

Facility Name & ID Number Golden Good Shepherd Home

0009175 Report Period Beginning: 11/01/15 Ending: 10/31/16

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	46	Skilled (SNF)	46	16,836	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	46	TOTALS	46	16,836	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	65	220	1,289	1,574	8
9	SNF/PED					9
10	ICF	5,039	8,207		13,246	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,104	8,427	1,289	14,820	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.03%

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)

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 46 and days of care provided 1,289

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 10/31/16 Fiscal Year: 10/31/16

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/15 Ending: 10/31/16

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	145,190	10,710	5,894	161,794		161,794		161,794		1
2	Food Purchase		153,228		153,228		153,228	(4,939)	148,289		2
3	Housekeeping	81,182	15,171		96,353		96,353		96,353		3
4	Laundry	21,405	6,914	38,678	66,997		66,997		66,997		4
5	Heat and Other Utilities			50,902	50,902		50,902		50,902		5
6	Maintenance	36,503	14,267	36,651	87,421		87,421		87,421		6
7	Other (specify):*										7
8	TOTAL General Services	284,280	200,290	132,125	616,695		616,695	(4,939)	611,756		8
	B. Health Care and Programs										
9	Medical Director			966	966		966		966		9
10	Nursing and Medical Records	899,468	87,216	7,716	994,400	(298)	994,102		994,102		10
10a	Therapy	62,902	444	282,333	345,679		345,679		345,679		10a
11	Activities	92,760	5,361	2,693	100,814		100,814	(481)	100,333		11
12	Social Services	28,230		962	29,192		29,192		29,192		12
13	CNA Training										13
14	Program Transportation		5,370		5,370		5,370		5,370		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,083,360	98,391	294,670	1,476,421	(298)	1,476,123	(481)	1,475,642		16
	C. General Administration										
17	Administrative	62,448			62,448		62,448		62,448		17
18	Directors Fees										18
19	Professional Services			34,669	34,669		34,669	(718)	33,951		19
20	Dues, Fees, Subscriptions & Promotions			39,062	39,062	(100)	38,962	(22,591)	16,371		20
21	Clerical & General Office Expenses	27,807	7,328	9,781	44,916		44,916		44,916		21
22	Employee Benefits & Payroll Taxes			191,288	191,288		191,288		191,288		22
23	Inservice Training & Education			327	327		327		327		23
24	Travel and Seminar			5,991	5,991	49	6,040	(299)	5,741		24
25	Other Admin. Staff Transportation		826		826	249	1,075		1,075		25
26	Insurance-Prop.Liab.Malpractice			45,942	45,942	100	46,042		46,042		26
27	Other (specify):*			2,940	2,940		2,940		2,940		27
28	TOTAL General Administration	90,255	8,154	330,000	428,409	298	428,707	(23,608)	405,099		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,457,895	306,835	756,795	2,521,525		2,521,525	(29,028)	2,492,497		29

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

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

Facility Name & ID Number

Golden Good Shepherd Home

#0009175

Report Period Beginning:

11/01/15

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			72,111	72,111		72,111	(7)	72,104			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,594	13,594		13,594	(50)	13,544			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,025	13,025		13,025		13,025			35
36	Other (specify):*			589	589		589		589			36
37	TOTAL Ownership			99,319	99,319		99,319	(57)	99,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,802		40,802		40,802		40,802			39
40	Barber and Beauty Shops			8,388	8,388		8,388		8,388			40
41	Coffee and Gift Shops		2,982		2,982		2,982		2,982			41
42	Provider Participation Fee			107,362	107,362		107,362		107,362			42
43	Other (specify):*			7,758	7,758		7,758	(7,758)				43
44	TOTAL Special Cost Centers		43,784	123,508	167,292		167,292	(7,758)	159,534			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,457,895	350,619	979,622	2,788,136		2,788,136	(36,843)	2,751,293			45

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

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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	(4,939)	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	(7)	30		9
10	Interest and Other Investment Income	(50)	32		10
11	Discounts, Allowances, Rebates & Refunds	(481)	11		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	(7,758)	43		24
25	Fund Raising, Advertising and Promotional	(22,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,017)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,843)		\$	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))	\$ (36,843)		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

