

Facility Name & ID Number GOOD SAM - PROPHETS RIVERVIEW

0012955 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	70	Skilled (SNF)	70	25,550	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	70	TOTALS	70	25,550	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,834	6,172	1,543	15,549	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,834	6,172	1,543	15,549	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.86%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

OUTPATIENT THERAPY

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 09/20/1967

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 1,340

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number **GOOD SAM - PROPHETS RIVERVIEW** # **0012955** Report Period Beginning: **01/01/2017** Ending: **12/31/2017**

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	153,608	7,164	6,270	167,042		167,042	(73)	166,969		1
2	Food Purchase		111,289		111,289		111,289	(4,655)	106,634		2
3	Housekeeping	38,914	11,445		50,359		50,359	(141)	50,218		3
4	Laundry	41,231	9,648		50,879		50,879	(129)	50,750		4
5	Heat and Other Utilities			65,395	65,395		65,395	(5,820)	59,575		5
6	Maintenance	64,574	3,375	70,731	138,680		138,680	(11,845)	126,835		6
7	Other (specify):*			1,078	1,078		1,078	(333)	745		7
8	TOTAL General Services	298,327	142,921	143,474	584,722		584,722	(22,996)	561,726		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,152,806	129,404	32,450	1,314,660		1,314,660	(85,411)	1,229,249		10
10a	Therapy		2,090	367,281	369,371		369,371	(141,883)	227,488		10a
11	Activities	60,896	6,816	8,152	75,864		75,864	(90)	75,774		11
12	Social Services	39,696	59	1,275	41,030		41,030	(1)	41,029		12
13	CNA Training										13
14	Program Transportation			2,644	2,644		2,644		2,644		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,253,398	138,369	426,202	1,817,969		1,817,969	(227,385)	1,590,584		16
	C. General Administration										
17	Administrative	99,462		163,996	263,458		263,458	36,894	300,352		17
18	Directors Fees										18
19	Professional Services			5,741	5,741		5,741		5,741		19
20	Dues, Fees, Subscriptions & Promotions			30,417	30,417		30,417	(25,662)	4,755		20
21	Clerical & General Office Expenses	95,303	78,886	42,351	216,540		216,540	(2,138)	214,402		21
22	Employee Benefits & Payroll Taxes			398,407	398,407		398,407	2,630	401,037		22
23	Inservice Training & Education			5,252	5,252		5,252		5,252		23
24	Travel and Seminar			12,951	12,951		12,951	(6,383)	6,568		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,482	38,482		38,482	32,604	71,086		26
27	Other (specify):*	10,895		4	10,899		10,899	(10,915)	(16)		27
28	TOTAL General Administration	205,660	78,886	697,601	982,147		982,147	27,030	1,009,177		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,757,385	360,176	1,267,277	3,384,838		3,384,838	(223,351)	3,161,487		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 - PROPHETS RIVERVIEW**

#0012955

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			164,455	164,455		164,455	(12,470)	151,985			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90	90		90		90			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,989	17,989		17,989		17,989			35
36	Other (specify):*											36
37	TOTAL Ownership			182,534	182,534		182,534	(12,470)	170,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		55		55		55		55			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,225	163,225		163,225		163,225			42
43	Other (specify):*			15,486	15,486		15,486	(14,866)	620			43
44	TOTAL Special Cost Centers		55	178,711	178,766		178,766	(14,866)	163,900			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,757,385	360,231	1,628,522	3,746,138		3,746,138	(250,687)	3,495,451			45

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

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	(4,655)	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	1,145	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	(320,343)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (323,853)		\$	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)	73,166		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 73,166		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (250,687)		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

