

Facility Name & ID Number Golden Good Shepherd Home

0009175 Report Period Beginning: 11/01/13 Ending: 10/31/14

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	883	921	1,363	3,167	8
9	SNF/PED					9
10	ICF	4,489	7,105		11,594	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,372	8,026	1,363	14,761	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.29%

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 42 and days of care provided 1,363

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/14 Fiscal Year: 10/31/14

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

Facility Name & ID Number

Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/13

Ending:

10/31/14

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	141,324	9,429	5,004	155,757		155,757	155,757			1
2	Food Purchase		146,828		146,828		146,828	(7,708)	139,120		2
3	Housekeeping	65,141	15,493	432	81,066		81,066		81,066		3
4	Laundry	19,407	3,094	50,635	73,136		73,136		73,136		4
5	Heat and Other Utilities			37,946	37,946		37,946		37,946		5
6	Maintenance	35,521	12,883	44,275	92,679		92,679		92,679		6
7	Other (specify):*										7
8	TOTAL General Services	261,393	187,727	138,292	587,412		587,412	(7,708)	579,704		8
	B. Health Care and Programs										
9	Medical Director			1,950	1,950		1,950		1,950		9
10	Nursing and Medical Records	899,485	99,458	4,654	1,003,597	(586)	1,003,011		1,003,011		10
10a	Therapy	59,579	141	185,704	245,424	586	246,010		246,010		10a
11	Activities	87,646	3,347	2,874	93,867		93,867	(23)	93,844		11
12	Social Services	26,551		600	27,151		27,151		27,151		12
13	CNA Training										13
14	Program Transportation		3,641		3,641		3,641		3,641		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,073,261	106,587	195,782	1,375,630		1,375,630	(23)	1,375,607		16
	C. General Administration										
17	Administrative	59,952			59,952		59,952		59,952		17
18	Directors Fees										18
19	Professional Services			36,143	36,143		36,143		36,143		19
20	Dues, Fees, Subscriptions & Promotions			21,258	21,258		21,258	(6,603)	14,655		20
21	Clerical & General Office Expenses	25,246	7,681	8,340	41,267		41,267		41,267		21
22	Employee Benefits & Payroll Taxes			152,711	152,711		152,711		152,711		22
23	Inservice Training & Education			483	483		483		483		23
24	Travel and Seminar			4,064	4,064	595	4,659	(290)	4,369		24
25	Other Admin. Staff Transportation		1,954		1,954	(674)	1,280		1,280		25
26	Insurance-Prop.Liab.Malpractice			43,302	43,302		43,302		43,302		26
27	Other (specify):*			2,979	2,979	79	3,058		3,058		27
28	TOTAL General Administration	85,198	9,635	269,280	364,113		364,113	(6,893)	357,220		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,419,852	303,949	603,354	2,327,155		2,327,155	(14,624)	2,312,531		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.

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#0009175

Report Period Beginning:

11/01/13

Ending:

10/31/14

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			50,669	50,669		50,669	(21)	50,648			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,410	5,410		5,410	(4,490)	920			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,799	5,799		5,799		5,799			35
36	Other (specify):*											36
37	TOTAL Ownership			61,878	61,878		61,878	(4,511)	57,367			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,438		39,438		39,438		39,438			39
40	Barber and Beauty Shops		42	10,266	10,308		10,308		10,308			40
41	Coffee and Gift Shops		3,398		3,398		3,398		3,398			41
42	Provider Participation Fee			104,322	104,322		104,322		104,322			42
43	Other (specify):*			12,312	12,312		12,312	(12,312)				43
44	TOTAL Special Cost Centers		42,878	126,900	169,778		169,778	(12,312)	157,466			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,419,852	346,827	792,132	2,558,811		2,558,811	(31,447)	2,527,364			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: 11/01/13