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Report Period Beginning: 11/01/15

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activities Income	\$ 0	11	1
2	2015 Expenses	(718)	19	2
3	Undocumented Expense	0	24	3
4	2015 Expense	(99)	24	4
5	Seminar not attended	(200)	24	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,017)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/15

Ending:

10/31/16

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,939)	0	0	0	0	0	0	0	0	0	0	(4,939)	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	(4,939)	0	(4,939)	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	(481)	0	0	0	0	0	0	0	0	0	0	(481)	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	(481)	0	(481)	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	(718)	0	0	0	0	0	0	0	0	0	0	(718)	19
20	Fees, Subscriptions & Promotions	(22,591)	0	0	0	0	0	0	0	0	0	0	(22,591)	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	(299)	0	0	0	0	0	0	0	0	0	0	(299)	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	(23,608)	0	(23,608)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,028)	0	(29,028)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golden Good Shepherd Home

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Report Period Beginning:

11/01/15

Ending:

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7)	0	0	0	0	0	0	0	0	0	0	(7)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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	(57)	0	(57)	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):*	(7,758)	0	0	0	0	0	0	0	0	0	0	(7,758)	43
44	TOTAL Special Cost Centers	(7,758)	0	(7,758)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,843)	0	(36,843)	45									

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

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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								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

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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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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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	First Financial		X	EMR Equip	\$1,417.58	02/14/14	\$ 55,881	\$ 19,909	01/14/18	10.0110	\$ 2,777	1								
2	Brown County State Bank		X	New Wing	\$5,000.00	04/29/15	243,900	169,774	04/29/20	3.2500	6,534	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Brown County State Bank		X	Construction Loan	Interest	06/19/14	300,000					6								
7	Brown County State Bank		X	Cash Flow	Interest	12/18/14	40,000	150,000	12/18/15	2.9500	4,283	7								
8												8								
9	TOTAL Facility Related				\$6,417.58		\$ 639,781	\$ 339,683			\$ 13,594	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 639,781	\$ 339,683			\$ 13,594	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.)

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 2015 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 2016 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:	2011	8	
	2012	9	
	2013	10	
	2014	11	
	2015	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.

2015 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 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

11/01/15 Ending:

10/31/16

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? [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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Facility, 475,705, \$ 37,727, 1. Row 2: (blank), 2. Row 3: TOTALS, 475,705, \$ 37,727, 3.

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/15

Ending:

10/31/16

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		146,737	5
6		1989	1989	84,694	2,117	40	2,117		58,404	6
7	4	2015	2015	354,549	9,091	39	9,091		14,394	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			653	23
24	Sprinkler System	1992		43,248	1,730	25	1,730		42,239	24
25	Floor & Foundation Improvements	1997		9,800	251	39	251		5,004	25
26	Parking Lot Expansion	1997		16,320	418	39	418		8,090	26
27	Oxygen Room Venting	1998		2,880	72	40	72		1,346	27
28	Backflow Valve	1998		959	39	25	38	(1)	696	28
29	Laundry Door	1998		3,555		15			3,535	29
30	Backflow Preventor	1999		3,128	157	20	156	(1)	2,761	30
31	Ceiling	1999		4,657	233	20	233		3,977	31
32	Kitchen Floor	2000		1,167		10			1,157	32
33	New Roof Nursing Home	2001		38,956	999	39	999		15,150	33
34	Concrete Activity Room Entrance	2003		4,975	332	15	332		4,477	34
35	Remodel Kitchen	2004		5,085	341	15	339	(2)	4,317	35
36	Concrete Correction	2007		6,500	432	15	433		4,270	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:

11/01/15

Ending:

10/31/16

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		\$ 2,310	37
38	New Doors	2007	1,584	106	15	106		1,012	38
39	Parking lot Improvements	2007	6,868	458	15	458		4,159	39
40	Sprinkler	2010	107,879	4,315	25	4,315		28,408	40
41	Nurse Call System	2010	58,134	2,907	20	2,907		17,924	41
42	Concrete Pad	2011	1,900	127	15	127		676	42
43	Sprinkler Addition	2012	28,700	1,148	25	1,148		5,358	43
44	Shower Room-Materials & Labor	2013	12,814	644	20	645	1	2,475	44
45	Shower Room-Alarm System	2013	3,774	185	20	185		716	45
46	Shower Room-Floor Tile	2013	5,800	291	20	291		1,118	46
47	Shower Room-Plumbing	2013	19,153	956	20	956		3,672	47
48	Generator Electrical Switch	2014	22,000	1,105	20	1,100	(5)	3,038	48
49	80 KW Cummins Generator	2014	37,983	1,899	20	1,899		5,223	49
50	sprinkler system	2015	16,400	820	20	820		1,298	50
51	Landscaping	2015	4,588	306	15	306		331	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)		\$ 1,407,710	\$ 36,926		\$ 36,919	\$ (8)	\$ 683,177	70

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/15

Ending:

10/31/16

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	\$ 286,582	\$ 33,755	\$ 33,755	\$	8	\$ 157,492	71
72	Current Year Purchases	8,986	554	554		8	554	72
73	Fully Depreciated Assets	392,887				8	391,681	73
74								74
75	TOTALS	\$ 688,455	\$ 34,309	\$ 34,309	\$		\$ 549,727	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 Van	2012	4,305	876	876		5	3,575	77
78										78
79										79
80	TOTALS			\$ 9,305	\$ 876	\$ 876	\$		\$ 8,575	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)	\$ 2,143,197	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,111	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,104	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,241,479	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	\$ 356,147	\$ 7,580	\$ 259,650	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 356,147	\$ 7,580	\$ 259,650	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/15

Ending: 10/31/16

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 13,025 Description: (Oxygen \$5871.22, Dishwasher \$828.00, Equip Rent \$3691.80, Copier Rent \$1691.47, Computer Lease \$942

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	10a-3	hrs	\$	1,389	\$ 111,139	\$	1,389	\$ 111,139	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		53	4,200		53	4,200	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,770	141,635		1,770	141,635	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 prescripts				40,802		40,802	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			\$	3,212	\$ 256,974	\$ 40,802	3,212	\$ 297,776	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **10/31/16**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (62,915)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	557,222		3
4	Supply Inventory (priced at <u>Fifo</u>)	4,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,937		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)	\$ 511,576	\$	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	1,659,041		14
15	Leasehold Improvements, at Historical Cost	(908,235)		15
16	Equipment, at Historical Cost	802,576		16
17	Accumulated Depreciation (book methods)	(592,894)		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>Organization Costs</u>	2,060		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,208,326	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,719,902	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 94,183	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000		29
30	Accrued Salaries Payable	96,535		30
31	Accrued Taxes Payable (excluding real estate taxes)	360		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,622		32
33	Accrued Interest Payable	4,336		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	(773)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 348,263	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,909		39
40	Mortgage Payable	169,774		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)	\$ 189,683	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 537,946	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,181,956	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,719,902	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,080,373	1
2	Restatements (describe):		2
3	Prior Period Adjustment	10,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,090,373	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	70,395	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	21,187	15
16	Other (describe) Rounding	1	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 91,583	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)	\$ 1,181,956	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/15

Ending: 10/31/16

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,715,247	1
2	Discounts and Allowances for all Levels	(6,499)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,708,748	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,428	6
7	Oxygen	1,207	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 53,635	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	1,390	12
13	Barber and Beauty Care	8,109	13
14	Non-Patient Meals	4,939	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,100	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,538	23
D. Non-Operating Revenue			
24	Contributions	46,564	24
25	Interest and Other Investment Income***	50	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,614	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance Reimb	144	28
28a	See Attached	29,852	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,996	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,858,531	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	616,695	31
32	Health Care	1,476,421	32
33	General Administration	428,409	33
B. Capital Expense			
34	Ownership	99,319	34
C. Ancillary Expense			
35	Special Cost Centers	59,930	35
36	Provider Participation Fee	107,362	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,788,136	40
41	Income before Income Taxes (line 30 minus line 40)**	70,395	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 70,395	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 581,616	44
45	Private Pay - Net Inpatient Revenue	1,609,079	45
46	Medicare - Net Inpatient Revenue	518,053	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,708,748	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:

11/01/15

Ending:

10/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,139	\$ 61,053	\$ 28.54	1
2	Assistant Director of Nursing	2,031	2,245	49,248	21.94	2
3	Registered Nurses	4,660	4,827	115,375	23.90	3
4	Licensed Practical Nurses	9,300	10,094	188,739	18.70	4
5	CNAs & Orderlies	33,892	35,707	406,446	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,320	3,755	62,902	16.75	8
9	Activity Director	1,930	2,070	24,461	11.82	9
10	Activity Assistants	6,457	7,007	68,299	9.75	10
11	Social Service Workers	1,793	1,988	28,230	14.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,773	2,024	27,636	13.65	14
15	Cook Helpers/Assistants	7,253	7,875	73,809	9.37	15
16	Dishwashers	4,689	4,801	43,745	9.11	16
17	Maintenance Workers	1,907	2,107	36,503	17.32	17
18	Housekeepers	7,689	8,257	81,182	9.83	18
19	Laundry	1,965	2,148	21,405	9.97	19
20	Administrator	1,871	2,091	62,448	29.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,759	1,995	27,807	13.94	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	1,245	1,342	16,663	12.42	31
32	Other Health C: Care Plan	1,898	2,151	47,501	22.08	32
33	Other(specify) <u>Geri Aides</u>	1,645	1,685	14,443	8.57	33
34	TOTAL (lines 1 - 33)	99,029	106,308	\$ 1,457,895 *	\$ 13.71	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	163	\$ 5,714	1-3	35
36	Medical Director	Contract	966	9-3	36
37	Medical Records Consultant	Contract	2,000	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	53	3,448	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	2,693	11-3	44
45	Social Service Consultant	12	962	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	261	\$ 15,783		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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/15

Ending:

10/31/16

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 \$2718
- (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? 9
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,396 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. \$ 107,362
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. \$ 4,939
- (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

