		FOR BHF USE					

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0007344

Facility Name: Good Sam Soc Mt Carroll

Address: 1006 North Lowden (Number) Mount Carroll (City) 61053 (Zip Code)

County: Carroll

Telephone Number: 815-244-7150 **Fax #** 815-244-3127

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1970

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) JOSEPH HERDINA
(Title) VICE PRESIDENT OF FINANCE

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Kim Kouri Telephone Number: 605-362-3178
Email Address:

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	72	Skilled (SNF)	72	26,280	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	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,492	11,005	2,105	21,602	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,492	11,005	2,105	21,602	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.20%

D. How many bed-hold days during this year were paid by the Department?
_____ (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)
MEALS ON WHEELS

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1970

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 1,847

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,368	11,792	6,725	230,885		230,885	(231)	230,654			1
2	Food Purchase		133,321		133,321		133,321	(12,274)	121,047			2
3	Housekeeping	55,772	10,800		66,572		66,572	(229)	66,343			3
4	Laundry	35,248	9,530		44,778		44,778	(202)	44,576			4
5	Heat and Other Utilities			81,546	81,546		81,546	(3,684)	77,862			5
6	Maintenance	55,925	7,440	71,214	134,579		134,579	(3,483)	131,096			6
7	Other (specify):*			281	281		281	(223)	58			7
8	TOTAL General Services	359,313	172,883	159,766	691,962		691,962	(20,326)	671,636			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,350,395	165,848	6,109	1,522,352		1,522,352	(93,264)	1,429,088			10
10a	Therapy		388	232,932	233,320		233,320	(29,124)	204,196			10a
11	Activities	66,706	2,475	2,617	71,798		71,798	(53)	71,745			11
12	Social Services	33,601		1,992	35,593		35,593		35,593			12
13	CNA Training											13
14	Program Transportation			4,403	4,403		4,403		4,403			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,450,702	168,711	250,453	1,869,866		1,869,866	(122,441)	1,747,425			16
	C. General Administration											
17	Administrative	60,001		205,280	265,281		265,281	77,880	343,161			17
18	Directors Fees											18
19	Professional Services			454	454		454		454			19
20	Dues, Fees, Subscriptions & Promotions			20,373	20,373		20,373	(13,852)	6,521			20
21	Clerical & General Office Expenses	145,503	126,606	35,004	307,113		307,113	(8,363)	298,750			21
22	Employee Benefits & Payroll Taxes			456,695	456,695		456,695	(2,874)	453,821			22
23	Inservice Training & Education			7,908	7,908		7,908	(27)	7,881			23
24	Travel and Seminar			3,198	3,198		3,198	(2,025)	1,173			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,122	21,122		21,122	4,773	25,895			26
27	Other (specify):*	14,607		3,024	17,631		17,631	(17,633)	(2)			27
28	TOTAL General Administration	220,111	126,606	753,058	1,099,775		1,099,775	37,879	1,137,654			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,030,126	468,200	1,163,277	3,661,603		3,661,603	(104,888)	3,556,715			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 Good Sam Soc Mt Carroll #0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			168,885	168,885		168,885		168,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,631	2,631		2,631		2,631			35
36	Other (specify):*											36
37	TOTAL Ownership			171,516	171,516		171,516		171,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,191	163,191		163,191		163,191			42
43	Other (specify):*			10,158	10,158		10,158	(10,158)				43
44	TOTAL Special Cost Centers			173,349	173,349		173,349	(10,158)	163,191			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,030,126	468,200	1,508,142	4,006,468		4,006,468	(115,046)	3,891,422			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 Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,274)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,441	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				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	(187,112)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (196,945)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	81,899		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 81,899		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,046)		37