Ending: 10/31/14

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	(6,644)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21)	30		9
10	Interest and Other Investment Income	(4,490)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,064)	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	(12,312)	43		24
25	Fund Raising, Advertising and Promotional	(6,603)	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	(313)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,447)		\$	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)	\$ (31,447)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Golden Good Shepherd Home

Report Period Beginning: ID# 0009175
 Ending: 11/01/13
 10/31/14

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Activities Income	\$ (23)	11	1
2	2013 Expenses	(290)	24	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		(313)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home# 0009175

Report Period Beginning:

11/01/13

Ending:

10/31/14

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	(7,708)	0	0	0	0	0	0	0	0	0	0	(7,708)	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	(7,708)	0	0	0	0	0	0	0	0	0	0	(7,708)	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	(23)	0	0	0	0	0	0	0	0	0	0	(23)	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	(23)	0	0	0	0	0	0	0	0	0	0	(23)	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	(6,603)	0	0	0	0	0	0	0	0	0	0	(6,603)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(290)	0	0	0	0	0	0	0	0	0	0	(290)	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	(6,893)	0	0	0	0	0	0	0	0	0	0	(6,893)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,624)	0	0	0	0	0	0	0	0	0	0	(14,624)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golden Good Shepherd Home# 0009175

Report Period Beginning:

11/01/13 Ending:10/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(21)	0	0	0	0	0	0	0	0	0	0	(21)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,490)	0	0	0	0	0	0	0	0	0	0	(4,490)	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	(4,511)	0	0	0	0	0	0	0	0	0	0	(4,511)	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):*	(12,312)	0	0	0	0	0	0	0	0	0	0	(12,312)	43
44	TOTAL Special Cost Centers	(12,312)	0	0	0	0	0	0	0	0	0	0	(12,312)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(31,447)	0	0	0	0	0	0	0	0	0	0	(31,447)	45

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/13

Ending:

10/31/14

VII. RELATED PARTIES

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

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

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: 11/01/13 Ending: 10/31/14

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:

11/01/13

Ending: 10/31/14

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	First Financial		X	EMR Equipment	\$1,417.58	02/14/14	\$ 55,881	\$ 47,027	01/14/18	10.0110	\$ 3,904					
2																
3																
4																
5																
Working Capital																
6	Brown County State Bank		X	Construction Loan	Interest	06/19/2014	300,000	278,157	01/19/15	2.9500	1,506					
7																
8																
9	TOTAL Facility Related				\$1,417.58		\$ 355,881	\$ 325,184			\$ 5,410					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 355,881	\$ 325,184			\$ 5,410					

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009 _____	8	FOR BHF USE ONLY		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 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 2013 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 2013.

	(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	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

11/01/13 Ending:

10/31/14

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/13

Ending:

10/31/14

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42	1963	1963	\$ 163,629	\$	50	\$	\$	\$ 163,629	4
5		1988	1988	208,384	5,210	40	5,210		136,318	5
6		1989	1989	84,694	2,117	40	2,117		54,169	6
7										7
8										8
Improvement Type**										
9	Building Addition		1967	5,285		20			5,285	9
10	Building Addition		1973	25,841		20			25,841	10
11	Sprinkler System		1975	30,963		20			30,963	11
12	Building Addition		1975	18,103		20			18,103	12
13	Building Addition		1975	1,313		20			1,313	13
14	Building Addition		1976	15,380		20			15,380	14
15	Building Addition		1977	3,981		15			3,981	15
16	Doors		1978	900		20			900	16
17	Building Addition		1980	3,165		15			3,165	17
18	Parking Lot		1985	7,475		15			7,475	18
19	Building Addition		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 Addition		1990	655		20			652	23
24	Sprinkler System		1992	43,248	1,730	25	1,730		38,779	24
25	Floor & Foundation Improvements		1997	9,800	251	39	251		4,501	25
26	Parking Lot Expansion		1997	16,320	418	39	418		7,253	26
27	Oxygen Room Venting		1998	2,880	72	40	72		1,202	27
28	Backflow Valve		1998	959	39	25	38	(1)	619	28
29	Laundry Door		1998	3,555		15			3,535	29
30	Backflow Preventor		1999	3,128	157	20	156	(1)	2,446	30
31	Ceiling		1999	4,657	233	20	233		3,511	31
32	Kitchen Floor		2000	1,167		10			1,157	32
33	New Roof Nursing Home		2001	38,956	999	39	999		13,152	33
34	Concrete Activity Room Entrance		2003	4,975	332	15	332		3,814	34
35	Remodel Kitchen		2004	5,085	341	15	339	(2)	3,635	35
36	Concrete Correction		2007	6,500	432	15	433		3,406	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:

11/01/13

Ending:

10/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire suppression System	2007	\$ 2,369	\$ 237	10	\$ 237		\$ 1,836	37
38	New Doors	2007	1,584	106	15	106		801	38
39	Parking lot Improvements	2007	6,868	458	15	458		3,244	39
40	Sprinkler	2010	107,879	4,315	25	4,315		19,778	40
41	Nurse Call System	2010	58,134	2,907	20	2,907		12,111	41
42	Concrete Pad	2011	1,900	127	15	127		422	42
43	Sprinkler Addition	2012	28,700	1,148	25	1,148		3,061	43
44	Shower Room-Materials & Labor	2013	12,814	2,080	20	2,077	(3)	3,830	44
45	Shower Room-Alarm System	2013	3,774		20				45
46	Shower Room-Floor Tile	2013	5,800		20				46
47	Shower Room-Plumbing	2013	19,153		20				47
48	Generator Electrical Switch	2014	22,000	828	20	828		828	48
49	80 KW Cummins Generator	2014	37,983	1,424	20	1,424		1,424	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)		\$ 1,032,173	\$ 25,961		\$ 25,955	\$ (7)	\$ 613,736	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 212,431	\$ 17,234	\$ 17,234	\$	9	\$ 135,574	71
72	Current Year Purchases	68,754	6,598	6,598		5	6,598	72
73	Fully Depreciated Assets	368,935					367,514	73
74								74
75	TOTALS	\$ 650,120	\$ 23,832	\$ 23,832	\$		\$ 509,686	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	95 Ford Bus	2006	\$ 5,000	\$	\$	\$	5	\$ 5,000	76
77	Resident Transportation	Ford Vav	2012	4,305	876	861	(15)	5	1,824	77
78										78
79										79
80	TOTALS			\$ 9,305	\$ 876	\$ 861	\$ (15)		\$ 6,824	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)	\$ 1,729,325	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,669	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,648	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,130,246	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	\$ 348,367	\$ 7,740	\$ 244,387	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 348,367	\$ 7,740	\$ 244,387	91

G. Construction-in-Progress

	Description	Cost	
92	New Wing	\$ 344,843	92
93			93
94			94
95		\$ 344,843	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: 11/01/13

Ending: 10/31/14

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 5,799 Description: Oxygen Lease \$2,433.00, Dishwasher \$711.55, Equipment Rent \$106.46, Copier \$2,547.94

(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.

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/13 Ending: 10/31/14
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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	10a-3	hrs	\$	706	\$ 56,480	\$	706	\$ 56,480	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		122	9,780		122	9,780	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a-3	hrs		1,356	108,460		1,356	108,460	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-2	# of prescrpts				39,438		39,438	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			\$	2,184	\$ 174,720	\$ 39,438	2,184	\$ 214,158	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: 11/01/13

Ending:

10/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/14

(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	\$ 12,573	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	414,852		3
4	Supply Inventory (priced at <u>fifo</u>)	4,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,222		6
7	Other Prepaid Expenses	332		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 444,979	\$	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	1,262,959		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	777,006		16
17	Accumulated Depreciation (book methods)	(1,374,634)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>	344,843		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,255,952	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,700,931	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 80,685	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	278,157		29
30	Accrued Salaries Payable	82,940		30
31	Accrued Taxes Payable (excluding real estate taxes)	530		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,805		32
33	Accrued Interest Payable	247		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Pyrl Liabilities</u>	(3,022)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 443,342	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	47,027		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)	\$ 47,027	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 490,369	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,210,562	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,700,931	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,225,949	1
2	Restatements (describe):		2
3	Previous Period Expense Adjustment-	5,733	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,231,682	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(49,270)	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) Cottages	28,150	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (21,120)	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)	\$ 1,210,562	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 2,431,876	1	
2	Discounts and Allowances for all Levels	(49,829)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,382,047	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	37,277	6	
7	Oxygen	140	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 37,417	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	1,955	12	
13	Barber and Beauty Care	9,563	13	
14	Non-Patient Meals	6,644	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,110	17	
18	Sale of Supplies to Non-Patients	33	18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry	6,079	22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,384	23	
D. Non-Operating Revenue				
24	Contributions	28,866	24	
25	Interest and Other Investment Income***	4,490	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,356	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>See Attached</u>	31,337	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,337	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,509,541	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	587,412	31	
32	Health Care	1,375,630	32	
33	General Administration	364,113	33	
B. Capital Expense				
34	Ownership	61,878	34	
C. Ancillary Expense				
35	Special Cost Centers	65,456	35	
36	Provider Participation Fee	104,322	36	
D. Other Expenses (specify):				
37	<u>Rounding</u>		37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,558,811	40	
41	Income before Income Taxes (line 30 minus line 40)**	(49,270)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (49,270)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 603,173	44
45	Private Pay - Net Inpatient Revenue	1,338,587	45
46	Medicare - Net Inpatient Revenue	440,287	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,382,047	49

* 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:

11/01/13

Ending:

10/31/14

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	3,570	3,758	\$ 77,378	\$ 20.59	1
2	Assistant Director of Nursing	1,928	2,179	57,905	26.57	2
3	Registered Nurses	3,503	3,601	81,555	22.65	3
4	Licensed Practical Nurses	11,125	11,950	206,715	17.30	4
5	CNAs & Orderlies	34,297	36,217	405,934	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,218	3,613	59,579	16.49	8
9	Activity Director	1,833	1,925	21,754	11.30	9
10	Activity Assistants	6,467	6,861	65,892	9.60	10
11	Social Service Workers	1,735	1,935	26,551	13.72	11
12	Dietician					12
13	Food Service Supervisor	1,973	2,141	26,828	12.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,886	7,534	69,381	9.21	15
16	Dishwashers	5,003	5,062	45,115	8.91	16
17	Maintenance Workers	1,964	2,120	35,521	16.76	17
18	Housekeepers	6,072	6,625	65,141	9.83	18
19	Laundry	1,822	2,066	19,407	9.39	19
20	Administrator	1,834	2,086	59,952	28.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,422	1,725	25,246	14.64	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	1,620	1,736	21,177	12.20	31
32	Other Health C: <u>Care Plan</u>	2,033	2,266	48,821	21.55	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,305	105,400	\$ 1,419,852 *	\$ 13.47	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	137	\$ 4,804	1-3	35
36	Medical Director	Contract	1,950	9-3	36
37	Medical Records Consultant	Contract	1,880	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,694	10-3	39
40	Physical Therapy Consultant	48	3,088	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,874	11-3	44
45	Social Service Consultant	8	600	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	235	\$ 17,890		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	8	80	10-3	52
53	TOTAL (lines 50 - 52)	8	\$ 80		53