GOOD SAM - PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	See Attached Schedule	\$ (73)	1	1
2	See Attached Schedule	(141)	3	2
3	See Attached Schedule	(129)	4	3
4	See Attached Schedule	(5,820)	5	4
5	See Attached Schedule	(11,845)	6	5
6	See Attached Schedule	(333)	7	6
7	See Attached Schedule	(85,411)	10	7
8	See Attached Schedule	(141,883)	10a	8
9	See Attached Schedule	(90)	11	9
10	See Attached Schedule	(1)	12	10
11	See Attached Schedule	(25,662)	20	11
12	See Attached Schedule	(3,283)	21	12
13	See Attached Schedule	(1,038)	22	13
14	See Attached Schedule	(6,383)	24	14
15	See Attached Schedule	(10,915)	27	15
16	See Attached Schedule	(12,470)	30	16
17	See Attached Schedule	(14,866)	43	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	(320,343)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM - PROPHETS RIVERVIEW# 0012955

Report Period Beginning:

01/01/2017

Ending:

12/31/2017**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(73)	0	0	0	0	0	0	0	0	0	0	(73)	1
2	Food Purchase	(4,655)	0	0	0	0	0	0	0	0	0	0	(4,655)	2
3	Housekeeping	(141)	0	0	0	0	0	0	0	0	0	0	(141)	3
4	Laundry	(129)	0	0	0	0	0	0	0	0	0	0	(129)	4
5	Heat and Other Utilities	(5,820)	0	0	0	0	0	0	0	0	0	0	(5,820)	5
6	Maintenance	(11,845)	0	0	0	0	0	0	0	0	0	0	(11,845)	6
7	Other (specify):*	(333)	0	0	0	0	0	0	0	0	0	0	(333)	7
8	TOTAL General Services	(22,996)	0	0	0	0	0	0	0	0	0	0	(22,996)	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	(85,411)	0	0	0	0	0	0	0	0	0	0	(85,411)	10
10a	Therapy	(141,883)	0	0	0	0	0	0	0	0	0	0	(141,883)	10a
11	Activities	(90)	0	0	0	0	0	0	0	0	0	0	(90)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(227,385)	0	0	0	0	0	0	0	0	0	0	(227,385)	16
	C. General Administration													
17	Administrative	0	36,894	0	0	0	0	0	0	0	0	0	36,894	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	(25,662)	0	0	0	0	0	0	0	0	0	0	(25,662)	20
21	Clerical & General Office Expenses	(2,138)	0	0	0	0	0	0	0	0	0	0	(2,138)	21
22	Employee Benefits & Payroll Taxes	(1,038)	3,668	0	0	0	0	0	0	0	0	0	2,630	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,383)	0	0	0	0	0	0	0	0	0	0	(6,383)	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	32,604	0	0	0	0	0	0	0	0	0	32,604	26
27	Other (specify):*	(10,915)	0	0	0	0	0	0	0	0	0	0	(10,915)	27
28	TOTAL General Administration	(46,136)	73,166	0	27,030	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(296,517)	73,166	0	(223,351)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM - PROPHETS RIVERVIEW# 0012955

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(12,470)	0	0	0	0	0	0	0	0	0	0	(12,470) 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	(12,470)	0	0	0	0	0	0	0	0	0	0	(12,470) 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):*	(14,866)	0	0	0	0	0	0	0	0	0	0	(14,866) 43
44	TOTAL Special Cost Centers	(14,866)	0	0	0	0	0	0	0	0	0	0	(14,866) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(323,853)	73,166	0	(250,687) 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	17 Admin/Accounting	\$ 163,996	The Evangelical Lutheran Good Samaritan Society	100.00%	\$ 200,890	\$ 36,894	1
2	V	22 Workers Compensation	48,532	The Evangelical Lutheran Good Samaritan Society	100.00%	82,265	33,733	2
3	V	22 Unemployment	38,482	The Evangelical Lutheran Good Samaritan Society	100.00%		(38,482)	3
4	V	26 Insurance	(1,448)	The Evangelical Lutheran Good Samaritan Society	100.00%	31,156	32,604	4
5	V	22 Group Health Insurance	185,837	The Evangelical Lutheran Good Samaritan Society	100.00%	194,254	8,417	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		\$ 435,399			\$ 508,565	\$ * 73,166	14

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

Facility Name & ID Number **GOOD SAM - PROPHETS RIVERVIEW** # **0012955** Report Period Beginning: **01/01/2017** Ending: **12/31/2017**

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number GOOD SAM - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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

Facility Name & ID Number **GOOD SAM - PROPHETS RIVERVIEW**

0012955

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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		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.)