Caremark	Physical Therapy					Occupational Therapy					Speech Therapy					Total	Total	Cook			
	Med A Hours	Dollars	Med B	Private	Private	Med A Hours	Dollars	Med B	Private	Private	Med A Hours	Dollars	Med B	Private	Private						
Nov-14	84.75	\$6,780.00	35.50	\$2,840.00	0.00	\$0.00	72.75	\$5,820.00	3.58	\$286.40	0.00	\$0.00	1.00	\$80.00	3.50	\$280.00	0.00	\$0.00	272.50	\$21,800.00	\$178.75
Dec-14	93.58	\$7,486.40	25.00	\$2,000.00	0.00	\$0.00	83.28	\$6,662.40	5.67	\$453.60	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	250.40	\$20,032.00	\$211.25
Jan-15	107.58	\$8,606.40	22.58	\$1,806.40	0.00	\$0.00	87.15	\$6,972.00	9.57	\$765.60	0.00	\$0.00	0.00	\$0.00	2.00	\$160.00	0.00	\$0.00	294.50	\$23,560.00	\$295.50
Feb-15	165.67	\$13,253.60	14.17	\$1,133.60	0.00	\$0.00	158.08	\$12,646.40	11.58	\$926.40	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	467.83	\$37,426.40	\$195.00
Mar-15	162.25	\$12,980.00	22.67	\$1,813.60	0.00	\$0.00	162.27	\$12,981.60	14.75	\$1,180.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	511.57	\$40,925.60	\$227.50
Apr-15	53.75	\$4,300.00	26.75	\$2,140.00	0.00	\$0.00	55.58	\$4,446.40	11.08	\$886.40	0.00	\$0.00	2.58	\$206.40	5.25	\$420.00	0.00	\$0.00	214.92	\$17,193.60	\$455.00
May-15	13.50	\$1,080.00	26.17	\$2,093.60	0.00	\$0.00	15.50	\$1,240.00	12.75	\$1,020.00	0.00	\$0.00	3.75	\$300.00	1.25	\$100.00	0.00	\$0.00	115.26	\$9,220.80	\$422.50
Jun-15	48.25	\$3,860.00	32.17	\$2,573.60	0.00	\$0.00	42.75	\$3,420.00	20.58	\$1,646.40	0.00	\$0.00	4.25	\$340.00	1.00	\$80.00	0.00	\$0.00	220.16	\$17,612.80	\$308.75
Jul-15	79.58	\$6,366.40	19.25	\$1,540.00	0.00	\$0.00	70.75	\$5,660.00	7.42	\$593.60	0.00	\$0.00	6.78	\$542.40	0.00	\$0.00	0.00	\$0.00	259.36	\$20,748.80	\$211.25
Aug-15	41.42	\$3,313.60	13.92	\$1,113.60	0.00	\$0.00	40.92	\$3,273.60	6.50	\$520.00	0.00	\$0.00	0.50	\$40.00	1.25	\$100.00	0.00	\$0.00	159.83	\$12,786.40	\$390.00
Sep-15	38.33	\$3,066.40	37.83	\$3,026.40	0.00	\$0.00	37.92	\$3,033.60	10.17	\$813.60	0.00	\$0.00	0.00	\$0.00	2.17	\$173.60	0.00	\$0.00	202.17	\$16,173.60	\$341.25
Oct-15	52.25	\$4,180.00	38.00	\$3,040.00	0.00	\$0.00	53.67	\$4,293.60	26.42	\$2,113.60	0.00	\$0.00	0.00	\$0.00	1.00	\$80.00	0.00	\$0.00	243.68	\$19,494.40	
	940.91	\$75,272.80	\$314.01	\$25,120.80	\$0.00	\$0.00	\$880.62	\$70,449.60	\$140.07	\$11,205.60	\$0.00	\$0.00	\$18.86	\$1,508.80	\$17.42	\$1,393.60	\$0.00	\$0.00	3,212.18	256,974.40	0.00 \$3,236.75

Consult	Consult	Consult					
Nov-14	46.67	\$3,733.60	22.50	\$1,800.00	2.25	\$180.00	
Dec-14	24.99	\$1,999.20	17.88	\$1,430.40	0.00	\$0.00	
Jan-15	39.09	\$3,127.20	26.03	\$2,082.40	0.50	\$40.00	
Feb-15	63.49	\$5,079.20	52.59	\$4,207.20	2.25	\$180.00	
Mar-15	88.58	\$7,086.40	61.05	\$4,884.00	0.00	\$0.00	
Apr-15	34.08	\$2,726.40	24.93	\$1,994.40	0.92	\$73.60	
May-15	21.00	\$1,680.00	20.34	\$1,627.20	1.00	\$80.00	
Jun-15	39.08	\$3,126.40	29.83	\$2,386.40	2.25	\$180.00	
Jul-15	41.45	\$3,316.00	31.16	\$2,492.80	2.97	\$237.60	
Aug-15	34.41	\$2,752.80	20.16	\$1,612.80	0.75	\$60.00	
Sep-15	42.84	\$3,427.20	30.33	\$2,426.40	2.58	\$206.40	
Oct-15	39.84	\$3,187.20	31.75	\$2,540.00	0.75	\$60.00	
	515.52	\$41,241.60	\$44,689.60	368.55	\$29,484.00	16.22	\$1,297.60
	1,770.44	\$141,635.20	\$111,139.20	1,389.24	\$111,139.20	52.50	\$4,200.00

706	\$75,272.80
7065	\$25,120.80
707	\$44,689.60
716	\$1,508.80
7161	\$1,393.60
717	\$1,297.60
755	\$70,449.60
756	\$11,205.60
757	\$29,484.00
	\$260,422.40
Cook	-\$3,448.00
	<u>\$256,974.40</u>