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	Adminstrator	0	\$ 59,952	Workers' Compensation Insurance	\$ 32,963	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	12,829	Advertising: Employee Recruitment	13,820	
				FICA Taxes	107,249	Health Care Worker Background Check	1,569	
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		INHAA	100	
				Employee Relations	1,893	IHCA	1,932	
				Vacation Accrual Adjustment	(2,223)	Drug Test	251	
						Emp Physicals	50	
						See List Attached	1,545	
						Less: Public Relations Expense	(3,707)	
						Non-allowable advertising	(2,895)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,952	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 152,711		\$ 14,655		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
n/a			\$ 0	n/a		\$ 0	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	In-State Travel	
C. Professional Services								
Vendor/Payee	Type		Amount					
Schmiedeskamo, Robertson, Neu & Legal	Legal		\$ 333					
Ability	Nilling Service		1,716					
WDM Support Services	Data Processing		18,402					
Accumed	Software Support		3,200					
American Healthtech	EMR Support		4,148					
Yolo	Website Support/Hosting		1,529					
Go Daddy	Web Fee		27					
Go to My PC	Remote Access		179					
Sheryl Deisler	Can Checkoff		175					
ETC			6,434					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 36,143	TOTAL			\$	Seminar Expense
								See list attached
								4,369
								Entertainment Expense
								(agree to Sch. V, line 24, col. 8)
								TOTAL
								\$ 4,369

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/13

Ending:

10/31/14

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. IHCA \$1932.00
- (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. \$ 23,402 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. \$ 104,322
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,644
- (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? 90
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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Golden Good Shepherd
#0009175
11/01/13 to 10/31/14

Board Members

Kenneth Miller
308 Prairie Mills Road
Golden, IL 62339

Karen Dickhut
305 North Main
Camp Point, IL 62320

Larry Gronewold
2561 Highway 94 North
Golden, IL 62339

Jane Roberts
412 Kiwanis Rd #3
Carthage, IL 62321

Cara Hoskins
208 West 5th St.
Golden, IL 62339

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

Gerald Buss
507 Main Street
Golden, IL 62339

Lori Mortimer
2484 East 2800 St
Golden, IL 62339

Golden Good Shepherd
#0009175
11/01/13 to 10/31/14

Reclassifications

1 Reclassify \$586.40 from Mediare Supplies to Speech Therapy due to coding error.

2 Reclassify \$674.27 from Business Mileage to Seminar due to coding error.

3 Reclassify \$78.86 from Seminars to Meetings-Food due to coding error.

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

Golden Good Shepherd
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11/01/13 to 10/31/14

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$1,442.50
REPAIRS & MAINT LAUNDRY	\$2,115.33
REPAIRS & MAINT HSKING	\$0.00
OUTSIDE SERVICES	\$5,139.48
MOWING	\$4,255.00
SNOW REMOVAL	\$2,290.00
REPAIRS & MAINT BUILDINGS	\$705.71
REPAIRS & MAINT EQUIPMENT	\$10,210.41
REPAIRS & MAINT GROUNDS	\$0.00
MUZAK	\$0.00
CABLE TV	\$2,724.37
Alarm	\$2,240.31
REFUSE	\$8,108.66
EXTERMITATOR	\$2,141.32
REPAIRS & MAINT GEN/ADM	\$2,901.50
TOTAL	<u>\$44,274.59</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	<u>\$7,680.83</u>
TOTAL	<u>\$7,680.83</u>

Schedule V. Line 14 ,Column 2

Auto Exp. & Service	\$1,561.75
Auto Gas & Oil	\$2,078.94
	<u>\$3,640.69</u>

Schedule V. Line 43, Column3

Bad Debt	\$12,312.00
----------	-------------

Contributions	\$0.00
Rounding	\$0.00
	<u>\$12,312.00</u>

Schedule V. Line 27, Column 8

Misc Expenses	\$2,978.82
Meetings-Food	\$78.86
Rounding	\$0.00
	<u>\$3,057.68</u>

Schedule XX. Question 12

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

Schedule XVII, Line 28a, Column 1

Transportation	\$1,530.00
Management Fee	\$18,000.00
Dietary Suppliments	\$4,982.17
Admissions	\$0.00
Activities Income	\$22.60
Uniform Sales	\$26.00
Personal Purchases	-\$193.15
Rebates	\$1,063.79
Gain on sale of Asset	\$4,015.00
Discounts	\$0.00
Doors Program	\$0.00
Misc	\$1,891.00
Rounding	
	<u>\$31,337.41</u>