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 2016 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 2017 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:	2012	<u> </u>	8
	2013	<u> </u>	9
	2014	<u> </u>	10
	2015	<u> </u>	11
	2016	<u> </u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAM - PROPHETS RIVERVIEW COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0012955

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 2016 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 2016.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.**

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			1967	\$ 321,110	\$		\$	\$	\$ 321,110	4
5										5
6										6
7										7
8										8
Improvement Type**										
9			1973	669					669	9
10			1974	483					483	10
11			1975	33,671					33,671	11
12			1977	3,561					3,561	12
13			1978	2,854					2,854	13
14			1979	10,205					10,205	14
15			1980	1,654	9		9		1,637	15
16			1981	60,747	1,404		1,404		55,465	16
17			1982	10,416					10,416	17
18			1983	850					850	18
19			1984	8,091					8,091	19
20			1985	13,799					13,799	20
21			1986	2,284					2,284	21
22			1987	78,081					78,081	22
23			1988	36,635					36,635	23
24			1989	90,335					90,335	24
25			1990	792,851					792,851	25
26			1991	4,175					4,151	26
27			1992	24,997					24,997	27
28			1993	3,641					3,641	28
29			1994	41,429					41,429	29
30			1995	16,185					16,185	30
31			1996	38,094	240		240		36,871	31
32			1997	45,715	1,572		1,572		40,137	32
33			1998	20,967	320		320		20,760	33
34			1999	17,314	172		172		17,072	34
35			2000	14,454	48		48		14,335	35
36			2001	40,084	1,242		1,242		35,520	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 - PROPHETS RIVERVIEW

0012955

Report Period Beginning:

01/01/2017 Ending: 12/31/2017

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		2002	\$ 145,918	\$ 114		\$ 114	\$	\$ 145,277	37
38		2003	62,734	4,182		4,182		62,625	38
39		2004	68,785	361		361		66,463	39
40		2005	217,404	7,849		7,849		193,345	40
41		2006	206,296	9,974		9,974		155,036	41
42		2007	238,987	10,333		10,333		154,146	42
43		2008	71,789	2,682		2,682		61,815	43
44		2009	76,672	4,190		4,190		32,412	44
45		2010	93,459	5,660		5,660		50,976	45
46		2011	90,870	5,842		5,842		42,565	46
47		2012	45,921	4,362		4,362		22,623	47
48		2013	79,444	7,665		7,665		31,810	48
49	SHORETEL PHONE SYSTEM	2014	44,976	4,498	120	4,498		17,241	49
50	TECHNOFLOOR INSTALL PROJECT	2014	21,866	2,187	120	2,187		7,107	50
51	NURSE CALL LIGHT SYSTEM	2014	84,390	8,439	120	8,439		26,020	51
52	TRINITY BOILER INDUCER MOTOR	2015	1,440	144	120	144		384	52
53	BUILDING-100/200 SHOWER RM RMD	2015	16,899	676	300	676		1,746	53
54	TILE-100/200 SHOWER RM RMD	2015	9,053	453	240	453		1,169	54
55	PLBG-100/200 SHOWER RM RMD	2015	1,054	53	240	53		136	55
56	BLDG-INTERIOR WALL REPAIR/PAIN	2016	49,259	1,970	300	1,970		3,284	56
57	PAINT-INTER WALL REPAIR/PAIN	2016	16,075	3,215	60	3,215		5,358	57
58	BLDG-REMODEL DISHWASHING ROOM	2016	10,305	412	300	412		687	58
59	DOUBLE HUNG WINDOWS	2016	43,635	2,182	240	2,182		3,636	59
60	PUSH BUTTON DIGITAL ACCESS	2016	853	57	180	57		104	60
61	HEAT EXCHANGE- S 300 WING RTU	2016	3,800	507	90	507		971	61
62	RESIDENT RM BLINDS (37)	2016	1,416	283	60	283		472	62
63	WATER HEATER	2016	8,400	840	120	840		1,190	63
64	BLINDS-DINING ROOM ADDITION	2017	3,872	774	60	774		774	64
65	BUILDING-DINING ROOM ADDITION	2017	194,127	7,765	300	7,765		7,765	65
66	CABINETS-DINING ROOM ADDITION	2017	12,966	864	180	864		864	66
67	CARPET-DINING ROOM ADDITION	2017	13,900	2,780	60	2,780		2,780	67
68	DOORS-DINING ROOM ADDITION	2017	3,750	250	180	250		250	68
69	ELECTRIC-DINING ROOM ADDITION	2017	14,500	967	180	967		967	69
70	TOTAL (lines 4 thru 69)		\$ 3,690,165	\$ 107,536		\$ 107,536	\$	\$ 2,820,092	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 3,690,165	\$ 107,536		\$ 107,536	\$	\$ 2,820,092	1
2	INSULATION-DINING ROOM ADD	2017	9,310	466		466		466	2
3	PAINT-DINING ROOM ADD	2017	7,698	1,540		1,540		1,540	3
4	PLUMBING-DINING ROOM ADD	2017	1,500	75		75		75	4
5	ROOF-DINING ROOM ADD	2017	9,160	458		458		458	5
6	SPRINKLER-DINING ROOM ADD	2017	4,950	198		198		198	6
7	WINDOWS-DINING ROOM ADD	2017	5,000	333		333		333	7
8	PLUMBING REPAIRS	2016	2,940	392		392		523	8
9	WINDOWS(9)-OFFICE/BEAUTY SHOP	2015	4,365	291		291		582	9
10	CISCO 24 PORT SWITCH	2015	1,126	225		225		582	10
11	PAINT	2017	10,167	339		339		339	11
12	LANDSCAPING - MULCH	2015	6,047	605		605		1,663	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	TOTAL (lines 1 thru 33)		\$ 3,752,428	\$ 112,458		\$ 112,458	\$	\$ 2,826,851	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 178,424	\$ 18,075	\$ 18,075	\$		\$ 138,715	71
72	Current Year Purchases	182,246	20,183	20,183			20,183	72
73	Fully Depreciated Assets	502,644	1,271	1,271			502,644	73
74								74
75	TOTALS	\$ 863,314	\$ 39,529	\$ 39,529	\$		\$ 661,542	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	Nursing home	Older Assets	Many	\$ 52,835	\$	\$	\$	4	\$ 52,835	76
77	Nursing home	1995 Chrysler van	2008	3,000				3	3,000	77
78	Nursing home	2010 Ford Transport	2012	19,000				4	19,000	78
79	Nursing home	2006 Ford Van	2012	16,018				4	16,018	79
80	TOTALS			\$ 90,853	\$	\$	\$		\$ 90,853	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)	\$ 4,721,595	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,987	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)	\$ 3,579,246	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	\$	\$	\$	86
87	Building and Land Improvements	2,353,455	79,021	973,747	87
88	FFE	101,096	6,120	63,450	88
89					89
90					90
91	TOTALS	\$ 2,454,551	\$ 85,141	\$ 1,037,197	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.

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 17,989 Description: General & Admin/Nursing Equipment Rental Lease

(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	Line 10A, Col 3	hrs	\$	9,375	\$ 140,629	\$ 54	9,375	\$ 140,683	1
2	Licensed Speech and Language Development Therapist	Line 10A, Col 3	hrs		2,209	33,136		2,209	33,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10A, Col 3	hrs		12,596	188,937	2	12,596	188,939	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	24,180	\$ 362,702	\$ 56	24,180	\$ 362,758	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 **12/31/2017**

