		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0009175

Facility Name: Golden Good Shepherd Home

Address: 101 Prairie Mills Road (Number) Golden (City) 62339 (Zip Code)

County: Adams

Telephone Number: 217-696-4421 **Fax #** 217-696-4393

HFS ID Number:

Date of Initial License for Current Owners: 12/09/63

Type of Ownership:

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

IRS Exemption Code 501 c 3

In the event there are further questions about this report, please contact:
Name: James G. Hull, C.P.A. **Telephone Number:** 217-228-1950
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/09 to 10/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) James G. Hull, C.P.A. — Vice President
(Firm Name & Address) WDM Computer Services, Inc. — 1900 Harrison, Quincy, IL 62301
(Telephone) 217-228-1950 **Fax #** 217-222-6053

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	42	TOTALS	42	15,330	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,242	1,687	1,086	5,015	8
9	SNF/PED					9
10	ICF	2,985	6,856		9,841	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,227	8,543	1,086	14,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.91%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 1,086

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 10/31/09 Fiscal Year: 10/31/09

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	126,133	5,275	6,344	137,752		137,752		137,752			1
2	Food Purchase		91,933		91,933		91,933	(3,564)	88,369			2
3	Housekeeping	66,493	12,993		79,486		79,486		79,486			3
4	Laundry	21,328	1,938	32,469	55,735		55,735		55,735			4
5	Heat and Other Utilities			39,653	39,653		39,653		39,653			5
6	Maintenance	30,130	9,832	32,599	72,561		72,561		72,561			6
7	Other (specify):*											7
8	TOTAL General Services	244,084	121,971	111,065	477,120		477,120	(3,564)	473,556			8
	B. Health Care and Programs											
9	Medical Director			1,875	1,875		1,875		1,875			9
10	Nursing and Medical Records	693,155	60,118	2,256	755,529		755,529	(408)	755,121			10
10a	Therapy	53,770	360	189,450	243,580		243,580		243,580			10a
11	Activities	90,140	8,170	1,908	100,218		100,218	(1,154)	99,064			11
12	Social Services	34,521	22	873	35,416		35,416		35,416			12
13	CNA Training											13
14	Program Transportation		5,378		5,378		5,378		5,378			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	871,586	74,048	196,362	1,141,996		1,141,996	(1,562)	1,140,434			16
	C. General Administration											
17	Administrative	52,340			52,340		52,340		52,340			17
18	Directors Fees											18
19	Professional Services			26,092	26,092		26,092		26,092			19
20	Dues, Fees, Subscriptions & Promotions			19,498	19,498		19,498	(11,596)	7,902			20
21	Clerical & General Office Expenses	56,806	11,390	7,337	75,533		75,533		75,533			21
22	Employee Benefits & Payroll Taxes			187,095	187,095		187,095		187,095			22
23	Inservice Training & Education			2,369	2,369		2,369		2,369			23
24	Travel and Seminar			1,896	1,896		1,896		1,896			24
25	Other Admin. Staff Transportation		1,220		1,220		1,220		1,220			25
26	Insurance-Prop.Liab.Malpractice			37,997	37,997		37,997		37,997			26
27	Other (specify):*							(1,363)	(1,363)			27
28	TOTAL General Administration	109,146	12,610	282,284	404,040		404,040	(12,959)	391,081			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,224,816	208,629	589,711	2,023,156		2,023,156	(18,085)	2,005,071			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: 11/01/09 Ending: 10/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			40,472	40,472		40,472	14	40,486			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(887)	(887)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,227	5,227		5,227		5,227			35
36	Other (specify):*											36
37	TOTAL Ownership			45,699	45,699		45,699	(873)	44,826			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,154		47,154		47,154		47,154			39
40	Barber and Beauty Shops			11,233	11,233		11,233		11,233			40
41	Coffee and Gift Shops		3,828		3,828		3,828		3,828			41
42	Provider Participation Fee			22,995	22,995		22,995		22,995			42
43	Other (specify):*			13,002	13,002		13,002	(11,638)	1,364			43
44	TOTAL Special Cost Centers		50,982	47,230	98,212		98,212	(11,638)	86,574			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,224,816	259,611	682,640	2,167,067		2,167,067	(30,596)	2,136,471			45

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,402)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(408)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14	30		9
10	Interest and Other Investment Income	(887)	32		10
11	Discounts, Allowances, Rebates & Refunds	(162)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,638)	43		24
25	Fund Raising, Advertising and Promotional	(11,596)	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	(2,017)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,596)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (30,596)		37