Cook	MelanieMDS	M. YoungDietician	Outcome	Activity/SS				
Nov-15	2.75	\$178.75	Nov-15	13.75	\$481.25	Nov-15	3.00	\$259.20
Dec-15	3.25	\$211.25	Nov-15	\$13.75	\$481.25	Dec-15	4.00	\$319.20
Jan-16	4.50	\$295.50	Jan-16	12.25	\$428.75	Jan-16	4.00	\$319.20
Feb-16	3.00	\$195.00	Feb-16	13.75	\$481.25	Feb-16	3.50	\$289.20
Mar-16	3.50	\$227.50	Mar-16	15.00	\$525.00	Mar-16	4.00	\$319.20
Apr-16	7.00	\$455.00	Apr-16	13.00	\$455.00	Apr-16	4.00	\$319.20
May-16	6.50	\$422.50	May-16	12.00	\$420.00	May-16	4.00	\$319.20
Jun-16	4.75	\$308.75	Jun-16	14.00	\$490.00	Jun-16	3.50	\$289.20
Jul-16	3.25	\$211.25	Jul-16	14.75	\$516.25	Jul-16	3.75	\$304.20
Aug-16	6.00	\$390.00	Aug-16	13.50	\$472.50	Aug-16	5.00	\$379.20
Sep-16	5.25	\$341.25	Sep-16	14.75	\$516.25	Sep-16	3.08	\$264.00
Oct-16	3.25	\$211.25	Oct-16	12.75	\$446.25	Oct-16	3.25	\$274.20
	53.00	\$3,448.00	0.00	\$2,000.00	163.25	\$5,713.75	45.08	\$3,655.20

Golden Good Shepherd
#0009175
11/01/15 to 10/31/16

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

Cynthia Cassens
2071 E. 220th St.
Camp Point, IL 62320

Lori Mortimer
2484 East 2800 St
Golden, IL 62339

Golden Good Shepherd
#0009175
11/01/15 to 10/31/16

Reclassifications

1 Reclassify \$100.00 from Line 20 to Line 28 due to coding error of Surety Bond.

2 Reclassify \$297.68 from nursing supplies to Seminar due to coding error.

3 Reclassify \$249.27 from seminars to business mileage due to coding error.

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

Golden Good Shepherd
 #0009175
 11/01/15 to 10/31/16

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$2,146.35
REPAIRS & MAINT LAUNDRY	\$0.00
REPAIRS & MAINT HSKING	\$0.00
OUTSIDE SERVICES	\$6,944.80
MOWING	\$4,270.00
SNOW REMOVAL	\$0.00
REPAIRS & MAINT BUILDINGS	\$203.00
REPAIRS & MAINT EQUIPMENT	\$9,086.92
REPAIRS & MAINT GROUNDS	\$0.00
MUZAK	\$0.00
CABLE TV	\$2,735.40
Alarm	\$1,623.30
REFUSE	\$5,613.80
EXTERMITATOR	\$2,222.77
REPAIRS & MAINT GEN/ADM	\$1,805.00
TOTAL	<u>\$36,651.34</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	<u>\$9,780.89</u>
TOTAL	<u>\$9,780.89</u>

Schedule V. Line 14, Column 2

Auto Exp. & Service	\$3,355.25
Auto Gas & Oil	<u>\$2,014.99</u>
	<u>\$5,370.24</u>

Schedule V. Line 43, Column3

Bad Debt	\$7,758.00
Contributions	\$0.00
Rounding	<u>\$0.00</u>
	<u>\$7,758.00</u>

Schedule V. Line 27, Column 3

Misc Expenses	\$2,940.12
Meals	\$0.00
Rounding	<u>\$0.00</u>
	<u>\$2,940.12</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	\$3,825.00
Management Fee	\$20,000.00
Dietary Supplements	\$3,204.30
Admissions	\$30.00
Activities Income	\$0.00
Uniform Sales	\$41.45
Education	\$142.49
Sales to employees	\$159.07
Personal Purchases	\$860.50
Rebates	\$481.09
Gain on sale of Asset	\$0.00
Discounts	\$0.00
Doors Program	\$0.00
Misc	\$1,109.05
Rounding	<u>-\$1.00</u>
	<u>\$29,851.95</u>

