,300	11.69	17
18	Housekeepers	6,345	6,632	55,292	8.34	18
19	Laundry	1,932	1,977	15,212	7.69	19
20	Administrator	1,988	2,120	48,322	22.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,987	2,191	33,705	15.38	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	1,575	1,676	15,094	9.01	31
32	Other Health Care Care Plan	1,946	2,129	36,819	17.29	32
33	Other(specify) Transportation	4	4	36	9.00	33
34	TOTAL (lines 1 - 33)	87,432	93,313	\$ 1,095,250 *	\$ 11.74	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	151	\$ 6,853	1-3	35
36	Medical Director	Contract	1,500	9-3	36
37	Medical Records Consultant	16	1,655	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	74	4,826	10a-1	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	627	11-3	44
45	Social Service Consultant	8	627	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	257	\$ 16,088		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: 11/01/07

Ending: 10/31/08

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			
Amanda Marlow	Administrator	0	\$ 48,321	Workers' Compensation Insurance	\$ 23,814	IDPH License Fee	\$			
				Unemployment Compensation Insurance	7,593	Advertising: Employee Recruitment	1,677			
				FICA Taxes	84,900	Health Care Worker Background Check	2,368			
				Employee Health Insurance		(Indicate # of checks performed <u>128</u>)				
				Employee Meals		Patient Background Checks	20			
				Illinois Municipal Retirement Fund (IMRF)*		Promotion/Public Relations	5,520			
				Employee Relations	1,163	Drug Tests	99			
				Employee Gifts	7,169	See List Attached	3,104			
				Employee Physicals	25					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 48,321	TOTAL (agree to Schedule V, line 22, col.8)			\$ 124,664	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,248
(List each licensed administrator separately.)								Less: Public Relations Expense		(3,297)
								Non-allowable advertising		(2,223)
								Yellow page advertising		()
B. Administrative - Other										
Description			Amount							
N/A			\$ 0							
TOTAL (agree to Schedule V, line 17, col. 3)			\$							
(Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
Accumed Services	Software Support		\$ 3,400	N/A		\$ 0	Out-of-State Travel	\$		
Ivans	Medicare Data Support		748							
WDM Computer Services, Inc.	Data Processing		13,174				In-State Travel			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 17,322	TOTAL			\$	Seminar Expense		
(If total legal fees exceed \$5,000, attach copy of invoices.)								See List Attached		3,569
								Entertainment Expense		()
								(agree to Sch. V, line 24, col. 8)		
								TOTAL		\$ 3,569

* 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 Network \$2,297.08
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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? 9 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,870 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 No 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. \$ 23,058
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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,491
- (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? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ 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 \$5,000, 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
11/01/07 to 10/31/08

Board Members

Kenneth Miller
308 Prairie Mills Road
Golden, IL 62339

Virgil Flesner
407 Albers
Golden, IL 62339

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

Brad Flesner
2074 East 2600th Street
Clayton, IL 62324

Cindy Keyes
2941 East 2600th
LaPrairie, IL 62346

Jim Taylor
411 West 3rd Street
Golden, IL 62339-1005

Gerald Buss
507 Main Street
Golden, IL 62339

Sherri Young
2498 East 2700th
Golden, IL 62339

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Reclassifications

1 Reclassify \$10.00 from License fees and into Inservice Training and Education. Education cost miscoded.

2 Reclassify \$30.00 from License fees and into Insurance expense. Bond cost miscoded.

3 Reclassify \$(39.00) from License fees and into Misc expense. Late fee credit miscoded.

4 Reclassify \$1204.31 from business mileage to seminar exp. Seminar mileage miscoded.

5 Reclassify \$25.00 from I-service training to Employee Benefits.

6 Reclassify \$

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Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$1,847.53
REPAIRS & MAINT BUILDING	\$7,901.70
REPAIRS & MAINT EQUIP	\$5,873.56
REPAIRS & MAINT GROUNDS	\$243.51
REPAIRS & MAINT LAUNDRY	\$138.01
REPAIRS & MAINT HSK	\$0.00
REPAIRS & MAINT GEN/ADM	\$279.70
OUTSIDE SERVICES	\$2,191.46
MOWING	\$3,000.00
SNOW REMOVAL	\$1,177.94
RENT	\$0.00
CABLE TV	\$217.06
Alarm	\$1,093.88
REPUSE	\$3,349.14
EXTERMITATOR	\$649.00
TOTAL	<u>\$27,962.49</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	<u>\$8,301.87</u>
TOTAL	<u>\$8,301.87</u>

Schedule V. Line 25, Column 2

Auto Exp. & Service	\$460.99
Auto Gas & Oil	\$2,421.93
Business Mileage Expense	<u>\$1,307.04</u>
	\$4,189.96