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

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

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

STATE OF ILLINOIS

Good Sam Soc Mt Carroll

ID# 0007344

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See Attached Schedule	$ (231)	1	1
2	See Attached Schedule	(229)	3	2
3	See Attached Schedule	(202)	4	3
4	See Attached Schedule	(3,684)	5	4
5	See Attached Schedule	(3,483)	6	5
6	See Attached Schedule	(223)	7	6
7	See Attached Schedule	(93,264)	10	7
8	See Attached Schedule	(29,124)	10a	8
9	See Attached Schedule	(53)	11	9
10	See Attached Schedule	(13,852)	20	10
11	See Attached Schedule	(10,804)	21	11
12	See Attached Schedule	(1,191)	22	12
13	See Attached Schedule	(27)	23	13
14	See Attached Schedule	(2,954)	24	14
15	See Attached Schedule	(17,633)	27	15
16	See Attached Schedule	(10,158)	43	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**	(187,112)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(231)	0	0	0	0	0	0	0	0	0	0	(231)	1
2	Food Purchase	(12,274)	0	0	0	0	0	0	0	0	0	0	(12,274)	2
3	Housekeeping	(229)	0	0	0	0	0	0	0	0	0	0	(229)	3
4	Laundry	(202)	0	0	0	0	0	0	0	0	0	0	(202)	4
5	Heat and Other Utilities	(3,684)	0	0	0	0	0	0	0	0	0	0	(3,684)	5
6	Maintenance	(3,483)	0	0	0	0	0	0	0	0	0	0	(3,483)	6
7	Other (specify):*	(223)	0	0	0	0	0	0	0	0	0	0	(223)	7
8	**TOTAL General Services**	(20,326)	0	0	0	0	0	0	0	0	0	0	(20,326)	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	(93,264)	0	0	0	0	0	0	0	0	0	0	(93,264)	10
10a	Therapy	(29,124)	0	0	0	0	0	0	0	0	0	0	(29,124)	10a
11	Activities	(53)	0	0	0	0	0	0	0	0	0	0	(53)	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**	(122,441)	0	0	0	0	0	0	0	0	0	0	(122,441)	16
	C. General Administration													
17	Administrative	0	78,809	0	0	0	0	0	0	0	0	0	78,809	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	(13,852)	0	0	0	0	0	0	0	0	0	0	(13,852)	20
21	Clerical & General Office Expenses	(8,363)	0	0	0	0	0	0	0	0	0	0	(8,363)	21
22	Employee Benefits & Payroll Taxes	(1,191)	(1,683)	0	0	0	0	0	0	0	0	0	(2,874)	22
23	Inservice Training & Education	(27)	0	0	0	0	0	0	0	0	0	0	(27)	23
24	Travel and Seminar	(2,954)	0	0	0	0	0	0	0	0	0	0	(2,954)	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	4,773	0	0	0	0	0	0	0	0	0	4,773	26
27	Other (specify):*	(17,633)	0	0	0	0	0	0	0	0	0	0	(17,633)	27
28	**TOTAL General Administration**	(44,020)	81,899	0	0	0	0	0	0	0	0	0	37,879	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(186,787)	81,899	0	0	0	0	0	0	0	0	0	(104,888)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(10,158)	0	0	0	0	0	0	0	0	0	0	(10,158)	43
44	**TOTAL Special Cost Centers**	(10,158)	0	0	0	0	0	0	0	0	0	0	(10,158)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(196,945)	81,899	0	0	0	0	0	0	0	0	0	(115,046)	45

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin/Accounting	$ 205,280	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 284,089	$ 78,809	1
2	V	22	Workers Compensation	59,844	The Evangelical Lutheran Good Samaritan Society	100.00%	54,247	(5,597)	2
3	V	22	Unemployment	335	The Evangelical Lutheran Good Samaritan Society	100.00%	530	195	3
4	V	26	Insurance	21,122	The Evangelical Lutheran Good Samaritan Society	100.00%	25,895	4,773	4
5	V	22	Group Health Insurance	198,914	The Evangelical Lutheran Good Samaritan Society	100.00%	202,633	3,719	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			$ 485,495			$ 567,394	$ * 81,899	14

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	John Holt	BOD President						2
3	H. theodore Grindal	BOD V-P						3
4	Gwen Wagstrom Halaas	BOD						4
5	Alan Gard	BOD						5
6	David Horazdovsky	BOD						6
7	Benjamin Anderson	BOD						7
8	Patricia Camero	BOD						8
9	Michael Deuth	BOD						9
10	Heather Krzmarsick	BOD						10
11	Connie March-Curtis	BOD						11
12	Guy Matson	BOD						12
13	John Racek	BOD						13
14	Jill Schumann	BOD						14
15	Dennis Stene	BOD						15
16	Sharon St. Mary	BOD						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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											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 Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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							$	$			$	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.)**

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2015 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:

2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Sam Soc Mt Carroll COUNTY Carroll