The following is a breakdown of Schedule XIX, Section F

Promotion/Public Relations	\$3,862.59
Adverstising	\$18,728.25
Elliot Publishers	\$24.00
Augusta Eagle	\$116.00
Brown County State Bank-Safe Deposit	\$10.00
Sec State Annual Fee	\$10.00
Quincy Herald Whig	\$160.00
Van Sticker	\$10.00
Nursing Home Admin License	\$102.50
AHT Software License	\$412.50
Rounding	<u>-\$1.00</u>
	<u>\$23,434.84</u>

Golden Good Shepherd
#0009175
11/01/15 to 10/31/16

Schedule V, Line 24 Column 3

2016 Conferences

Date	Location	Sponsor	Workshop	Attendees	Registration Cost	Mileage	Meals	Hotel	Parking/Taxi	
11/6/2015	Quincy IL	Fred Pryor Seminars	Dealing with Difficult People	Rampley	99.00	34.50				
11/6/2015	Quincy IL	Fred Pryor Seminars	Dealing with Difficult People	Watterkotte	99.00					
1/12-13/2016	Quincy IL	FEMA/ACHD	Emergency Management	Marlow	Free	32.40	13.10			
4/20/2016	Covington IN	Illiana Alzheimers Alliance	Alzheimer's Disease: Challenges & Choices	Marlow	80.00	225.72	84.17	102.52		
4/20/2016	Covington IN	Illiana Alzheimers Alliance	Alzheimer's Disease: Challenges & Choices	Wiewel	30.00					
4/20/2016	Covington IN	Illiana Alzheimers Alliance	Alzheimer's Disease: Challenges & Choices	Whitaker	30.00					
4/21-22/2016	Rock Island IL	IANFP	Spring Workshop	Eidson	75.00	135.00				
4/12/2016	Keokuk IL	Cent Effec Non Profits	Non PrOfit Leadership Academy	Marlow	85.00	44.28	9.95			
5/24/2016	Springfield, IL	HFS	Medicaid Fee for sevice billing	Rampley	Free	118.80				
6/8-9/2016	Bloomington, IL	INHAA	Administrators Conference	Marlow	95.00	131.76	36.00	99.68		
6/8-9/2016	Bloomington, IL	INHAA	Administrators Conference	Whitaker	95.00					
7/14/2016	Quincy IL	Quincy Sr Ctr	Mental Health First Aid	Marlow	Free					
8/4-5/2016	Peoria IL	INHAA	INHAA Fall Conference	Scogins	95.00	136.40	46.75	224.00		
8/10/2016	St. Louis MO	Pharmerica	Clinical Geriatric Symposium	Scogins	Free	181.50	15.90	128.95		
8/24/2016	Quincy IL	Fred Pryor Seminars	Making Transition from Staff to Supervisor	Scogins	99.00		20.00			
8/24/2016	Quincy IL	Fred Pryor Seminars	Making Transition from Staff to Supervisor	Zimmerman	99.00					
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Marlow	795.00	122.04	224.93	347.14	32.31	
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Whitaker						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Meador						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Rampley		122.04				
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Watterkotte		122.04	89.77		14.00	
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Stock						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Hiland		122.04				
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Laning						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Zimmerman		105.84		124.32	7.00	
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Cloutier						
9/13/15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Bartimus				113.12		
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Engel		105.84			7.00	
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Vertrees		105.84				
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Johnson						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Mowen						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Elderidge						
9/13-15/16	Peoria IL	IHCA	IHCA Convention/Trade Show	Henderson		105.84			7.00	
10/11/2016	Northbrook IL	Alzheimers Assoc	Annual Research Symposium	Marlow				167.63		
10/11/2016	Northbrook IL	Alzheimers Assoc	Annual Research Symposium	Whitaker						
10/11/2016	Quincy IL	Blessing Health System	Wound Conference	Engel	65.00	32.40				
Totals					1,841.00	1,984.28	540.57	1,307.36	67.31	5,740.52