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

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

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

Golden Good Shepherd Home

ID# 0009175

Report Period Beginning: 11/01/09

Ending: 10/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activities Income	$ (1,154)	11	1
2	Misc Charges	(863)	27	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,017)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home **#** 0009175 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,564)	0	0	0	0	0	0	0	0	0	0	(3,564)	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**	(3,564)	0	0	0	0	0	0	0	0	0	0	(3,564)	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	(408)	0	0	0	0	0	0	0	0	0	0	(408)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,154)	0	0	0	0	0	0	0	0	0	0	(1,154)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,562)	0	0	0	0	0	0	0	0	0	0	(1,562)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,596)	0	0	0	0	0	0	0	0	0	0	(11,596)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,363)	0	0	0	0	0	0	0	0	0	0	(1,363)	27
28	**TOTAL General Administration**	(12,959)	0	0	0	0	0	0	0	0	0	0	(12,959)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,085)	0	0	0	0	0	0	0	0	0	0	(18,085)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golden Good Shepherd Home # 0009175 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	14	0	0	0	0	0	0	0	0	0	0	14	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(887)	0	0	0	0	0	0	0	0	0	0	(887)	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**	(873)	0	0	0	0	0	0	0	0	0	0	(873)	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):*	(11,638)	0	0	0	0	0	0	0	0	0	0	(11,638)	43
44	**TOTAL Special Cost Centers**	(11,638)	0	0	0	0	0	0	0	0	0	0	(11,638)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,596)	0	0	0	0	0	0	0	0	0	0	(30,596)	45

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 11/01/09 Ending: 10/31/10

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).

COTTAGES - PRIVATE PAY RESIDENTIAL FACILITIES

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	475,705		$ 37,727	1
2					2
3	TOTALS	475,705		$ 37,727	3

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1963	1963	$ 163,629	$ 3,273	50	$ 3,273	$	$ 153,811	4
5			1988	1988	208,384	5,210	40	5,210		115,479	5
6			1989	1989	84,694	2,117	40	2,117		45,700	6
7											7
8											8
	Improvement Type**										
9	Building Addidtion			1967	5,285		20			5,285	9
10	Building Addidtion			1973	25,841		20			25,841	10
11	Sprinkler System			1975	30,963		20			30,963	11
12	Building Addidtion			1975	18,103		20			18,103	12
13	Building Addidtion			1975	1,313		20			1,313	13
14	Building Addidtion			1976	15,380		20			15,380	14
15	Building Addidtion			1977	3,981		15			3,981	15
16	Doors			1978	900		20			900	16
17	Building Addidtion			180	3,165		15			3,165	17
18	Parking Lot			185	7,475		15			7,475	18
19	Building Addidtion			1983	4,174		15			4,174	19
20	Garage			1986	6,473		15			6,473	20
21	Landscaping			1988	620		10			620	21
22	Asphalt			1989	950		15			950	22
23	Building Addidtion			1990	655	27	20	33	6	652	23
24	Sprinkler System			1992	43,248	1,730	25	1,730		31,860	24
25	Floor & Foundation Improvements			1997	9,800	251	39	251		3,496	25
26	Parking Lot Expansion			1997	16,320	418	39	418		5,579	26
27	Owygen Room Venting			1998	2,880	72	40	72		913	27
28	Backflow Valve			1998	959	39	25	38	(1)	465	28
29	Laundry Door			1998	3,555	237	15	237		2,844	29
30	Backflow Preventor			1999	3,128	157	20	156	(1)	1,817	30
31	Ceiling			1999	4,657	233	20	233		2,580	31
32	Kitchen Floor			2000	1,167	19	10	30	11	1,157	32
33	New Roof Nursing Home			2001	38,956	999	39	999		9,156	33
34	Concrete Activity Room Entrance			2003	4,975	332	15	332		2,487	34
35	Remodel Kitchen			2004	5,085	341	15	339	(2)	2,270	35
36	Concrete Correction			2007	6,500	432	15	433	1	1,679	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: 11/01/09 Ending: 10/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire suppression System	2007	$ 2,369	$ 237	10	$ 237	$	$ 888	37
38	New Doors	2007	1,584	106	15	106		378	38
39	Parking lot Improvements	2007	6,868	458	15	458		1,412	39
40	Sprinkler	2010	107,879	2,517	25	2,517		2,517	40
41	Nurse Call System	2010	58,134	484	20	484		484	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 900,049	$ 19,689		$ 19,703	$ 14	$ 512,247	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: 11/01/09 Ending: 10/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 216,163	$ 17,941	$ 17,941	$	9	$ 125,909	71
72	Current Year Purchases	41,325	1,842	1,842		9	1,842	72
73	Fully Depreciated Assets	302,466				9	302,152	73
74								74
75	TOTALS	$ 559,954	$ 19,783	$ 19,783	$		$ 429,903	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	95 Ford Bus	2006	$ 5,000	$ 1,000	$ 1,000	$	5	$ 4,083	76
77										77
78										78
79										79
80	TOTALS			$ 5,000	$ 1,000	$ 1,000	$		$ 4,083	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,502,730	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,472	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,486	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 946,233	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 & Med Clinic	$ 465,949	$ 11,669	$ 289,551	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 465,949	$ 11,669	$ 289,551	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: 11/01/09 Ending: 10/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,227 Description: Oxygen $2597.75, Copier $2579.46, Carpet Shampooer $49.79
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	792	$ 63,320	$	792	$ 63,320	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		146	11,640		146	11,640	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,356	108,500		1,356	108,500	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				47,154		47,154	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	2,293	$ 183,460	$ 47,154	2,293	$ 230,614	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 57,081	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	256,845		3
4	Supply Inventory (priced at FIFO)	4,000		4
5	Short-Term Investments	100,220		5
6	Prepaid Insurance	12,515		6
7	Other Prepaid Expenses	619		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 431,280	$	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	1,300,922		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	630,029		16
17	Accumulated Depreciation (book methods)	(1,235,784)		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): Rounding	1		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 940,946	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,372,226	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 86,903	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,224		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,508		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,520		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 153,155	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 153,155	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,219,071	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,372,226	$	48