The following is a breakdown of Schedule XIX, Section F

CLIA	
CC	\$123.15
Village of Golden	\$250.00
Am Health Tech	\$638.00
Sams Club	\$45.00
Il Sec of State	\$10.00
Safe Deposit	\$10.00
Subscriptions	\$469.55
Rounding	-\$1.00
	<u>\$1,544.70</u>

	Pvt Skilled	Pvt Int.	PA Skilled	PA Int.	Medicare	Total
Nov	41	667	90	300	104	1202
Dec	90	662	93	310	99	1254
Jan	71	616	87	309	197	1280
Feb	84	558	92	280	131	1145
Mar	80	609	96	366	126	1277
Apr	90	510	90	409	152	1251
May	74	567	68	431	121	1261
Jun	35	580	52	425	149	1241
Jul	85	621	56	406	93	1261
Aug	88	589	62	434	65	1238
Sep	90	555	60	409	67	1181
Oct	93	571	37	410	59	1170
	921	7105	883	4489	1363	14761

Golden Good Shepherd
 #0009175
 11/01/13 to 10/31/14

Schedule V, Line 24 Column 3

Training/Continuing Education Attendance - 2014

<u>Workshop Title</u>	<u>Host/Provider</u>	<u>Location</u>	<u>Date</u>	<u>Attendee</u>	<u>Registration \$</u>	<u>Date of Ch</u>	<u>Mileage</u>	<u>Hotel</u>
INHAA Annual Convention	INHAA	Springfield	11/5-6/2013	Amanda Marlow	\$135.00			\$132.85
INHAA Annual Convention	INHAA	Springfield	11/5-6/2013	Jill Scogins	\$135.00			
INHAA Annual Convention	INHAA	Springfield	11/5-6/2013	Heather Whitaker	\$135.00			
Long Term Care Nurses Assoc	LTCNA	Springfield	3/26-27/14	Katie Bowen	\$200.00			\$133.28
Long Term Care Nurses Assoc	LTCNA	Springfield	3/26-27/14	Jill Scogins	\$200.00			
NHRMA Annual Mtg	NHRMA	Springfield	5/7/2014	Amanda Marlow	Free		\$103.23	
NHRMA Annual Mtg	NHRMA	Springfield	5/7/2014	Katie Bowen	Free			
NHRMA Annual Mtg	NHRMA	Springfield	5/7/2014	Jill Scogins	Free			
Do No Harm Training	Public Health	Springfield	6/12/2014	Jill Scogins	Free		\$111.00	
Dementia Intervention	Cross Country Education	Peoria	7/18/2014	Sarah Vertrees	\$169.00		\$117.60	
Dementia Intervention	Cross Country Education	Peoria	7/18/2014	Renee Waters	\$169.00			
Dementia Intervention	Cross Country Education	Peoria	7/18/2014	Halee Eichman	\$169.00			
Dementia Intervention	Cross Country Education	Peoria	7/18/2014	Bridget King	\$169.00			
Dementia Intervention	Cross Country Education	Peoria	7/18/2014	Mary LaBonte	\$169.00			
Disaster Preparedness Update: Be Ready for Anythi	IHCA	Webinar	8/21/2014	Amanda Marlow	\$105.00			
Fall Wound Conference	Blessing Hospital	Quincy	10/7/2014	Jill Scogins	\$75.00			
Fall Wound Conference	Blessing Hospital	Quincy	10/7/2014	Tiffany Engel	\$75.00			
Fall 2014 IANFP Workshop	IANFP	Peoria	10/16-17/2014	Marilyn Eidson	\$75.00			\$79.52
Martin Brothers Food Show/Conference	Martin Brothers	Waterloo IA	9/21-22/2014	Amanda Marlow	free		\$237.44	
INHAA Annual Convention	INHAA	Springfield	10/29-30/2014	Amanda Marlow	\$125.00		\$105.00	\$321.31
INHAA Annual Convention	INHAA	Springfield	10/29-30/2014	Jordin Wiewel	\$125.00		\$105.00	
INHAA Annual Convention	INHAA	Springfield	10/29-30/2014	Katie Bowen	\$125.00			
INHAA Annual Convention	INHAA	Springfield	10/29-30/2014	Jill Scogins	\$125.00			
INHAA Annual Convention	INHAA	Springfield	10/29-30/2014	Heather Whitaker	\$125.00			