FACILITY IDPH LICENSE NUMBER 0007344

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,795 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (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	Land		1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1970	$ 388,819	$		$	$	$ 388,819	4
5				1991	805,551					805,551	5
6				2010	192,900	7,716		7,716		45,010	6
7											7
8											8
	Improvement Type**										
9				1970	3,703					3,703	9
10				1971	262					262	10
11				1975	1,986					1,986	11
12				1976	2,090					2,090	12
13				1977	185					185	13
14				1979	6,037					6,037	14
15				1980	1,559					1,559	15
16				1981	33,937					33,627	16
17				1982	29,188					29,188	17
18				1983	8,193					8,193	18
19				1984	1,224					1,224	19
20				1986	4,163					4,163	20
21				1987	15,273					15,273	21
22				1988	6,707					6,707	22
23				1989	5,010					5,010	23
24				1990	6,322					6,322	24
25				1991	98,155					95,713	25
26				1992	10,350					10,350	26
27				1993	4,260					4,260	27
28				1994	66,654					66,654	28
29				1995	36,466					36,466	29
30				1996	78,462	3,822		3,822		75,927	30
31				1997	24,046	749		749		22,674	31
32				1998	16,770	520		520		15,502	32
33				1999	37,004	736		736		34,204	33
34				2000	88,586	994		994		74,048	34
35				2002	51,858	2,201		2,201		47,818	35
36				2003	58,269	2,822		2,822		37,346	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 Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2004	$ 13,568	$ 441		$ 441	$	$ 10,805	37
38		2005	109,024	3,523		3,523		63,199	38
39		2006	385,284	18,411		18,411		178,069	39
40		2007	29,076	1,192		1,192		23,966	40
41		2008	155,962	10,544		10,544		83,012	41
42		2009	128,025	7,936		7,936		50,898	42
43		2010	177,516	11,598		11,598		87,443	43
44		2011	15,113	1,384		1,384		6,447	44
45	OUTSIDE METAL DOOR W WINDOW	2012	1,770	89	240	89		339	45
46	GENERATOR REPAIRS/SERVICE	2012	2,629	263	120	263		964	46
47	ASBESTOS-FLOORING ABATEMENT	2012	90,701	9,070	120	9,070		30,989	47
48	VINYL FLOORING	2012	92,467	9,247	120	9,247		31,593	48
49	MCLAIN BOILER W 2WATER HEATERS	2012	34,754	1,738	240	1,738		6,372	49
50	CASCADE PREMIER SPA	2012	19,440	1,941	120	1,941		6,339	50
51	TRANE FAN COIL COOL & HEATER	2012	2,962	296	120	296		889	51
52	DIRECT TV SYSTEM	2012	20,220	2,022	120	2,022		6,403	52
53	SHORETEL PHONE SYSTEM	2013	36,398	3,640	120	3,640		10,616	53
54	FIRE DOORS IN KIT/DIN ROOM WIN	2013	3,517	352	120	352		1,026	54
55	GENERATOR REPAIRS	2013	2,629	526	60	526		1,446	55
56	REPLACE ROOFTOP UNITS	2013	91,850	9,185	120	9,185		23,728	56
57	BLDG-200 WING SPA ROOM RMDL	2014	18,284	731	300	731		1,280	57
58	ELECT-200 WING SPA ROOM RMDL	2014	4,500	300	180	300		525	58
59	PLBG-200 WING SPA ROOM RMDL	2014	2,200	110	240	110		193	59
60	BLDG-SNF NEW FLOORING	2014	633	25	300	25		40	60
61	VINYL-SNF NEW FLOORING	2014	6,262	626	120	626		991	61
62	NEW GARAGE IDOT BUS	2014	23,498	940	300	940		1,253	62
63	BUILDING-REMODEL DINING ROOM	2014	8,905	356	300	356		475	63
64	FIRE PUMP REPAIR, INSPECTION	2014	2,434	243	120	243		264	64
65	PARKING LOT/BUS SLAB/SHED	2015	20,897	464	180	464		464	65
66	ELECTRIC-EMERGENCY LIGHTING	2015	2,489	97	180	97		97	66
67	EMERGENCY LIGHTING	2015	3,270	127	180	127		127	67
68	CHAIN LINK FENCE AT GENERATOR	2013	584	39	180	39		97	68
69	CONCRETE PARKING LOT & SIDEWLK	2014	4,000	200	240	200		300	69
70	TOTAL (lines 4 thru 69)		$ 3,594,847	$ 117,214		$ 117,214	$	$ 2,516,518	70