***(See instructions.)**

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,244,436	1
2	Restatements (describe):		2
3	Prior Year Adjustment	363	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,244,799	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(34,115)	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) Cottage/Med Clinic	8,387	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (25,728)	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)**	$ 1,219,071	24 *

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,024,744	1
2	Discounts and Allowances for all Levels	(34,824)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,989,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,706	6
7	Oxygen	149	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,855	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	3,501	12
13	Barber and Beauty Care	10,792	13
14	Non-Patient Meals	3,402	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275	17
18	Sale of Supplies to Non-Patients	408	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,977	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 22,355	23
	D. Non-Operating Revenue		
24	Contributions	65,368	24
25	Interest and Other Investment Income***	887	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66,255	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See List Attached	9,567	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,567	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,132,952	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	477,120	31
32	Health Care	1,141,996	32
33	General Administration	404,040	33
	B. Capital Expense		
34	Ownership	45,699	34
	C. Ancillary Expense		
35	Special Cost Centers	75,217	35
36	Provider Participation Fee	22,995	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,167,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	(34,115)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (34,115)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,132	$ 50,204	$ 23.55	1
2	Assistant Director of Nursing	1,141	1,220	28,390	23.27	2
3	Registered Nurses	1,275	1,299	26,791	20.62	3
4	Licensed Practical Nurses	10,482	11,293	192,612	17.06	4
5	CNAs & Orderlies	28,902	30,675	346,983	11.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,406	3,687	53,770	14.58	8
9	Activity Director	1,778	1,994	22,715	11.39	9
10	Activity Assistants	6,181	6,976	67,425	9.67	10
11	Social Service Workers	2,822	3,095	34,521	11.15	11
12	Dietician					12
13	Food Service Supervisor	1,753	1,884	20,358	10.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,654	9,278	84,279	9.08	15
16	Dishwashers	2,399	2,470	21,496	8.70	16
17	Maintenance Workers	1,933	2,051	30,130	14.69	17
18	Housekeepers	7,051	7,524	66,493	8.84	18
19	Laundry	2,421	2,547	21,328	8.37	19
20	Administrator	1,914	2,074	52,340	25.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,603	3,898	56,806	14.57	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	761	791	8,220	10.39	31
32	Other Health Ca Care Plan Coord	1,931	2,131	39,955	18.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,399	97,019	$ 1,224,816 *	$ 12.62	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	181	$ 6,344	1-3	35
36	Medical Director	Contract	1,875	9-3	36
37	Medical Records Consultant	16	1,760	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	59	3,851	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,908	11-3	44
45	Social Service Consultant	10	873	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	287	$ 16,611		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8	75	10-3	52
53	TOTAL (lines 50 - 52)	8	$ 75		53

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Marlow	Administrator	0	$ 52,340
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,340

B. Administrative - Other

Description	Amount
n/a	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Accucare	Software Support	$ 5,160
Ivans	Billing Services	696
WDM Computer Services	Data Processing	20,048
Go Daddy	Web Site Maint	188
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,381
Unemployment Compensation Insurance	5,496
FICA Taxes	93,492
Employee Health Insurance	4,306
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	6,420
TOTAL (agree to Schedule V, line 22, col.8)	$ 187,095

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

Description	Line #	Amount
n/a		$ 0
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	2,033
Health Care Worker Background Check	1,210
(Indicate # of checks performed 27)	
Patient Background Checks 11	
Il Sec of State	10
Promo/Public Relations	7,228
See Attached	3,320
Drug Testing	333
Rounding	1
Less: Public Relations Expense	(7,228)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,902

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,896
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,896

**See instructions.

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/09 Ending: 10/31/10

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 **Report Period Beginning:** 11/01/09 **Ending:** 10/31/10

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 $1,983.96**

(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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,282** 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. $ **22,995**
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. $ **3,402**

(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. $ **0**
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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/a**
Attach invoices and a summary of services for all architect and appraisal fees.