Schedule V. Line 43, Column 3

Misc. Exp.	\$3,126.34
Rounding	\$1.00
Charitable Contributions	<u>\$0.00</u>
	\$3,127.34

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	\$42,000.00
Admissions	\$0.00
Dietary Supplements	\$4,307.30
Activities Income	\$884.87
Personal Purchases	\$791.37
Rebates	\$211.00
Gain on Sale of Assets	\$0.00
Discounts	\$0.00
Doors Program	\$727.23
Misc	\$985.15
Rounding	<u>\$0.00</u>
	<u>\$49,906.92</u>

The following is a breakdown of Schedule XIX, Section F

Sam's Club Membership	\$35.00
INHA	\$100.00
Notary Fee	\$32.00
Administrator's License Fee	\$100.00
CMS User Fee	\$168.00
Annual Report Filing fee	\$5.00
ESN Dues	\$2,297.08
Subscriptions	\$366.13
Rounding	\$1.00
	<u>\$3,104.21</u>

	Pvt Skilled	Pvt Int.	PA Skilled	PA Int.	Medicare	Total
Nov	276	419	120	339	44	1198
Dec	234	400	151	399	35	1219
Jan	245	369	155	380	74	1223
Feb	169	358	145	305	127	1104
Mar	233	367	161	309	144	1214
Apr	240	360	159	287	91	1137
May	214	403	194	242	132	1185
Jun	225	384	210	267	74	1160
Jul	273	372	236	248	103	1232
Aug	255	380	217	260	105	1217
Sep	171	450	180	270	89	1160
Oct	140	503	173	254	113	1183
	<u>2675</u>	<u>4765</u>	<u>2101</u>	<u>3560</u>	<u>1131</u>	<u>14232</u>

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Schedule V, Line 24 Column 3

Date	Seminar	Location	Who Attended	Mileage/		Meals	Hotel	Total
				Regist.	Auto Exp.			
11/6/2008	Act. Workshop	Breese, IL	L. Beebe		\$186.24	\$24.24	\$86.40	\$296.88
2/15/2008	Medicare Part A & B Reimbursement for SNF's	St. Louis, MO	H. Whitaker A. Cobern	\$358.00	\$142.40		\$172.28	\$672.68
3/19/2008	Road to Excellence-Customer Sat.	Springfield, IL	A. Marlow	\$95.00	\$85.85			\$180.85
2/20/2008	BRAG'S	Quincy, IL	M. Bruns	\$16.00				\$16.00
4/9/2008	Dimensions of Dementia	Quincy, IL	M. Bruns	\$35.00	\$30.30			\$65.30
4/3/2008	INHAA Conference	Peoria, IL	A. Marlow	\$95.00	\$106.05		\$103.23	\$304.28
4/11/2008	Spoon River Acty Assn Workshop	Macomb, IL	M. Bruns	\$25.00	\$35.35			\$60.35
4/16/2008	Brag's Acty Director Mtg	Quincy, IL	M. Bruns	\$10.00	\$30.30			\$40.30
8/12/2008	IHCA'S MDS 101	Springfield, IL	K. Bowen	\$200.00	\$90.90			\$290.90
8/14/2008	INHAA	Springfield, IL	A. Marlow	\$95.00	\$90.90		\$99.68	\$285.58
8/26/2008	LSN's New OBRA Regs	Springfield, IL	A. Marlow K. Wilson	\$170.00	\$90.90			\$260.90
9/10/2008	Certificate Program in Geriatrics	Macomb, IL	A. Marlow	\$450.00	\$67.67			\$517.67
9/12/2008	Activity Dir. Workshop	Macomb, IL	M. Bruns	\$15.00	\$35.35			\$50.35
Oct-08	Blessings Fall Conference	Quincy, IL	K. Bowen	\$40.00	\$30.30			\$70.30
10/15/2008	IL Pioneer Conference	Springfield, IL	H. Whitaker A. Cobern K. Bowen	\$275.00	\$181.80			\$456.80
Totals								<u><u>\$3,569.14</u></u>

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The following is a breakdown of Schedule V Line 23 Column 3

Vendor	Purpose	Expense
Alz Association	Alz. Training	\$224.00
American Red Cross	CPR Training	\$56.00
Mike Miller	Driver's Ed Training	\$500.00
American Red Cross	CPR Training	\$298.90
American Red Cross	CPR Training	\$135.00
Briggs	MDS User Manual	\$83.21
Chase Credit Charge	Medicare Ref. Guide	\$109.00
Chase Credit Charge	MDS Manual	\$105.30
Chase Credit Charge	State Operations Manual	\$62.69
Chase Credit Charge	Mds code/Nursing Drug Boc	\$175.15
Chase Credit Charge	Geriatrics Reference Manua	\$35.00
John Wood Community College	Ceu's	\$10.00
		<u>\$1,794.25</u>