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 430,205	$ 39,889	$ 39,889	$		$ 259,818	71
72	Current Year Purchases	69,322	7,706	7,706			7,706	72
73	Fully Depreciated Assets	681,307	3,433	3,433			681,307	73
74								74
75	TOTALS	$ 1,180,834	$ 51,028	$ 51,028	$		$ 948,831	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	Bus		2002	$ 42,763	$	$	$	6	$ 42,763	76
77	Caravan	2002 Oldsmobile	2005	15,173				4	15,173	77
78	Truck	2005 Chevy	2009	14,272				4	14,272	78
79										79
80	TOTALS			$ 72,208	$	$	$		$ 72,208	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)	$ 4,853,609	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 168,242	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,242	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,537,557	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 15,910	92
93			93
94			94
95		$ 15,910	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 Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 2,631 Description: Nursing Equipment Rental
(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 Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 10A, col 3	hrs	$	7,152	$ 107,285	$	7,152	$ 107,285	1
2	Licensed Speech and Language Development Therapist	Line 10A, col 3	hrs		1,557	23,351		1,557	23,351	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10A, col 3	hrs		6,820	102,296		6,820	102,296	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$	15,529	$ 232,932	$	15,529	$ 232,932	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 Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ 32,776	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 17,633)	587,009		3
4	Supply Inventory (priced at)	6,466		4
5	Short-Term Investments	8,402		5
6	Prepaid Insurance	22,903		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,561		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 662,117	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	3,221,628		14
15	Leasehold Improvements, at Historical Cost	373,214		15
16	Equipment, at Historical Cost	1,253,043		16
17	Accumulated Depreciation (book methods)	(3,537,558)		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):	205,330		22
23	Other(specify):	17,150		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,538,527	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,200,644	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,766	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,475		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,851		30
31	Accrued Taxes Payable (excluding real estate taxes)	(496)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 328,596	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 328,596	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,872,048	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,200,644	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,777,769	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,777,769	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	347,659	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 347,659	17
	B. Transfers (Itemize):		
18	**Foundation Transfer**	(1,526)	18
19	**Dnr Restricted Accounts**	11,836	19
20	**SBA**	(263,690)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (253,380)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,872,048	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,231,785	1
2	Discounts and Allowances for all Levels	(1,225,456)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,006,329	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	901,383	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 901,383	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	120	13
14	Non-Patient Meals	12,889	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	227,148	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,803	19
20	Radiology and X-Ray	3,639	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 250,599	23
	D. Non-Operating Revenue		
24	Contributions	65,957	24
25	Interest and Other Investment Income***	27,161	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 93,118	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	87,530	28
28a	Misc Oncome/PY Settlements	15,168	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 102,698	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,354,127	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	691,962	31
32	Health Care	1,869,866	32
33	General Administration	1,099,775	33
	B. Capital Expense		
34	Ownership	171,516	34
	C. Ancillary Expense		
35	Special Cost Centers	10,158	35
36	Provider Participation Fee	163,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,006,468	40
41	**Income before Income Taxes (line 30 minus line 40)****	347,659	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 347,659	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,112,972	44
45	Private Pay - Net Inpatient Revenue	2,028,940	45
46	Medicare - Net Inpatient Revenue	837,265	46
47	Other-(specify)	118,737	47
48	Other-(specify)	(1,091,585)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,006,329	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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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	2,097	1,901	$ 66,503	$ 34.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,205	16,154	455,428	28.19	3
4	Licensed Practical Nurses	4,257	3,783	90,798	24.00	4
5	CNAs & Orderlies	53,979	48,886	696,902	14.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,145	1,849	35,210	19.04	9
10	Activity Assistants	3,469	3,315	30,534	9.21	10
11	Social Service Workers	1,781	1,727	34,657	20.07	11
12	Dietician					12
13	Food Service Supervisor	2,090	1,869	39,323	21.04	13
14	Head Cook	5,708	5,099	61,618	12.08	14
15	Cook Helpers/Assistants	11,632	10,676	110,327	10.33	15
16	Dishwashers					16
17	Maintenance Workers	3,265	3,012	53,939	17.91	17
18	Housekeepers	5,826	5,058	57,079	11.28	18
19	Laundry	3,934	3,411	36,940	10.83	19
20	Administrator	1,943	1,805	60,001	33.24	20
21	Assistant Administrator					21
22	Other Administrative	4,877	4,184	105,142	25.13	22
23	Office Manager	3,645	3,201	78,251	24.45	23
24	Clerical					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	1,932	1,670	35,620	21.33	31
32	Other Health Care(specify)					32
33	Other(specify)	869	810	14,020	17.31	33
34	TOTAL (lines 1 - 33)	131,654	118,410	$ 2,062,292 *	$ 17.42	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		$		35
36	Medical Director		2,400	Ln 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,606	Ln 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	58	1,745	Ln 11, Col 3	44
45	Social Service Consultant	58	1,746	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	116	$ 10,497		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	50	1,503	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	50	$ 1,503		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Luann Brewington	Administrator	0	$ 60,001
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,001

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 205,280
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 205,280

C. Professional Services

Vendor/Payee	Type	Amount
Fees		$ 454
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 454

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,844
Unemployment Compensation Insurance	457
FICA Taxes	151,337
Employee Health Insurance	198,914
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	48,809
Taxable gifts	10,078
Other	715
Marketing/Resource	
Work Comp	
Page 5 adjustments	(16,333)
TOTAL (agree to Schedule V, line 22, col.8)	$ 453,821

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,756
Health Care Worker Background Check (Indicate # of checks performed ____)	
Patient Background Checks	
Dues	5,408
Publications	3,209
Less: Public Relations Expense	( )
Non-allowable advertising	(13,852)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,521

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,025
In-State Travel	1,173
Seminar Expense	
Out of State Travel	(2,025)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,173

**See instructions.

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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
					Amount of Expense Amortized Per Year								
	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		$		$	$	$	$	$	$	$	$	$

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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. **LSN-4379**

(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? **7.83**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,642** Line **10**

(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. $ **163,191**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(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. $ **12,274**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **10%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON LARSON ALLEN**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.