Golden Good Shepherd
#0009175
11/01/08 to 10/31/09

Board Members

Kenneth Miller
308 Prairie Mills Road
Golden, IL 62339

Kent Flesner
2425 East 2100th Street
Camp Point, IL 62320

Larry Gronewold
2561 Highway 94 North
Golden, IL 62339

Merlin Flesner
702 Hanna Street
Golden, IL 62339

Harlan Passley
RR1, Box 53
LaPrairie, IL 62346

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

Gerald Buss
507 Main Street
Golden, IL 62339

Golden Good Shepherd
#0009175
11/01/08 to 10/31/09

Reclasssifications

1 Reclassify $

2 Reclassify $

3 Reclassify $

4 Reclassify $

5 Reclassify $

6 Reclassify $

Golden Good Shepherd
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11/01/08 to 10/31/09

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	$1,261.68
REPAIRS & MAINT LAUNDRY	$0.00
REPAIRS & MAINT HSKING	$0.00
OUTSIDE SERVICES	$10,980.94
MOWING	$3,530.00
SNOW REMOVAL	$2,035.00
REPAIRS & MAINT BUILDINGS	$1,274.97
REPAIRS & MAINT EQUIPMENT	$2,162.23
REPAIRS & MAINT GROUNDS	$150.89
MUZAK	$0.00
CABLE TV	$3,191.21
Alarm	$467.50
REFUSE	$6,229.00
EXTERMITATOR	$1,315.50
REPAIRS & MAINT GEN/ADM	$0.00
TOTAL	$32,598.92

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	$7,336.99
TOTAL	$7,336.99

Schedule V. Line 14 ,Column 2

Auto Exp. & Service	$3,283.84
Auto Gas & Oil	$2,094.86
	$5,378.70

Schedule V. Line 43, Column3

Misc. Exp.	$862.91
Bad Debt	$11,638.36
Contributions	$500.00
Rounding	$1.00
	$13,002.27

Schedule XX. Question 12

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

Schedule XVII, Line 28a, Column 1

Management Fee	$0.00
Admissions	$0.00
Dietary Suppliments	$1,455.40
Activities Income	$1,153.91
Personal Purchases	$2,851.52
Rebates	$162.18
Transportation	$1,433.00
Discounts	$0.00
Doors Program	$0.00
Misc	$2,510.75
Rounding	$0.00
	$9,566.76

The following is a breakdown of Schedule XIX, Section F

Sam's Club Membership	$35.00
INHAA	$100.00
NNHA	$139.35
AAHSA	$544.65
LSN Dues	$1,983.96
Quincy Chamber of Commerce	$181.00
Subscriptions	$336.18
	$3,320.14

	Pvt Skilled	Pvt Int.	PA Skilled	PA Int.	Medicare	Total
Nov	205	511	232	193	41	1182
Dec	212	527	216	217	70	1242
Jan	205	552	193	217	119	1286
Feb	167	556	141	196	93	1153
Mar	140	580	186	248	119	1273
Apr	90	557	209	236	119	1211
May	98	585	208	248	107	1246
Jun	110	563	180	240	95	1188
Jul	155	615	186	248	62	1266
Aug	144	627	186	276	57	1290
Sep	72	594	150	334	87	1237
Oct	89	589	155	332	117	1282
	1687	6856	2242	2985	1086	14856

Golden Good Shepherd

#0009175

11/01/08 to 10/31/09

Schedule V, Line 24 Column 3

Date	Seminar	Location	ho	Attende	Regist.	Mileage/ Auto Exp.	Meals	Hotel	CEU's	Total

Golden Good Shepherd
#0009175
11/01/08 to 10/31/09

Schedule V, Line 23 Column 3

American Red Cross	11/19/2009	$118.00	CPR Class
LSN	6/9/2010	$1,000.00	MDS 3.0 Implementation Webinar
Multimedia Sales	2/22/2010	$720.00	Elder Awareness Webinar
Multimedia Sales	5/31/2010	$406.00	Elder Awareness Webinar
Joy Manuel	9/29/2010	$124.70	CNA Recertification
		$2,368.70	