<u>Meals</u>	<u>Totals</u>
\$72.24	\$340.09
	\$135.00
	\$135.00
	\$333.28
	\$200.00
\$10.55	\$113.78
	\$0.00
	\$0.00
	\$111.00
	\$286.60
\$71.11	\$240.11
	\$169.00
	\$169.00
	\$169.00
	\$105.00
	\$75.00
	\$75.00
	\$154.52
\$23.49	\$260.93
\$140.42	\$691.73
	\$230.00
	\$125.00
	\$125.00
	\$125.00
Total	<u><u>\$4,369.04</u></u>

Golden Good Shepherd
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11/01/13 to 10/31/14

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

<u>Date</u>	<u>Training</u>	<u>Cost</u>	<u>Total</u>
12/1/2013	Hippa Training Manual	\$483.03	\$483.03
			<u>\$483.03</u>

Caremark	P.T. Hours	Dollars	O.T. Hours	Dollars	S.T. Hours	Dollars	Total	Total	Cook
Nov-13	116.75	\$9,340.00	64.75	\$5,180.00	7.75	\$620.00	189.25	\$15,140.00	1.75 \$113.75
Dec-13	133.25	\$10,660.00	60.25	\$4,820.00	17.25	\$1,380.00	210.75	\$16,860.00	5.00 \$325.00
Jan-14	197.00	\$15,760.00	94.00	\$7,520.00	18.75	\$1,500.00	309.75	\$24,780.00	5.00 \$325.00
Feb-14	126.00	\$10,080.00	71.75	\$5,740.00	16.00	\$1,280.00	213.75	\$17,100.00	2.25 \$146.25
Mar-14	115.50	\$9,240.00	72.00	\$5,760.00	16.25	\$1,300.00	203.75	\$16,300.00	4.50 \$292.50
Apr-14	131.25	\$10,500.00	67.50	\$5,400.00	9.25	\$740.00	208.00	\$16,640.00	2.25 \$146.25
May-14	105.50	\$8,440.00	53.75	\$4,300.00	14.50	\$1,160.00	173.75	\$13,900.00	6.50 \$422.50
Jun-14	110.50	\$8,840.00	63.25	\$5,060.00	11.75	\$940.00	185.50	\$14,840.00	5.00 \$325.00
Jul-14	101.25	\$8,100.00	48.00	\$3,840.00	1.75	\$140.00	151.00	\$12,080.00	3.75 \$243.75
Aug-14	65.25	\$5,220.00	38.50	\$3,080.00	1.50	\$120.00	105.25	\$8,420.00	3.75 \$243.75
Sep-14	73.50	\$5,880.00	29.50	\$2,360.00	2.00	\$160.00	105.00	\$8,400.00	3.50 \$227.50
Oct-14	80.00	\$6,400.00	42.75	\$3,420.00	5.50	\$440.00	128.25	\$10,260.00	4.25 \$276.25
	1,355.75	\$108,460.00	706.00	\$56,480.00	122.25	\$9,780.00			47.50 \$3,087.50

2,231.50 \$177,807.50

- 706 \$60,073.60
- 7065 \$19,780.80
- 707 \$31,693.10
- 716 \$5,086.40
- 7161 \$1,300.00
- 717 \$2,807.20
- 755 \$32,662.40
- 756 \$7,495.20
- 757 \$16,322.40

\$177,221.10

Reclass \$586.40 From 61600

\$177,807.50