(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	\$ 52,703	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 76,190)	677,566		3
4	Supply Inventory (priced at)	22,917		4
5	Short-Term Investments	45,878		5
6	Prepaid Insurance	4,697		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,214		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 809,975	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	5,666,893		14
15	Leasehold Improvements, at Historical Cost	438,992		15
16	Equipment, at Historical Cost	1,055,263		16
17	Accumulated Depreciation (book methods)	(4,616,446)		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):	112,537		22
23	Other(specify):	166,754		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,838,993	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,648,968	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 209,512	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,955		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,153		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,154		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	<u>Security Deposits</u>	15,525		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 392,299	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Liabilities</u>	1,712,164		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,712,164	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,104,463	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,544,505	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,648,968	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,814,153	1
2	Restatements (describe):		2
3	Senior Living	(82,304)	3
4	Apartments	4,714	4
5	Audit Adjustment	38,642	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,775,205	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(303,055)	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)	\$ (303,055)	17
	B. Transfers (Itemize):		
18	Dnr restricted	(15,872)	18
19	SOA Accounts	88,227	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 72,355	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,544,505	24 *

* This must agree with page 17, line 47.

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,056,530	1
2	Discounts and Allowances for all Levels	(1,193,475)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,863,055	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	36,075	5
6	Therapy	1,194,112	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,230,187	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		13
14	Non-Patient Meals	4,689	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205,593	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,856	19
20	Radiology and X-Ray	6,015	20
21	Other Medical Services	15,260	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 238,413	23
D. Non-Operating Revenue			
24	Contributions	53,856	24
25	Interest and Other Investment Income***	8,441	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,297	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Nursing/Medical Supplies</u>	48,205	28
28a	<u>Misc Income/PY Settlements</u>	925	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 49,130	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,443,082	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	584,722	31
32	Health Care	1,817,968	32
33	General Administration	982,147	33
B. Capital Expense			
34	Ownership	182,534	34
C. Ancillary Expense			
35	Special Cost Centers	15,541	35
36	Provider Participation Fee	163,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,746,137	40
41	Income before Income Taxes (line 30 minus line 40)**	(303,055)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (303,055)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,098,164	44
45	Private Pay - Net Inpatient Revenue	1,178,878	45
46	Medicare - Net Inpatient Revenue	663,270	46
47	Other-(specify)	140,561	47
48	Other-(specify)	(1,217,818)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,863,055	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.

Facility Name & ID Number **GOOD SAM - PROPHETS RIVERVIEW**

0012955

Report Period Beginning: **01/01/2017**

Ending:

12/31/2017

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	1,690	1,916	\$ 57,321	\$ 29.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,742	14,054	403,384	28.70	3
4	Licensed Practical Nurses	4,721	5,499	138,540	25.19	4
5	CNAs & Orderlies	37,219	40,977	544,187	13.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,602	1,813	27,898	15.39	9
10	Activity Assistants	2,300	2,606	32,261	12.38	10
11	Social Service Workers	1,512	1,726	39,636	22.96	11
12	Dietician					12
13	Food Service Supervisor	1,578	1,724	22,664	13.15	13
14	Head Cook	4,594	5,133	62,432	12.16	14
15	Cook Helpers/Assistants	6,257	6,861	69,858	10.18	15
16	Dishwashers					16
17	Maintenance Workers	3,827	4,262	70,271	16.49	17
18	Housekeepers	3,614	3,969	40,026	10.08	18
19	Laundry	3,328	3,865	42,468	10.99	19
20	Administrator	2,055	2,381	92,661	38.92	20
21	Assistant Administrator					21
22	Other Administrative	3,841	4,407	97,582	22.14	22
23	Office Manager	1,452	1,557	23,669	15.20	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	1,107	1,379	20,267	14.70	31
32	Other Health Care(specify)					32
33	Other(specify)	512	564	10,895	19.32	33
34	TOTAL (lines 1 - 33)	93,951	104,693	\$ 1,796,020 *	\$ 17.16	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	118	\$ 4,996	Ln 1, Col 3	35
36	Medical Director		14,400	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	65	2,594	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	41	1,190	Ln 11, Col 3	44
45	Social Service Consultant	43	1,275	Ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	267	\$ 24,455		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	104	\$ 5,206	Ln 10, Col 3	50
51	Licensed Practical Nurses	398	15,915	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	166	4,972	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	668	\$ 26,093		53

Facility Name & ID Number GOOD SAM - PROPHETS RIVERVIEW

0012955

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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 \$3,264
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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? _____
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. \$ _____
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. \$ _____
- (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? 16%
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 LARSEN ALLEN
- (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